Legal Aspects of Mental Capacity

To Austin

Legal Aspects of Mental Capacity

A practical guide for health and social care professionals

SECOND EDITION

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WILEY Blackwell

This edition first published 2016 © 2008, 2016 by John Wiley & Sons, Ltd
First edition published 2008 by Blackwell Publishing, Ltd

Registered Office
John Wiley & Sons, Ltd, The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK

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Library of Congress Cataloging-in-Publication Data

Names: Dimond, Bridgit, author.
Title: Legal aspects of mental capacity : a practical guide for health and social care professionals / Bridgit Dimond.
Description: Second edition. | Chichester, West Sussex ; Hoboken, NJ : John Wiley & Sons, Inc., 2016. | Includes bibliographical references and index.
Identifiers: LCCN 2016002291 (print) | LCCN 2016002972 (ebook) | ISBN 9781119045342 (paperback) | ISBN 9781119045359 (pdf) | ISBN 9781119045366 (epub)
Subjects: | MESH: Great Britain. Mental Capacity Act 2005. | Mental Competency–legislation & jurisprudence | Informed Consent–legislation & jurisprudence | Great Britain
Classification: LCC KD737 (print) | LCC KD737 (ebook) | NLM W 32.5 FA1 | DDC 344.4104/4–dc23
LC record available at http://lccn.loc.gov/2016002291

A catalogue record for this book is available from the British Library.

Wiley also publishes its books in a variety of electronic formats. Some content that appears in print may not be available in electronic books.

Cover image: Getty/shuoshu

Set in 8.5/12pt Meridien by SPi Global, Pondicherry, India

1 2016

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Preface

The numbers of adults who are incapable of making their own decisions will never be known exactly but there are probably over 2 million. The number thought to be suffering from dementia is probably over 700 000, and this number is likely to rise as life expectancy increases. Mental incapacity covers a variety of conditions. Some may never have had capacity such as those with severe learning disabilities or who have been born with serious brain damage. Others may lose their capacity through deterioration and diseases such as Alzheimer's or through trauma such as road accidents. Some may suffer impairment temporarily, and others lose mental capacity never to recover it. As a consequence significant decisions must be made on behalf of such diverse persons and for varying lengths of time. Such persons must be protected from exploitation and abuse. They are entitled to receive a good quality of life.

Legislation to provide a framework for the protection of mentally incapacitated and vulnerable adults and for decisions to be taken on their behalf has been in the pipeline for over 15 years. In the absence of statutory provision, the courts have had to fill the gaps and the common law (judge made law) has laid down the principles on when and how decisions are to be taken on behalf of such persons. The Mental Capacity Act 2005 was thus long awaited and its effects are being felt across all fields of health and social care. All health and social services professionals are finding that the Act and Regulations made under it affect their work and the decisions they make. It is the intention of this book to assist practitioners in understanding the basic provisions of the Act and how it applies to their professional responsibilities. It is also intended to be of assistance to the many carers who are forced into or find themselves in the position of having to make decisions on behalf of mentally incapable relatives and friends. It has been decided not to include the full text of the Act as an appendix as originally planned, since all the legislation including the statutory instruments can be easily downloaded free of charge from the Internet and references are given accordingly. Similarly the Code of Practice on both the Mental Capacity Act and the supplement on Deprivation of Liberty Safeguards can be downloaded from the Ministry of Justice website.

A basic guide to the statutory provisions is set out in the first chapter. Each chapter setting out the basic provisions includes a series of scenarios dealing with practical concerns, which are discussed in the light of the new legislation. The aim of these scenarios is to show how the many facets of the Act and the regulations apply. Earlier cases are cited to illustrate how the new statutory provisions are likely to change or continue existing practice. In addition an extensive glossary and list of abbreviations are included to assist the reader who is not conversant with the law and its terminology. A list of useful websites is included for further information to be accessed. There is also a chapter dealing with some of the differences in Wales which sets out briefly the situation in Scotland and Northern Ireland. Scotland has its own Adults with Incapacity Act 2000, which came into force during the drafting of the provisions for the rest of the United Kingdom and undoubtedly had a strong influence on these. Northern Ireland is in the process of enacting a Mental Capacity Bill. Unfortunately space does not permit full coverage of these provisions. They each deserve a book in their own right.

The aim of the book is to make the law clearer and more understandable to the health and social services professional and to the informal carers. Inevitably as the Act is implemented, disputes over interpretation and application arise, which in turn has led to a body of case law on its interpretation. In the case of Deprivation of Liberty Safeguards, there is likely to be new legislation to overcome what have been seen as *labyrinthine provisions*. This work is aimed at providing a useful foundation for an understanding of the law protecting those adults who lack mental capacity to make specific decisions, and due to the speed of changes in this area, a website linked to the book is available at www.blackwellpublishing.com/dimond to highlight major developments.

In writing this book, I have had my nephew, a registered nurse for those with learning disabilities, very much in mind, and it is to him that this book is dedicated.

Acknowledgements

In addition to those whose help I acknowledged in the first edition, namely, Tessa Shellens and her colleagues, Penny Llewellyn, Gareth Barclay, Susan Elsmore, Peter Lawler, Dave Tomlin, Hugh Davies and Austin Dorrity, I would also like to thank Sian Catt, John Harvey, and Robert Jenkins. The copyright of The Stationery Office for Statutes and Statutory Instruments and of the various publishers for law reports is also acknowledged as is the permission from 39 Essex Street Chambers to quote their comments on the Cheshire West Supreme Court decision.

I also wish to put on record my indebtedness to my family for their unceasing encouragement and in particular to Bette for her painstaking indexing of cases, statutes, and contents and her invaluable and constant support.

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Glossary

Advance decision: When someone who has mental capacity (is able to make and understand a decision) decides that they do not want a particular type of treatment if they lack capacity in the future. A doctor must respect this decision if it is valid and applicable. An advance decision must be about treatment a person wants to refuse and when that person wants to refuse it.

Advocacy: Independent help and support with understanding issues and putting forward a person's own views, feelings, and ideas.

Age assessment: An assessment, for the purpose of the deprivation of liberty safeguards, of whether the relevant person has reached age 18.

Appeal: When there is disagreement with a decision that has been made in court and an application is made for the case to be looked at again.

Application to register: Form that a *donor* or their *attorney* fill in to say that they want a *lasting power of attorney* to begin.

Approved mental health professional: A social worker or other professional approved by a local social services authority to act on behalf of a local social services authority in carrying out a variety of functions under mental health legislation.

Assessor: A person who carries out a deprivation of liberty safeguards assessment.

Asset: Something that a person owns.

Attorney: (also known as *donee*) Someone who has the *legal* right to make choices and decisions on behalf of someone else (the *donor*). The donor chooses who their attorney will be. Also known as donee or holder of the power of attorney.

Attorney's authority: What a *donor* says in their *lasting power of attorney* that an *attorney* can do (including any restrictions or conditions provided on their authority).

Best interests: Anything done for people without *capacity* must be in their best interests (there is no legal definition of best interests but the criteria to be used are in Section 4 of the Mental Capacity Act 2005). Best interests means thinking about what is best for the person, not about what anyone else wants. (An advance decision or instructions in a lasting power of attorney may require decisions which are not in P's best interests.)

Best interests assessment: An assessment, for the purpose of the deprivation of liberty safeguards, of whether deprivation of liberty is in a detained person's best interests, is necessary to prevent harm to the person, and is a proportionate response to the likelihood and seriousness of that harm.

Bolam test: The test laid down by McNair J in the case of *Bolam v. Friern HMC* on the standard of care expected of a professional in cases of alleged *negligence*.

Bournewood case: A case where the European Court of Human Rights held that UK law was in breach of Article 5. Bournewood judgment. The commonly used term for the October 2004 judgment by the European Court of Human Rights in the case of *HL v the United Kingdom* that led to the introduction of the **deprivation of liberty safeguards:**.

Bournewood safeguards: Legal provisions made to fill the gap revealed by the Bournewood case. Known as **deprivation of liberty safeguards**.

Burden of proof: The duty of a party to litigation to establish the facts, or in criminal proceedings the duty of the prosecution to establish both the *actus reus* and the *mens rea* of the offence.

Capacity: The mental ability to make decisions about a particular matter at a particular time (the legal definition of people who lack capacity is in Section 2 of the Mental Capacity Act 2005).

Care home: A care facility registered with and inspected by the Care Quality Commission.

Care Quality Commission: The regulator for health and adult social care that took over regulation of health and adult social care from April 1, 2009.

Carer: Someone who provides unpaid care by looking after a friend or neighbor who needs support because of sickness, age, or disability. Not usually a paid care worker.

Case citation: Each case is reported in an official series of cases according to the following symbols: *Re F* (i.e., in the matter of F) or *F v. West Berkshire Health Authority* [1989] 2 All ER 545 which means the year 1989, volume 2 of the All England Law Reports, page 545. Each case can be cited by means of this reference system. In the case of *Whitehouse v. Jordan*, Whitehouse is the claimant and Jordan the defendant and "v." stands for versus, that is, against. Other law reports include: AC, Appeals Court; QB, Queens Bench Division; and WLR, Weekly Law Reports. Most cases are now accessible from the bailli website (www.bailii.org/) and use the citation of EWHC (England and Wales High Court) or EWCA Civ (England and Wales Court of Appeal Civil proceedings) or UKSC (United Kingdom Supreme Court) with the year and page number. Thus the Chester case can be found at [2014] UKSC 19.

Case conference: A meeting to talk about a person's care or support.

Certificate provider: An independent person who completes a Part C certificate to say that the *donor* understands the *lasting power of attorney* form and is not under pressure to make it.

Citizens Advice Bureau: Provides free information and helps people sort out their legal or money problems (www.citizensadvice.org.uk).

Civil action: Proceedings brought in the civil courts.

Civil partnership: A relationship between two people of the same sex which, when registered, gives certain *legal* rights and responsibilities (the legal definition of civil partnership is in Section 1 of the Civil Partnership Act 2004).

Civil wrong: An act or omission which can be pursued in the civil courts by the person who has suffered the wrong (see *tort*).

Claimant: The person bringing a civil action (originally *plaintiff*).

Code of Practice: Separate, detailed statutory guidance on the Mental Capacity Act 2005.

Conditions: Requirements that a supervisory body may impose when giving a standard deprivation of liberty authorization, after taking account of any recommendations made by the best interests assessor.

Common law: Law derived from the decisions of judges, case law, judge made law.

Condition to an LPA: Tells an *attorney* to act in a particular way.

Consent: Agreeing to a course of action such as a care plan or treatment regime. For consent to be legally valid, the person giving it must have the capacity to take the decision, have been given sufficient information to make the decision, and not have been under any duress or inappropriate pressure.

Court of Protection: Specialist court for all issues relating to people who lack capacity (the Court of Protection is established under Section 45 of the *Mental Capacity Act 2005*).

Court of Protection visitor: Someone who is appointed to report to the *Court of Protection* on a particular matter, for example, checking on *attorneys*. (Court of Protection visitors are established under Section 61 of the Mental Capacity Act 2005.)

Criminal courts: Courts such as magistrates and crown courts hearing criminal cases.

Criminal wrong: An act or omission which constitutes an offence and can be pursued in the criminal courts by prosecution.

Customary occasion: An occasion, for example, a birthday, on which presents are usually given.

Declaration: A ruling by the court, setting out the legal situation.

Deed of revocation: Used to cancel *enduring powers of attorney* or *ordinary powers of attorney*.

Department for Constitutional Affairs: The Government department which had responsibility for upholding justice, rights, and democracy. The department also had responsibility for policy on LPAs. Now replaced by the Ministry of Justice (www.justice.gov.uk).

Deprivation of liberty: Is a term used in the European Convention on Human Rights about circumstances when a person's freedom is taken away. Its meaning in practice is being defined through case law in particular the Supreme Court decision in *P (by his litigation friend the Official Solicitor) v Cheshire West and Chester Council & Anor* [2014] UKSC 19.

Deprivation of liberty safeguards: The framework of safeguards under the Mental Capacity Act 2005 for people who need to be deprived of their liberty in a hospital or care home in their best interests for care or treatment and who lack the capacity to consent to the arrangements made for their care or treatment.

Deprivation of liberty safeguards assessment: Any one of the six assessments that need to be undertaken as part of the standard deprivation of liberty authorization process.

Deputy: Someone appointed by the *Court of Protection* to make decisions for a person who lacks capacity.

Distinguished (of cases): The rules of precedent require judges to follow decisions of judges in previous cases, where these are binding upon them. However in some circumstances it is possible to come to a different decision because the facts of the earlier case are not comparable to the case now being heard, and therefore the earlier decision can be *distinguished*.

Donor: Person who makes a *lasting power of attorney*.

Donee: A person appointed under a *lasting power of attorney* who has the legal right to make decisions within the scope of their authority on behalf of the person (the **donor:**) who made the lasting power of attorney.

Eligibility assessment: An assessment, for the purpose of the deprivation of liberty safeguards, of whether or not a person is rendered ineligible for a standard deprivation of liberty authorization because the authorization would conflict with requirements that are, or could be, placed on the person under the Mental Health Act 1983.

Enduring power of attorney: Is created under the Enduring Powers of Attorney Act 1985 and deals only with property and affairs. It has not been possible to create any new EPA since October 2007.

European Convention on Human Rights: A convention drawn up within the Council of Europe setting out a number of civil and political rights and freedoms, and setting up a mechanism for the enforcement of the obligations entered into by contracting states.

European Court of Human Rights: The court to which any contracting state or individual can apply when they believe that there has been a violation of the European Convention on Human Rights.

***F (Re)* ruling:** The House of Lords held that a professional who acts in the best interests of an incompetent person who is incapable of giving consent does not act unlawfully if he follows the accepted standard of care according to the *Bolam test*.

Fee: Money that a person has to pay for something.

Good faith: When a person acts in good faith, they act honestly, fairly and without any intention of taking unfair advantage.

Guardianship under the Mental Health Act 1983: The appointment of a guardian to help and supervise patients in the community for their own welfare or to protect other people. The guardian may be either a local authority or a private individual approved by the local authority.

Independent advocate: A person who speaks up for someone else. The advocate will be independent of the person making a decision.

Independent mental capacity advocate: An advocate appointed under the Mental Capacity Act 2005 to provide support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them (this is not necessary when the IMCA is appointed for the protection of the adult). The IMCA service was established by the Mental Capacity Act 2005.

Independent report: A report written by somebody who is not linked to the case.

Informal: Of a patient who has entered hospital without any statutory requirements.

Joint attorneys: When a *donor* appoints more than one *attorney* and they are *joint attorneys*, they must always act together, for example, all of them must sign every check made out.

Joint and several attorneys: When a *donor* appoints more than one *attorney* and they are *joint and several attorneys* they can act together and they can act independently of each other.

Judicial review: An application to the High Court for a judicial or administrative decision to be reviewed and an appropriate order made, for example, declaration.

Lack capacity: Not being able to make or understand a particular decision or choice at a particular time.

Lasting power of attorney: Where a person (the donor) gives the other person (the attorney or donee) the right to make decisions about property, money, or their well-being on their behalf in the future. A lasting power of attorney (LPA) is created under the Mental Capacity Act 2005.

Law of agency: Law which applies when one person acts as an agent for another person, like an attorney does for a donor.

Least restrictive intervention: Anything done for people without *capacity* should have regard to the least restriction of their basic rights and freedoms.

Legal: To do with the law.

Legal aid and help: Financial assistance and help with going to court.

Legal profession: People who work with the law, such as solicitors and barristers.

Legal representation: Having someone who works with the law, like a solicitor, to tell a court your views.

Life-sustaining treatment: Treatment that, in the view of the person providing health care, is needed to keep a person alive.

Litigation friend: Needed when someone does not have capacity to tell a solicitor they want to go to court. It could be a relative or a friend or, when there is no one else appropriate, the Official Solicitor who then tells the solicitor what is wanted.

Local authority: In the deprivation of liberty safeguards context, the local council responsible for social services in any particular area of the country.

Magistrate: A person (see *JP and stipendiary*) who hears summary (minor) offences or indictable offences which can be heard in the magistrates' court.

Main code: The Code of Practice for the Mental Capacity Act 2005.

Managing authority: The person or body with management responsibility for the hospital or care home in which a person is, or may become, deprived of their liberty.

Maximum authorization period: The maximum period for which a supervisory body may give a standard deprivation of liberty authorization, which must not exceed the period recommended by the best interests assessor, and which cannot be for more than 12 months.

Mediation: Helping people come to an agreement.

Mediator: A person who helps people come to an agreement.

Mens rea: The mental element in a crime (contrasted with *actus reus*).

Mental Capacity Act 2005: An Act of Parliament which makes the law about how to support and protect people who cannot make their own decisions. The Act makes it clear who can take decisions, in which situations, and how they should go about this. It lets people plan ahead for a time when they may lack capacity to make their own decisions about some things. It also creates new powers such as *lasting powers of attorney and deputies of the Court of Protection* and covers other issues to do with people who lack *capacity*.

Mental capacity assessment: An assessment, for the purpose of the **deprivation of liberty safeguards:**, of whether a person lacks capacity in relation to the question of whether or not they should be accommodated in the relevant hospital or care home for the purpose of being given care or treatment.

Mental disorder: Any disorder or disability of the mind, apart from dependence on alcohol or drugs as defined in the Mental Health Act 1983 as amended by the Mental Health Act 2007.

Mental Health Act 1983: Legislation mainly about the compulsory care and treatment of patients with mental health problems. It covers detention in hospital for mental health treatment, supervised community treatment, and guardianship.

Mental health assessment: An assessment, for the purpose of the deprivation of liberty safeguards, of whether a person has a mental disorder.

Named person/named people: People a *donor* chooses to be notified when the *application to register* is made.

Negligence (1): A breach by the defendant of a legal duty to take reasonable care not to injure the claimant or cause him loss.

Negligence (2): The attitude of mind of a person committing a civil wrong as opposed to intentionally.

No refusals assessment: An assessment, for the purpose of the **deprivation of liberty safeguards**, of whether there is any other existing authority for decision making for the relevant person that would prevent the giving of a standard deprivation of liberty authorization. This might include any valid advance decision, or valid decision by a deputy or donee appointed under a lasting power of attorney.

Office of the Public Guardian/OPG: Will help the Public Guardian carry out his duties. It will keep a register of *lasting powers of attorney* and check on what *attorneys* are doing among other things. (Section 57 of the Mental Capacity Act 2005 establishes the officer called the Public Guardian, and the functions of the Public Guardian are in Section 58.)

Official Solicitor: Needed when someone does not have capacity to tell a solicitor they want to go to court and no one else can act for them. The Official Solicitor then acts for them or asks other solicitors to do it.

Ombudsman: A Commissioner (e.g., health, local government) appointed by the Government to hear complaints.

One-off decision by the court: A single decision by the *Court of Protection*.

Out of pocket expenses: When an *attorney* spends their own money to pay for expenses incurred in doing the things that a *donor* has asked them to do in their *lasting power of attorney*.

Personal welfare decisions: A person's day-to-day well-being and physical well-being, and includes decisions about where a person lives, what they wear and what they eat.

Plaintiff: Term formerly used to describe one who brings an action in the civil courts. Now the term *claimant* is used.

POVA: Safeguard made to protect vulnerable adults from abuse and exploitation.

Practice direction: Guidance issued by the head of the court to which they relate on the procedure to be followed.

Pre-action protocol: Rules of the Supreme Court provide guidance on action to be taken before legal proceedings commence.

Precedent: A decision which may have to be followed in a subsequent court hearing.

President: The head of the Court of Protection.

Presumption of capacity: Every adult has the right to make their own decisions and must be assumed to have *capacity* to do so unless it is proved otherwise on a balance of probabilities.

Prima facie: At first sight, or sufficient evidence brought by one party to require the other party to provide a defense.

Professional attorney: Someone who is paid for the services they provide as an *attorney*.

Property and affairs: The things a person owns (like a house or flat) and the money they have.

Prosecution: The pursuing of criminal offences in court.

Public Guardian: The head of the *Office of the Public Guardian*.

Public Guardian Board: A group of people who advise the Lord Chancellor on the work of the Public Guardian.

Public Guardianship Office: Helps the Public Guardian carry out his duties, for example, dealing with the registration of *lasting powers of attorney* and checking that *deputies* chosen by the Court of Protection are doing their job.

Qualifying requirement: Any one of the six qualifying requirements (age, mental health, mental capacity, best interests, eligibility and no refusals) that need to be assessed and met in order for a standard **deprivation of liberty:** authorization to be given.

Ratio: The reasoning behind the decision in a court case.

Reasonable doubt: To secure a conviction in criminal proceedings the prosecution, must establish *beyond reasonable doubt* the guilt of the accused.

Register of LPAs: A register of all *lasting powers of attorney* kept by the *Office of the Public Guardian*.

Registration process: The *donor*, *attorney*(s), and *certificate provider* complete the *lasting power of attorney*, an *application to register* is filled in and sent to the *OPG*, and the *OPG* checks the LPA and the *application to register*.

Relevant hospital or care home: The hospital or care home in which the person is, or may become, deprived of their liberty.

Relevant person: A person who is, or may become, deprived of their liberty in a hospital or care home in accordance with the **deprivation of liberty safeguards**.

Relevant person's representative: A person, independent of the relevant hospital or care home, appointed to maintain contact with the relevant person, and to represent and support the relevant person in all matters relating to the operation of the deprivation of liberty safeguards.

Remit/remitting: Remitting a fee means a person does not have to pay it.

Replacement attorney: Chosen by a *donor* to replace the original *attorney* if they are no longer able to act.

Restraint: The use or threat of force to help carry out an act that the person resists. Restraint may only be used where it is necessary to protect the person from harm and is proportionate to the risk of harm.

Restriction of liberty: An act imposed on a person that is not of such a degree or intensity as to amount to a deprivation of liberty.

Restriction to an LPA: Tells an *attorney* they cannot do something.

Review: A formal, fresh look at a relevant person's situation when there has been, or may have been, a change of circumstances that may necessitate an amendment to, or termination of, a standard deprivation of liberty authorization. The outcome of a review includes termination of authorization,

varying of the conditions attached to the authorization, and changing the reason recorded that the person meets the criteria for authorization.

Revoke: Cancel.

Seal/sealing: Once the *registration process* is complete, the *OPG* will seal each page of the *lasting power of attorney* to show it is valid.

Solicitor: A lawyer who is qualified on the register held by the Law Society.

Standard authorization: An authorization given by a supervisory body, after completion of the statutory assessment process, giving lawful authority to deprive a relevant person of their liberty in the relevant hospital or care home.

Standard of proof: The level that the party who has the burden of proof must satisfy, for example, on a balance of probabilities (civil courts); beyond all reasonable doubt (criminal courts).

Statute law (statutory): Law made by Parliament, also known as Acts of Parliament.

Statutory instrument: Orders and regulations having binding force. They must usually be laid before Parliament and will usually become law if they are confirmed by a simple resolution of both Houses (affirmative resolution). Some become law after they have been laid for a prescribed period unless they are annulled by a resolution of either House (negative resolution).

Stipendiary magistrate: A legally qualified magistrate who is paid (i.e., has a stipend).

Supervised community treatment: Arrangements under which people can be discharged from detention in hospital under the Mental Health Act 1983, but remain subject to the Act in the community rather than in hospital. Patients on supervised community treatment can be recalled to hospital if treatment in hospital is necessary again.

Supervisory body: A local authority (in England) or a local health board or Welsh Ministers (in Wales) that is responsible for considering a deprivation of liberty request received from a managing authority, commissioning the statutory assessments, and where all the assessments agree, authorising deprivation of liberty.

Time out: A stage in the psychological treatment of a patient when he/she is temporarily excluded from social contact.

Tort: A civil wrong excluding breach of contract. It includes *negligence*, *trespass* (*to the person*, goods, or land), nuisance, breach of statutory duty, and defamation.

Transition: A change in the law often preceded by interim temporary provisions.

Trespass to the person: A wrongful direct interference with another person. Harm does not have to be proved to obtain compensation.

Trust corporation: A company which satisfies certain conditions, for example, the trustee department of a bank.

Unauthorized deprivation of liberty: A situation in which a person is deprived of their liberty in a hospital or care home without the deprivation being authorized by either a standard or urgent deprivation of liberty authorization.

Unreasonable: Behaving in a difficult, unfair, or awkward way.

Urgent authorization: An authorization given by a managing authority for a maximum of seven days, which may subsequently be extended by a maximum of a further seven days by a supervisory body, that gives the managing authority lawful authority to deprive a person of their liberty in a hospital or care home while the standard deprivation of liberty authorization process is undertaken.

Vicarious liability: The liability of an employer for the wrongful acts of an employee committed while in the course of employment.

List of abbreviations

A4A	Action for Advocacy
ACPC	Area Child Protection Committee
ACAS	Advisory, Conciliation and Arbitration Service
ACMD	Advisory Council on the Misuse of Drugs
Advice	Now Established by ASA to improve range and quality of information
AMHP	Approved mental health professional
ANH	Artificial nutrition and hydration
ASA	Advice Services Alliance
ASW	Approved social worker
CEHR	Commission for Equality and Human Rights
CHAI	Commission for Healthcare Audit and Inspection (Formerly CHI, now replaced by CQC)
CHC	Community Health Council
CHI	Commission for Health Improvement (Replaced by CHAI) and CQC
CHRE	Council for Healthcare Regulatory Excellence (Formerly CRHP)
COREC	Central Office for NHS Research Ethics Committees
CPS	Crown Prosecution Service
CRHP	Council for the Regulation of Healthcare Professionals (Now the CHRE)
CSCI	Commission for Social Care Inspection
CSIP	Care Services Improvement Partnership
CSIW	Care Standards Inspectorate for Wales
CQC	Care Quality Commission between CPS and CRHE
DCA	Department for Constitutional Affairs (replaced by Ministry for Justice)
DGH	District General Hospital
DH	Department of Health
DHA	District Health Authority
DHSS	Department of Health and Social Security (Divided in 1989 into DH and DSS)
DNA	Deoxyribonucleic acid
DS	Director of Adult Services
DSS	Department of Social Security
DWP	Department for Work and Pensions
EC	European Community
ECHR	European Court of Human Rights
EEC	European Economic Community
EMI	Elderly mentally infirm
EPA	Enduring Power of Attorney
EWTD	European Working Time Directive
FHSA	Family Health Service Authority
GAfREC	Governance Arrangements for NHS Research Ethics Committees
GMC	General Medical Council
GP	General practitioner
HFEA	Human Fertilisation and Embryology Authority
HIW	Healthcare Inspectorate Wales
ICAS	Independent Complaints Advocacy Service
IMCA	Independent Mental Capacity Advocate
ITP	Intention to practice
IV	Intravenous(ly) or intravenous infusion
IVF	In vitro fertilization
JP	Justice of the peace
LA	Local authority
LHA	Local Health Authority
LHB	Local Health Board
LD	Learning disabilities
LPA	Lasting power of attorney
LREC	Local Research Ethics Committee
LSA	Local Supervising Authority
LSAMO	Local Supervising Authority Midwifery Officer
LSSA	Local Social Services Authority
MCA	Mental Capacity Act 2005
MCIP	Mental Capacity Implementation Programme
MDA	Making Decisions Alliance
MHA	Mental Health Act 1983
MHAC	Mental Health Act Commission
MHRT	Mental Health Review Tribunal
MREC	Multi-Centre Research Ethics Committee
NAW	National Assembly for Wales
NCA	National Care Association
NHS	National Health Service
NHS SMS	NHS Security Management Service
NICE	National Institute for Clinical Excellence (up to March 31, 2005)
NICE	(from April 1, 2005) National Institute for Health and Clinical Excellence
NMC	Nursing and Midwifery Council
NPfIT	National Programme for Information Technology
NPSA	National Patient Safety Agency
NR	Nearest relative
NSF	National Service Framework
OCN	Open College Network
OPG	Office of the Public Guardian
OS	Official Solicitor
PALS	Patient Advocacy and Liaison Services
PCC	Professional Conduct Committee
PCT	Primary Care Trust
PGO	Public Guardianship Office
PIAG	Patient Information Advisory Group
POVA	Protection of Vulnerable Adults

PPC Preliminary Proceedings Committee
PPI Patient and Public Involvement
PREP Post-Registration Education and Practice
PVS Permanent Vegetative State
QCA Qualifications and Curriculum Authority
REC Research Ethics Committee
RHA Regional Health Authority
RMO Responsible Medical Officer
RNLD Registered Nurse for Learning Disabilities
RSCPHN Registered Specialist Community Public Health Nurses
SCIE Social Care Institute for Excellence
SCIG Social Care Information Governance
SCT Supervised Community Treatment
SHA Strategic Health Authority
SI Statutory Instrument
SOAD Second Opinion Appointed Doctor
SSA Site specific assessment
UKCC United Kingdom Central Council for Nursing, Midwifery and Health Visiting (replaced by NMC)
UKECA United Kingdom Ethics Committee Authority
WAG Welsh Assembly Government
WHO World Health Organization

CHAPTER 1

Introduction: Anatomy of the Mental Capacity Act and its terms

This introductory chapter provides a simple guide to the legislation, the sources of further help, the terms used, the organizations involved, and the structure of this book.

The Mental Capacity Act 2005 had been awaited for over 15 years and fills a huge gap in the statutory (i.e., by Act of Parliament) provisions for decision making on behalf of mentally incapacitated adults. This introduction sets out the main provisions of the Act in a nutshell and explains some of the terms used, the links with later chapters, and the scenarios where these topics are considered in full.

Two basic concepts underpin the Act—the concept of capacity and the concept of best interests:

Mental capacity: only if an adult (i.e., a person over 16 years) (referred to in this book as P) lacks mental capacity can actions be taken or decisions made on his or her behalf. Capacity is defined in Sections 2 and 3 (see Chapter 4). It is important to stress that the term "mental capacity" is used in a specific functional way. A person may have the capacity to make one type of decision but not another. For this reason, the term "requisite" mental capacity is used frequently throughout this book to remind readers that it is the capacity in relation to a specific decision which is in question.

Best interests: if decisions are to be made or action taken on behalf of a mentally incapacitated person, then they must be made or taken in the best interests of that person. The steps to be taken to determine "best interests" are set out in Section 4. There is no statutory definition of "best interests" (see Chapter 5). Where a person has appointed an attorney for property and affairs or personal welfare or set up an **advance decision**, the provisions within the instruments apply, and these may differ from the best interests of the person lacking mental capacity.

Principles: Section 1 sets out five basic principles which apply to the determination of capacity and to acting in the best interests of a mentally incapacitated adult. These five principles are as follows:

1. A person must be assumed to have capacity unless it is established that he or she lacks capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him or her to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he or she makes an unwise decision.
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his or her best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

These principles are considered in Chapter 3.

Human rights: the United Kingdom was a signatory to the European Convention on Human Rights in 1950, and those wishing to bring an action under its provisions went to Strasbourg where the ECHR was based. However as a consequence of the Human Rights Act 1998, most of the articles of the Convention were

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Legal Aspects of Mental Capacity: A Practical Guide for Health and Social Care Professionals, Second Edition. Bridgit Dimond.
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incorporated into the laws of England, Wales Northern Ireland, and Scotland. This enabled any persons who claim that their human rights as set out in Schedule 1 to the Human Rights Act 1998 have been violated by a public authority to bring an action in the courts of the United Kingdom (UK) (Schedule 1 is discussed in Chapter 3). The definition of exercising functions of a public nature has been extended and is considered in Chapter 3.

The Convention on the International Protection of Adults is given statutory force by the Mental Capacity Act (MCA) and is set out in Schedule 3 to the MCA. Its provisions are considered in Chapter 3.

P is the person who lacks (or who is alleged to lack) capacity to make a decision(s) in relation to any matter.

Lasting power of attorney (*LPA*): the Act enables a person, known as P, when mentally capacitated to appoint a person known as the **donee** to make decisions about P's personal welfare at a later time when P lacks mental capacity. The LPA can also cover financial and property matters, and these powers can be exercised even when the donor has the requisite mental capacity. The LPA may be general and not identify particular areas of decision making, or it may specify the areas in which the donee can make decisions. It replaces the **enduring power of attorney** (EPA) which only covered decisions on property and finance. There are transitional provisions to cover the situation where a person has drawn up an EPA, and these are set out in Schedule 4 and discussed in Chapter 17. LPAs are considered in Chapter 6.

Court of Protection: a new Court of Protection replaced the previous Court of Protection and has powers to make decisions on personal welfare in addition to property and affairs. (The previous Court could only consider matters relating to property and affairs.) Its powers, functions, constitution, and appointment of the **Court of Protection visitors and deputies** are discussed in Chapter 7.

Deputies: the Court of Protection has the power to appoint deputies to make decisions on the personal welfare, property, and affairs of the mentally incapacitated adult. These powers and the restrictions upon them are considered in Chapter 7.

The Office of the Public Guardian is appointed by the Lord Chancellor to set up and maintain registers of LPAs, EPAs, and deputies. It supervises deputies and provides information to the Court of Protection. It also arranges for visits by the Court of Protection visitors. A **Public Guardian Board** scrutinizes and reviews the way in which the Public Guardian discharges its functions. These offices are discussed in Chapter 7.

Independent mental capacity advocates (IMCAs): the Act makes provision for such persons to be appointed to represent and support mentally incapacitated adults in decisions about accommodation, serious medical treatment, and adult protection situations. These advocates are appointed under **independent mental capacity advocate services** which are established to provide independent advocates for mentally incapacitated adults in specified circumstances. They represent and support mentally incapacitated adults in decisions by NHS organizations on serious medical treatment and in decisions by NHS organizations and local authorities on accommodation. The original remit of the IMCAs has been extended to cover care reviews and situations where adult protection measures are being taken. The arrangements for advocacy are considered in Chapter 8.

Litigation friend: the court can appoint anyone to be a litigation friend (a parent or guardian, family member or friend, a solicitor, professional advocate, a Court of Protection deputy, an attorney under an LPA). If there is no suitable person, the Official Solicitor can be appointed. A certificate of suitability must be completed, and there must be no conflict of interest between the litigation friend and P. The Court of Protection Rules 140 to 149 make provision for the appointment of litigation friends (see Chapter 7).

Official Solicitor: the OS acts as the litigation friend or solicitor to those who lack the capacity to make their own decisions or conduct litigation. The role is more fully considered in Chapter 7.

Relevant person's representative: when a Deprivation of Liberty has been authorized, the supervisory body must appoint a representative in respect of the person concerned. The role of the RPR is to maintain contact with P and support and represent them in matters relating to their deprivation of liberty. Regulations covering the appointment, termination,

and payment were passed in 2008.[1] They are discussed in Chapter 14. In the case of *AB* v. *LCC (A Local Authority)* [2011],[2] Mostyn J considered the difference between an RPR and a litigation friend. The case is considered in Chapter 14 on Deprivation of Liberty Safeguards.

Advance decisions to refuse treatment (also known as living wills or advance refusals) are given statutory recognition, and special requirements are specified if these advance decisions are to cover the withdrawal or withholding of life-sustaining treatment. The definitions of an advance decision and the statutory provisions are considered in Chapter 9.

Research on mentally incapacitated adults is subject to specific qualifications, and unless these are complied with, the research cannot proceed. The provisions are discussed in Chapter 10.

Codes of Practice must be prepared by the Lord Chancellor, and their legal significance is considered in Chapter 17.

An offence of ill treatment or wilful neglect of a person who lacks capacity is created by the Act, and this offence, together with other criminal offences in relation to a mentally incapacitated adult and the accountability of those who make decisions on their behalf, is discussed in Chapter 11.

Court cases: there have been some significant judicial decisions on the aspects of the Act. The most significant include the following:

Aintree University Hospitals NHS Foundation Trust v. *James* [2013][3] (see Chapter 5).

P (by his litigation friend the Official Solicitor) v. *Cheshire West and Chester Council & Anor and P and Q (by their litigation friend, the Official Solicitor) (Appellants)* v. *Surrey County Council (Respondent)* [2014][4] (see Chapter 14).

Nicklinson and Anor R (on the application of) (Rev 1) [2014][5]—assisted suicide (see Chapters 2 and 11).

R (McDonald) v. *Kensington and Chelsea Royal London Borough Council* [2011]; *McDonald* v. *UK Chamber judgement* [2014][6] ECHR 492, article 8—rights and night-time attendance (see Chapter 3); ECHR *McDonald* v. *UK* (Application no 4241/12), European Court of Human Rights, Times Law Report 2014.

Dunhill v. *Burgin*. The Times Law Report, March 28, 2014, SC [2014][7]—capacity to litigate (see Case Study 4.3).

Montgomery v. *Lanarkshire Health Board* [2015] UKSC[8]—duty to give patient information about any material risks involved in the treatment. The Supreme Court recognized the doctrine of informed consent (see Chapter 2).

Mental health and mental capacity

Treatments for mental disorder given to patients who are detained under the **Mental Health Act 1983** (as amended by the 2007 Act) are excluded from the provisions of the MCA. The distinction between the concepts of mental disorder and mental incapacity is considered in Chapter 13.

Deprivation of Liberty safeguards

The **Bournewood case**, sometimes referred to as the **Bournewood gap**, was heard by the European Court of Human Rights which held that it was a breach of Article 5(1) for a person with learning disabilities to be kept in a psychiatric hospital under the common law doctrine of necessity (and therefore without being detained under the Mental Health Act 1983). As a consequence of this decision, it was apparent that the mental health law in England and Wales did not provide sufficient protection for those persons incapable of giving consent to admission to a psychiatric hospital and who were being held outside the Mental Health Act 1983 in breach of Article 5(1). This gap in the law, the case itself, the Department of Health (DH) consultation paper on how the gap could be filled, and the provisions made in the Mental Health Act to fill the gap are considered in Chapters 3 and 14. The necessary changes to the MCA are known as the **Deprivation of Liberty safeguards** and are considered in Chapter 14.

Coming into force of the MCA

The IMCA service came into force in England in April 2007 and in Wales in October 2007.

The criminal offence of ill treatment or wilful neglect of a person who lacks capacity came into force in April 2007.

Sections 1–4 covering the principles, definition of mental capacity, best interest and guidance in the Code of Practice came into force in relation to IMCAs in April 2007.

All other provisions came into force in October 2007 (except for specific provisions relating to research—see Chapter 10).

Protection of mentally incapacitated adults provided in other statutory provisions is also included in this book to provide a comprehensive view and is considered in Chapter 11.

Statutory law (made by Parliament) and **common law** (judge made or case law) are contrasted and explained in Chapter 2, which sets out the background to the passing of the Mental Capacity Act 2005.

Since devolution, Wales has enjoyed the ability to pass its own statutory instruments and issue its own guidance on health and social services law. Chapter 18 considers some of the differences in Wales. The Code of Practice drafted by the Department of Constitutional Affairs does however apply to Wales.

Scotland enacted an Adults with Incapacity (Scotland) Act in 2000, and the main legislation for Scotland and Northern Ireland is considered briefly in Chapter 18 of this book.

Bolam test: this is taken from a case heard in 1957[9] which was concerned with how negligence should be established. The judge held that the doctor must act in accordance with a responsible and competent body of relevant professional opinion. This is discussed in Chapter 11 on accountability.

Protection of Vulnerable Adults (*POVA*): Government policy supported by several statutory provisions is designed to support vulnerable adults (see Chapter 11).

General authority: this was a concept used in earlier versions of the Mental Capacity Bill to denote the power of a person to act out of necessity in the best interests of a mentally incapacitated adult. However it was considered to be misleading by the Joint Committee of the Houses of Parliament and was not included in the MCA.

Children: the MCA applies to young persons over 16 years and adults. There are some provisions however which can apply to persons younger than that, and there are differences in law between the young person of 16 or 17 and a person of 18 and over. These are considered in Chapter 12.

Human tissue and organ removal, storage, and use: special protection is given to those lacking the requisite mental capacity to give consent to the removal, storage, and use of human tissue and organs by the MCA and the Human Tissue Act and regulations under both Acts. This topic is considered in Chapter 15.

Sources of help

Any person trying to unravel the impact that the MCA has on their work or on the rights of the mentally incapacitated adult for whom they care will find extremely extensive resources for assistance. The main source of assistance is the website of the Ministry of Justice[10] which took over from the Department for Constitutional Affairs (DCA) in May 2007. The Ministry of Justice through the Office of the Public Guardian has published many leaflets and booklets explaining the Act for a wide variety of readers, and these can be downloaded from its website. They include a guide for users/clients or patients (*Making decisions about your health welfare or finance. Who decides when you can't?* (OPG601)); for family, friends, and other unpaid carers (OPG602); for people who work in health and social care (OPG603); for advice workers (OPG604), an easy read guide (OPG605); and for independent mental capacity advocates (OPG606). They are accessible on the Ministry of Justice website.[11]

The Mental Capacity Act 2005 itself can be downloaded from the Ministry of Justice website and from the UK legislation site.[12] All the Statutory Instruments referred to can be downloaded from these sites. Hard copies of the legislation can be purchased from the Stationery Office. The Chambers at 39 Essex Street run a website which issues a newsletter, summarizes, and comments on Court of Protection cases which can be accessed.[13]

The Social Care Institute for Excellence provides guidance and training on a variety of topics and has set up a Mental Capacity Act (MCA) Directory which can be accessed on its website.[14]

Many other resources on the MCA and DOLs are listed in Appendix B to the Care Quality Commission fifth annual report monitoring the use of DOLs 2013/4 which is available online.[15] It gives the title of the document, the provider, and its website.

The Code of Practice has been compiled by the Lord Chancellor across a significant number of areas (see Chapter 17). It can be accessed from the website of the Ministry of Justice.[16] The Code of Practice should be

followed by health and social services professionals and those listed in Section 42(4). However whilst it is not statutorily binding upon the informal or unpaid carer, there would be considerable benefit for such persons to follow the guidance in the code. An additional Code of Practice has been prepared to cover Deprivation of Liberty Safeguards[17] (see Chapter 14). The Code of Practice relating to the Mental Health Act was revised in 2015.

Explanatory Memorandum: accompanying the statute and available from the HMSO website is an Explanatory Memorandum which provides guidance in understanding some of the statutory provisions. It is not in itself the law but could provide some help in comprehending some of the more difficult provisions.

Memorandum submitted to the Joint Committee on Human Rights in response to its letter of 18 November 2004: the report of the Joint Committee of Parliament[18] provides further insight into the thinking behind the legislation and is discussed throughout this book as appropriate. The report can be downloaded from the Ministry of Justice website.

Professional guidance: many of the professional associations of those involved in the care of mentally incapacitated adults are drawing up detailed guidance for their members on the provisions of the Act, and this is available from their websites (see website list).

Protocols, procedures, guidance from the Care Quality Commission, and other regulatory organizations: guidance has been issued by the CQC. Its recommendations following visits of inspection are not in themselves the law, but they could provide evidence of good practice. Similarly, conclusions and recommendations following inquiries carried out by the Health Service Commissioner or Ombudsman and the Ombudsman for local authorities may be extremely helpful to those involved in the care of those lacking mental capacity. The Nursing and Midwifery Council and the General Medical Council and other regulatory bodies have also issued guidance on the MCA for their registered practitioners.

Protocols, procedures, and guidance from employers: many National Health Service (NHS) trusts and care trusts and social services departments have prepared protocols, guidelines, policies, etc., to assist their staff in implementing the laws which apply to decision making on behalf of mentally incapacitated adults. These in general should be followed by the staff, but registered practitioners also need to use their professional discretion and ensure that such guidance is in accordance with the basic principles of law and practice, as recommended in the codes of practice of their registered bodies.

Protocols, procedures, guidance, and information from organizations involved in the care and protection of mentally incapacitated adults: many organizations which are involved in providing care and protection for mentally incapacitated adults gave advice and information to Parliament and in particular to the Joint Committee during the progress of the Mental Incapacity and Mental Capacity Bills through Parliament. These organizations have continued to advise their members and other interested persons on the best practice in caring for and offering support and assistance to those lacking mental capacity. The websites of some of these organizations are set out in the list of websites on pages x to xiv. They include the Alzheimer's Society and Mencap.

Professional legal advice

39 Essex Street Chambers has a Court of Protection team which provides online updates on cases relating to the Mental Capacity Act and has also produced a training DVD to provide a comprehensive training to assist decision makers in understanding the legal requirements imposed by the MCA and the courts. Further information is available on its website.[19] The Local Government Lawyer website also provides guidance on the Act and recent cases.[20]

Terms used

Many of the terms employed in the Act may alienate those who are seeking to obtain a greater understanding of the law. Many of the probably unfamiliar terms such as lasting power of attorney, donee, deputy, and advance decision are considered in context and are mentioned previously with the chapters cited in which they are further discussed.

A **glossary**, supplied at the end of this book, explains other legal terms with which the reader may not be familiar.

Organizations involved in the care and support of adults who lack mental capacity

The causes of mental incapacity are diverse. Some suffer from severe learning disabilities acquired as a result of brain damage at birth or genetic causes and would therefore never have enjoyed having capacity. Others may have lost their mental capacity as a result of deteriorating diseases such as Alzheimer's or of a trauma such as a road accident. These persons once had capacity, and it is possible from discussions with family and friends to piece together a picture of that person's earlier beliefs, philosophy, and likes and dislikes which can be used in determining "best interests."

The organizations providing support for such adults include the following:

Public authorities: NHS England, NHS trusts, clinical commissioning groups, care trusts, social services departments.

Charitable and voluntary organizations: these include many residential and care homes, community support homes, care agencies, and leisure organizations providing services for the disabled.

Profit-making organizations: these provide many and varied services, often in contract with public authorities.

All such organizations may provide useful information on the care and support of those lacking mental capacity. A list of websites is provided in this book.

Scenarios are included in each of the main chapters to illustrate some of the situations which may arise and to assist in explaining how the new statutory provisions are likely to work.

Future changes: inevitably there have been disputes over the interpretation of some of the statutory provisions, and these disputes have resulted in court hearings and judgments which set precedents on how the Act is to be interpreted and thus become part of the common law (see Chapter 2). The House of Lords Select Committee carried out a postlegislative scrutiny of the Mental Capacity Act in 2013–4[21] and made many significant recommendations for change. The Government responded positively[22] and as a consequence there are likely to be significant changes in particular to the regulations relating to the deprivation of liberty safeguards and to the criminal offence of ill treatment or wilful neglect of a person lacking mental capacity under Section 44. The recommendations and response are discussed in each relevant chapter. In 2015 the Law Commission was asked to review the law on Deprivation of Liberty Safeguards. It is due to report with draft legislation at the end of 2016, and following consultation and Parliamentary debate, revised legislation could be implemented by the end of 2017.

Quick fire quiz, QFQ1

1 What two concepts underline the Mental Capacity Act 2005?
2 How does the Act define "best interests"?
3 What are the five principles set out in the Act?
4 What is the difference between statute and common law?
5 How does the Human Rights Act 1998 relate to the Mental Capacity Act 2005?
6 Can a lasting power of attorney be exercised on behalf of a person who has the requisite mental capacity?

Answers can be found on pages 335–343.

References

1 The Mental Capacity (Deprivation of Liberty) Appointment of Relevant Person's Representative Regulations 2008 SI 1315.
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3 *Aintree University Hospitals NHS Foundation Trust* v. *James* [2013] UKSC 67.
4 *P (by his litigation friend the Official Solicitor)* v. *Cheshire West and Chester Council & Anor and P and Q (by their litigation friend, the Official Solicitor) (Appellants)* v. *Surrey County Council (Respondent)* [2014] UKSC 19.
5 *Nicklinson and Anor R (on the application of) (Rev 1)* [2014] UKSC 38.
6 *R (McDonald)* v. *Kensington and Chelsea Royal London Borough Council* [2011] UKSC 11; *McDonald* v. *UK Chamber judgement* [2014] ECHR 492; ECHR *McDonald* v. *UK* (Application no 4241/12), European Court of Human Rights, Times Law Report 2014.
7 *Dunhill* v. *Burgin*. The Times Law Report, March 28, 2014 SC [2014] UKSC 18.
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18 House of Lords and House of Commons Joint Committee on the Draft Mental Incapacity Bill Session 2002–2003. H.L. paper 189–91; H.C. 1083–1.
19 www.39essex.com
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22 HM government valuing every voice respecting every right: making the case for the Mental Capacity Act, the Government response to the House of Lords Select Committee on the Mental Capacity Act, June 2014.

CHAPTER 2

Background to the legal system and the Mental Capacity Act

THIS CHAPTER COVERS THE FOLLOWING TOPICS

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Introduction

Legislation relating to decision making on behalf of mentally incapacitated adults was on the drawing board for over 15 years. This chapter explains the distinction between statutory and nonstatutory law, discusses why statutory provision was considered necessary, and looks briefly at the steps leading to the Mental Capacity Act 2005.

The legal system

The law derives from two main sources:

1. *Acts of Parliament and Statutory Instruments which are enacted under the powers given by the former*: these are known as statutory sources and include the legislation of the European Community. These take precedence over all other laws. Laws of the European Community automatically become part of the law of the United Kingdom. The Council and the Commission have law-making powers, and this can be in the form of regulations or directives. The Human Rights Act 1998 is in a special position (see Chapter 3). Acts of Parliament and Statutory Instruments have chapter numbers for each year or a serial number. A website makes for easy access to Acts of Parliament and Statutory Instruments.[1]
2. *The common law (also known as case law or judge-made law)*: this is made up of the decisions by judges in individual cases which are often, but not always, interpretations of statute law. The judge, in deciding a particular case, is bound by a previous decision on the law made by judges in an earlier case, if it is relevant to the facts before him and if that decision

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was made by a higher court than the one in which he or she is sitting. There is a recognized order of precedence so that, for example, a decision by the Supreme Court (formerly the House of Lords) is binding on all other courts except itself but would be subject to relevant precedents of the European Court of Justice. The decisions are recorded by officially recognized reporters so that in a case similar to a previous one, the earlier decision can be put before the court. If the facts and the situation are comparable and the decision was made by a court whose decisions are binding, then the earlier precedent will be followed. If there are grounds for distinguishing the earlier case (i.e., showing that there are significant differences from the earlier case), then the earlier case may not be followed.

Of vital importance to the system of precedence is a reliable procedure for recording the facts and decisions of any court case. Each court has a recognized system of reporting, and the case is quoted by a reference which should enable the full report of the case to be found easily. An example is given in the glossary under *case citation*.

Changing the law

There are recognized rules for interpreting Acts of Parliament and in relation to the following of case precedents. Ultimately, however, if the law is unsatisfactory and fails to provide justice, the courts look to the Houses of Parliament to remedy the situation by the new legislation. For example, in the case of Nicklinson, the Supreme Court decided that it was for Parliament to clarify the law on assisted suicide and that the present situation was unsatisfactory.[2] (The case is considered in Chapter 11.) There is a right of appeal on matters of law to courts of higher jurisdiction. An appeal can be taken to the Court of Appeal and from there to the Supreme Court (which replaced the House of Lords in 2009), if permission is granted. Until the Supreme Court has pronounced on a particular point of law, there may be considerable uncertainty as to what the law in a given situation is. A number of cases relating to mental capacity have been referred to the Supreme Court in recent years.

Official guidance and advice

Department of Health (DH) circulars, Department of Social Security (DSS) circulars, and Nursing and Midwifery Council (NMC) codes of practice are not legally binding, but they are recommended practice. Breach of these codes and guidance may be evidence of failure to follow the approved practice but cannot in itself result in successful civil or criminal action. The status of the Mental Capacity Act Code of Practice and the supplement on Deprivation of Liberty Safeguards is considered in Chapter 17.

Human rights

The rights recognized in the European Convention on Human Rights, which were brought into force in this country in October 2000, have also had a major impact on the rights and the protection of mentally incapacitated and vulnerable adults. This is considered in Chapter 3.

Judicial review

Administrative and other actions can be challenged in the High Court by an application for judicial review. Public funding for legal costs in judicial review is available from legal professionals and advice agencies, which have contracts with the Legal Services Commission as part of the Community Legal Service.[3] Judicial review allows people with a sufficient interest in a decision or action by a public body to ask a judge to review the lawfulness of an enactment or a decision, action, or failure to act in relation to the exercise of a public function. An example of a case where an application was made for judicial review of a decision by a local authority to reorganize its care homes with a private operator is shown in Case Study 2.1. A person with learning difficulties was successful in his judicial review of the LA's failure to fufil its statutory responsibilities in relation to his educational and leisure time activities under education legislation and the Human Rights Act. However he failed to obtain any quashing order because this would have meant a rewrite of the revenue budget which could not be reopened. The Supreme Court held that, although he was not entitled to have a declaration, he was entitled to have his costs awarded, since he was

Case Study 2.1 An example of a judicial review.[6]

Care home residents applied for judicial review of a decision by the local authority to seek a private sector operator to accept a transfer of, operate, and expand two care homes and to close another two care homes once the residents had been transferred to suitable alternative accommodation. It was argued that the private operator was exercising functions of a public nature and that the residents' rights were protected under Article 8 of the European Convention on Human Rights (see Chapter 3). The application was refused on the grounds that the private operator was not exercising functions of a public nature. The transfer did not absolve the local authority of its duty to ensure that the residents' rights under Articles 3 and 8 were protected.

a successful claimant, and to deny his costs would be likely to dissuade claimants from pursuing legitimate public law challenges.[4]

There have been recent changes to rules relating to the application for judicial review. Regulations[5] require the Lord Chancellor to refuse to pay legal aid for judicial review unless the court gives permission to bring judicial review proceedings or (the court neither refusing nor granting permission) the Lord Chancellor thinks it reasonable to pay remuneration. Thus an application for judicial review is limited to those who have a direct link to the policy or decision being criticized.

As a consequence of this decision, the definition of exercising functions of a public nature has been extended to include the provision of care under specific statutory enactments. Only those who fund their own care cannot claim the protection of the Human Rights Act against a public authority or an organization exercising functions of a public nature. This is considered in Chapter 3.

The law relating to trespass to the person and consent

It is a basic principle of the common law that a mentally competent adult is able to refuse even lifesaving treatment, for a good reason, a bad reason, or no reason at all.[7] To act contrary to the wishes of a mentally competent person, in the absence of any legal justification such as the Mental Health Act 1983 or the Police and Criminal Evidence Act 1984 is known as a trespass to the person, that is, a civil wrong. In certain circumstances it may also be a crime (see glossary under **trespass to the person**).

Case Study 2.2 *Re B* [2002].[8]

Miss B suffered a ruptured blood vessel in her neck which damaged her spinal cord. As a consequence she was paralyzed from the neck down and was on a ventilator. She was of sound mind and knew that there was no cure for her condition. She asked for the ventilator to be switched off. Her doctors wished her to try out some special rehabilitation to improve the standard of her care and felt that an intensive care ward was not a suitable location for such a decision to be made. They were reluctant to perform such an action as switching off the ventilator without the court's approval. Miss B applied to court for a declaration to be made that the ventilator could be switched off.

An action for trespass which belongs to a group of civil wrongs (known as "torts") is one of the oldest remedies in law (known as a right of action in law); it includes an assault and a battery. An action for assault could arise where the employee of the defendant (in this context normally the employer of the health professional, who would be sued because of its vicarious liability for the actions of the employee) causes a claimant reasonable apprehension of the infliction of a battery upon him/her; a battery arises where there is intentional and direct application of force to another person.

Assault and battery are also used to describe possible criminal actions, but when the terms are used in relation to a trespass to the person, a civil action brought in the civil courts (i.e., Small Claims Court, County Court, High Court) for compensation by a claimant is being considered. The fact that the defendant has acted out of good motives, for example, the best interests of the claimant, is not a valid defense where the claimant is an adult, has the requisite mental capacity, and has not given consent to that intervention.

Unlike an action for negligence (see Chapter 11), harm does not have to be proved. The mere fact that a trespass has occurred is sufficient to bring an action. The legal action is known as actionable per se, that is, actionable without proof of harm having been suffered.

An example of a case where a woman was able to refuse lifesaving treatment is shown in Case Study 2.2. The main issue in the case was the mental competence of Miss B. If she were held to be mentally competent, then she could refuse to have lifesaving treatment for a good

reason, a bad reason, or no reason at all. She was interviewed by two psychiatrists who gave evidence to the court that she was mentally competent. The judge therefore held that she was entitled to refuse to be ventilated. The judge Dame Elizabeth Butler-Sloss, President of the Family Division, held that Miss B possessed the requisite mental capacity to make decisions regarding her treatment, and thus the administration of artificial respiration by the trust against her wishes amounted to an unlawful trespass.

Dame Elizabeth Butler-Sloss restated the principles which had been laid down by the Court of Appeal in the case of St George's Healthcare Trust[9]:

- There was a presumption that a patient had the mental capacity to make decisions whether to consent to or refuse medical or surgical treatment offered.
- If mental capacity was not an issue and the patient, having been given the relevant information and offered the available option, chose to refuse that treatment, that decision had to be respected by the doctors. Considerations of what the best interests of the patient would involve were irrelevant.
- Concern or doubts about the patient's mental capacity should be resolved as soon as possible by the doctors within the hospital or other normal medical procedures.
- Meanwhile the patient must be cared for in accordance with the judgment of the doctors as to the patient's best interests.
- It was most important that those considering the issue should not confuse the question of mental capacity with the nature of the decision made by the patient, however grave the consequences. Since the view of the patient might reflect a difference in values rather than an absence of competence, the assessment of capacity should be approached with that in mind and doctors should not allow an emotional reaction to, or strong disagreement with, the patient's decision to cloud their judgment in answering the primary question of capacity.
- Where disagreement still existed about competence, it was of the utmost importance that the patient be fully informed, involved and engaged in the process, which could involve obtaining independent outside help, of resolving the disagreement since the patient's involvement could be crucial to a good outcome.
- If the hospital was faced with a dilemma which doctors did not know how to resolve, that must be recognised and further steps taken as a matter of priority. Those in charge must not allow a situation of deadlock or drift to occur.
- If there was no disagreement about competence, but the doctors were for any reason unable to carry out the patient's wishes, it was their duty to find other doctors who would do so.
- If all appropriate steps to seek independent assistance from medical experts outside the hospital had failed, the hospital should not hesitate to make an application to the High Court or seek the advice of the Official Solicitor.
- The treating clinicians and the hospital should always have in mind that a seriously physically disabled patient who was mentally competent had the same right to personal autonomy and to make decisions as any other person with mental capacity.

It was reported on April 29, 2002 that Miss B had died peacefully in her sleep after the ventilator had been switched off.

See Case Study 11.14[10] for a discussion of the case of Miss B in the context of the crimes of murder, manslaughter, and assisted suicide (Chapter 11).

Where a mentally capacitated person has given consent to medical treatment, then in the absence of fraud or duress, an action for trespass to the person cannot be brought. However if the patient has suffered harm, he or she could bring an action in negligence if there has been a failure to provide information which would have caused the patient to rethink the giving of consent. The patient does not have to prove that had they had that information they would have refused to consent.[11] The Supreme Court has recently stated that a patient is entitled to receive information about any material risks involved in any recommended treatment.[12] In this case the doctor did not tell the expectant woman that since she was diabetic, shoulder dystocia was a risk in a natural birth, and the baby was able to claim compensation for the severe disabilities he or she suffered as a consequence. The Supreme Court held that the Bolam test used by the House of Lords in the Sidaway case[13] was no longer relevant to modern times and informed consent was now an accepted doctrine in law.

> **Case Study 2.3** Sterilization of a mentally incapacitated adult (*Re F (Mental Patient: Sterilisation)* [1990]).
>
> F was 36 years old and had severe learning disabilities, with the mental age of a small child. She lived in a mental hospital and had formed a sexual relationship with a male patient. The hospital staff considered that she would be unable to cope with a pregnancy and recommended that she should be sterilized, considering that other forms of contraception were unsuitable. Her mother supported the idea of a sterilization operation, but because F was over 18 years old, she did not have the right in law to give consent on her behalf. The mother therefore applied to court for a declaration that an operation for sterilization was in her best interests and should be declared lawful.

Decisions relating to mental capacity

In the absence of statutory provision (i.e., prior to the bringing into force of the Mental Capacity Act 2005), disputes relating to the presence or absence of mental capacity and the decisions to be made in the event of capacity being seen to be lacking have been made by the courts. In the leading case of *Re F*,[14] the House of Lords held that doctors could take action out of necessity, on behalf of a mentally incapacitated adult who was incapable of making her own decisions. The action had to be taken in her best interests and had to follow the reasonable standard of care. The facts of the case are shown in Case Study 2.3.

The judge granted the declaration sought by F's mother. The Official Solicitor (who acts on behalf of the mentally incapacitated adult) appealed against the declaration to the Court of Appeal, which upheld the judge's order. The Official Solicitor then appealed to the House of Lords. The House of Lords held that there was at common law (i.e., judge made law or case law) the power for a person to act in the best interests of a mentally incapacitated adult. This power is derived from the principle of necessity.

The principle of necessity

Necessity may arise in an emergency situation, for example, when an unconscious person comes into hospital, and the health professionals should do no more than is reasonably required in the best interests of the patient, before he/she recovers consciousness. Necessity may also arise in a situation where a person is permanently or semipermanently lacking mental capacity. In such a situation, there is no point in waiting for the patient to give consent. According to Lord Goff:

> The need to care for him [the patient] is obvious; and the doctor must then act in the best interests of his patient just as if he had received his consent so to do. Were this not so, much useful treatment and care could, in theory at least, be denied to the unfortunate.

The doctor must act in accordance with a responsible and competent body of relevant professional opinion. This is known as the Bolam test, taken from a case heard in 1957[15] (see Chapter 11 and Scenario 11.6).

In the case shown in Case Study 2.3, the House of Lords issued a declaration that sterilization was in the best interests of F and could proceed. It did recommend that in the future such cases of sterilization for social reasons (as opposed, e.g., to sterilization which resulted from an operation to remove a cancerous growth) should be brought before the courts for a declaration to be made.

The courts have also had to decide on the appropriate treatment for sufferers from Creutzfeldt–Jakob disease (vCJD) which is shown in Case Study 2.4.

> **Case Study 2.4** Treatment for vCJD sufferers (*Simms* v. *an NHS Trust and the Secretary of State for Health*[16]).
>
> JS a boy of 18 years and JA a girl of 16 years suffered from vCJD, and in each case the parents sought declaratory relief that each lacked capacity to make a decision about future treatment proposed for them and that it was lawful in their best interests to receive it. The proposed treatment was new and so far untested on human beings. The judge concluded in the light of all the evidence and the circumstances that it was in the best interests of JS and JA to receive the treatment: JA as a 16-year-old came under the Children Act 1989, and the direct responsibility of the judge under Section 1 was to consider the child's welfare as the paramount consideration. (Subsequently the NHS Trust's two committees, one on Clinical Governance and Quality and the other the Drugs and Therapeutic Panel, decided that the treatment could not be approved, and the DH was investigating other possible facilities for the provision of the treatment.)

Weaknesses of common law

The absence of statutory provisions has meant that the courts have had to make declarations on the absence of mental capacity and to determine what actions appear to be in the interests of the mentally incapacitated person on

the basis of existing case law or the common law. There was no statutory right for a person to make treatment or care decisions on behalf of a mentally incapacitated person over 18 years (apart from decisions on the treatment for mental disorder of patients detained under the Mental Health Act 1983). Parents or guardians have the right to make decisions on behalf of young persons and children up to the age of 18 years, but once the offspring are 18 years, parents no longer have the right at common law to make decisions on their behalf, even though the young person lacks the requisite mental capacity.

However the legal principles in the precedents set by the courts lack the clarity and detail that statutes and statutory regulations would provide, and there has been considerable pressure over many years for statutory provision for decision making on behalf of mentally incapacitated adults.

Law Commission

The ninth item of the Fourth Programme of Law Reform undertaken by the Law Commission in 1989[17] was the laws relating to decision making on behalf of mentally incapacitated adults. In the course of its work, it published several Consultation papers. The first was an overview of mentally incapacitated adults and decision making published in 1991.[18] This was followed by other papers[19] on specific topics such as medical treatment and research and the protection of vulnerable adults and led ultimately to the Law Commission's report on mental incapacity which included draft legislation, that is, a Mental Incapacity Bill.[20]

Events since 1995

It would have been possible for the Law Commission's Mental Incapacity Bill printed at the end of its final report in 1995 to have been placed before Parliament for debate and enactment in 1995. However there was not the political will to progress at that time. The advent of the Labour Government in 1997 led to the publication of a new Consultation paper, issued from the Lord Chancellor's Office, called *Who Decides?*.[21] It set out the issues which had been considered by the Law Commission between 1991 and 1995. *Who Decides?* was followed by a White Paper, *Making Decisions*,[22] in October 1999.

Subsequently draft legislation to bring the proposals set out in the White Paper into force was published in June 2003[23] and was the subject of scrutiny by a Joint Committee of the House of Commons and House of Lords. The Joint Committee published its report in November 2003 and made almost 100 recommendations on changes to the draft Bill, including the change of title to Mental Capacity Bill.[24] A revised Mental Capacity Bill was introduced into Parliament in 2004 and was the subject of considerable parliamentary debate, especially over the statutory provision for living wills or advance decisions (see Chapter 9). In Scotland the Adults with Incapacity (Scotland) Act 2000 covers the situation of decision making on behalf of incapacitated adults (see Chapter 18).

Mental Capacity Act 2005

The Mental Capacity Bill received the royal assent in April 2005, but whilst some provisions came into force in April 2007, the rest was not brought into force until October 2007 (see Chapter 17). Why the delay? Time was required for many Consultation papers to be published including one on the draft Code of Practice and on the regulations to be drawn up under the Act. A new administrative organization for the Court of Protection had to be established and the Office of the Public Guardian set up. Regulations were required to be drafted under the powers set forth in the Act to be consulted upon and approved by Parliament. In addition, of course, extensive training was required, not just of the health and social services professionals but also of the judiciary and those allocated with the administration of the new provisions and charities and organizations concerned with the protection of vulnerable adults and the adults themselves.

Mental health legislation

There is a distinction between mental incapacity and mental disorder as defined in the Mental Health Act 1983. It is possible for a person to lack the mental capacity to make certain decisions but not to be suffering from mental disorder. The definition of mental disorder under the 1983 Act as amended by the 2007 Act is considered in Chapter 13.

Under the Mental Health Act 2007, learning disabilities is not itself a mental disorder (unless it is associated with abnormally aggressive or seriously irresponsible conduct on the person's part), but when person is being assessed for a deprivation of liberty authorization under the Mental Capacity Act when mental disorder must be established, then any qualifications on the definition of learning disability is disregarded. This is further explained in Chapter 14. The definition of mental capacity is issue specific. Thus a person with learning disabilities may be incapable of making certain decisions but capable of others.

Mental health legislation must also be reviewed in the light of the Human Rights Act 1998. Article 5 of the European Convention on Human Rights recognizes that:

> everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law

This right is subject to specified exceptions including:

> the lawful detention … of persons of unsound mind

The Court of Appeal has held that where a patient refused to consent to treatment, the court would not give permission for the treatment to proceed unless medical necessity was convincingly shown.[25] The case is shown in Case Study 2.5.

In another case, the Court of Appeal held that the state had a duty to protect incompetent patients and that Section 2 of the Mental Health Act 1983 was incompatible with Article 5(4) of the European Convention on Human Rights.[26] This was overruled by the House of Lords, but the European Court of Human Rights held that there was a breach of article 5(4) but only in respect of the first 27 days of the detention. (The case is considered in Case Study 3.2.)

Case Study 2.5 *R (N)* v. *Dr M and Others* (2002).

The responsible medical officer drew up for a detained patient (the claimant) a treatment plan, which included administering by injection antipsychotic medicine for the prevention or alleviation of psychotic illness. The claimant did not consent to that treatment. A second doctor appointed under the provisions of the Mental Health Act 1983 to provide a second opinion issued a certificate that the patient was suffering from paranoid psychosis/severe personality disorder and required regular antipsychotic treatment. The patient challenged those decisions. An independent psychiatrist advised that the claimant was very unlikely to be suffering from a psychotic illness and should not be given antipsychotic medication. The Court of Appeal held that the judge had to be satisfied that the proposed treatment was both in the claimant's best interests and medically necessary for the purposes of Article 3 of the Human Rights Convention. The best interest test went wider than medical necessity: the standard of proof required was that the court should be satisfied that medical necessity had been convincingly shown. Provided the judge applied the correct approach to determining whether there had been a breach of a Convention right, the review of a decision which would otherwise violate a person's right under Article 6 would be sufficient for Convention purposes. The claimant lost her appeal.

Reform of the Mental Health Act 1983

Discussions on the reform of the Mental Health Act 1983 had been taking place for over 8 years. An expert committee was set up by the Government in 1998 under the chairmanship of Professor Richardson to review the Mental Health Act 1983. Its terms of reference included the degree to which the current legislation needed updating and to ensure that there was a proper balance between safety (both of individuals and the wider community) and the rights of individual patients. It was required to advise the Government on how mental health legislation should be shaped to reflect contemporary patterns of care and treatment and to support its policy as set out in *Modernising Health Services*.[27]

The Expert Committee presented its preliminary proposals, which set out the principles on which any future legislation should be based, in April 1999, and its full report was published in November 1999.[28] The Government presented its proposals for reform in 1999, with a final date for response by March 31, 2000.[29] The Consultation Paper was followed by a White Paper issued on December 20, 2000,[30] which proposed a new legal framework for the mentally disordered, and the second part made provision for high-risk patients. The White Paper stated that new mental health legislation would provide a single framework for the application of compulsory powers for care and treatment and that the new legislation would be compatible with the European Convention on Human Rights.

A draft Bill[31] was then published in 2002 for further consultation. This met with considerable criticism, and provision for a new Mental Health Bill was not made in the Queen's speech in November 2003. However the Secretary of State for Health announced that a revised

Mental Health Bill was to be brought forward for prelegislative scrutiny. A further draft Mental Health Bill was published in November 2006 which, rather than introduce a new Mental Health Act (MHA), sought to amend the provisions of the Mental Health Act 1983.

The resultant Mental Health Act 2007 is very much a compromise on the radical proposals initially put forward in 1997. It amends the Mental Capacity Act 2005 to fill the gaps in the law revealed by the Bournewood case (see Chapters 3 and 14 and the scenarios in Chapter 14 on the Deprivation of Liberty Safeguards). It introduces a compulsory treatment order in the community and ensures that those with personality disorders can be compelled to be treated. It also provides rights to advocacy, safeguards on using electroconvulsive treatment, and removes the right of a parent to overrule the refusal of a child of 16 and 17 years to be admitted to psychiatric hospital. The MHA is considered in Chapter 13.

Inherent jurisdiction of the court

As a senior court of record, the new Court of Protection is not part of the High Court and has no inherent jurisdiction. Its statutory powers define its jurisdiction, and these are considered in Chapter 7.

The High Court does have powers from its inherent jurisdiction, and in spite of the MCA and the amendments resulting from the introduction of the Bournewood safeguards, the High Court has still found it necessary to use its inherent jurisdiction to protect adults who lack the requisite mental capacity. The Court of Appeal in the case of *DL* v. *A Local Authority* [2012][32] (see Case Study 2.6) confirmed that the inherent jurisdiction of the High Court survived the MCA. Where a vulnerable adult does not lack capacity but requires protection, the case would be referred to the High Court and its inherent jurisdiction rather than the Court of Protection.

"Vulnerable" was described rather than defined in the case of *Re SA* (Vulnerable Adult with Capacity: Marriage) [2005][33] where Munby J outlined the role of the inherent jurisdiction of the court, in this case to make a declaration relating to a forced marriage. The vulnerable adult whilst not lacking mental capacity might require the protection of the court because of constraint, coercion, undue influence, or other vitiating factors. A declaration

Case Study 2.6 *DL* v. *A Local Authority and Others* [2012].[37]

DL was considered to be bullying his elderly parents with whom he lived. They were not lacking capacity but held to be under his undue influence. DL argued that the MCA provided a total statutory code for those lacking capacity, and it was not open to the court to consider a jurisdiction outside the Act. The Court of Appeal held that if there are matters outside the statutory scheme to which the inherent jurisdiction applies, then that jurisdiction continues to be available to continue as the great safety net. Inherent jurisdiction of the court survived and was targeted solely at those adults whose ability to make decisions for themselves has been compromised by matters other than those covered by the MCA (this could include being under constraint, subject to coercion, or undue influence). Public policy justified its survival. Making an interim judgment to give P the space to make the decision for himself is not the totality of the High Court's inherent powers.

in relation to a nonmarriage cannot be made under the MCA, and so the inherent jurisdiction of the court is utilized to declare a sham marriage a nonmarriage.[34] Similarly in the case of an *LA* v. *SY*,[35] Mr Justice Keehan invoked the inherent jurisdiction of the High Court to declare that the ceremony in which P had been involved was a nonmarriage.

Guidance has been published by the Official Solicitor on the appointment of an OS as litigation friend in family proceedings and proceedings under the inherent jurisdiction.[36]

The exercise of inherent powers by the High Court must ensure that the provisions of articles 5 and 8 of the Human Rights Convention are not breached and Munby J set out in the case of the *City of Sunderland* v. *PS* [2007] (see Case Study 2.7) (where detention of P in a care home was being considered) the requirements to ensure there were no infringements of these rights. He decided that the inherent jurisdiction of the High Court to protect the welfare of adults who lacked mental capacity enabled the court to make an order to stop a daughter (who wanted her mother to return to her care) preventing the mother from being moved from a hospital to a care home. The move to the care home was considered to be in the best interests of the mother. The facts are shown in Case Study 2.7.

This case should be contrasted with Re DE (an adult patient), JE, and Surrey County Council, which is considered in Chapter 3 (see Case Study 3.1).[40] In that case the court declared that the actions of Surrey County

Case Study 2.7 Inherent powers of the court. ***City of Sunderland*** v. ***PS*** [2007].[38]

PS was admitted to hospital on January 22, 2007. She was ready for discharge by February 7, 2007, but her daughter (CA) informed the hospital that she was intending to discharge her mother into her own care rather than into the care of the T unit, a residential care and elderly mentally infirm unit where P had lived since July 28, 2006. The T unit had been identified as suitable for meeting PS's permanent needs at a meeting, convened by the LA and attended by CA in November 2006. Concerns were increased by CA's request to the hospital that they should not inform the LA of what she was planning. The LA made an ex parte out-of-hours telephone application to a judge, and he made an interim order for PS to be moved to the T unit over the weekend until a hearing on the following Tuesday. Mr Justice Munby of the Family Division made interim declarations that PS lacked the capacity (1) to litigate, (2) to decide where she should reside, (3) to decide whom she had contact with, (4) to decide on issues concerning her care, and (5) to manage her financial affairs. [5 separate declarations on capacity were required because capacity is always issue-specific author's note.] The judge made an interim order that it was lawful as being in her best interests that PS reside at the T unit. The local authority was concerned that CA might attempt to remove PS from the T unit, and the judge granted an injunction, backed by a penal notice, restraining CA from doing anything to obstruct or prevent PS from remaining at the T unit. The local authority also sought an order permitting it to use appropriate means to stop CA removing PS. The judge was satisfied that the inherent jurisdiction of the court enabled it to protect vulnerable adults and cited the House of Lords in ***Re F***.[39] However he noted that any exercise of its inherent jurisdiction must be compatible with the various requirements of Article 5 of the European Convention on Human Rights. He suggested that the following minimum requirements must be satisfied in order to comply with Article 5:

1. The detention must be authorised by the court on application made by the local authority and before the detention commences.
2. Subject to the exigencies of urgency or emergency, the evidence must establish unsoundness of a kind or degree warranting compulsory confinement. In other words, there must be evidence establishing at least a prima facie case that the individual lacks capacity and that confinement of the nature proposed is appropriate.
3. Any order authorising detention must contain provision for an adequate review at reasonable intervals, in particular with a view to ascertaining whether there still persists unsoundness of mind of a kind or degree warranting compulsory confinement.

The judge made an order that it was lawful being in PS's best interests for the local authority by its employees or agents to use reasonable and proportionate measures to prevent PS from leaving the T unit.

There was also concern that CA, who was empowered to sign cheques on her mother's behalf, was not applying PS's modest savings appropriately in meeting PS's requirements. The judge therefore made an order that it was in PS's best interests that her financial affairs were managed by the Director of Adult Services (DS). DS was appointed to be receiver of the property, money, and income of PS and authorized to take all such steps as may be necessary to preserve the same with power to pay and apply the income to or for the benefit of PS. The fact that the Court of Protection had jurisdiction to make such an order did not prevent the court from making one. The judge considered that it would be an unnecessary burden and, in his judgment, wholly disproportionate to the very modest amounts involved to condemn the parties to the trouble and expense of separate proceedings in the Court of Protection.

Council in requiring a resident to remain in a care home were contrary to his Article 5 rights.

The High Court also used its inherent jurisdiction in a situation where a wife, in her 80s, was objecting to the decision that her husband, who was 90, should live in a home for the elderly mentally infirm (EMI). Mrs S considered that he should live with her at home, with the assistance of a support package provided by the local authority and primary care trust.[41] The judge held that it was in Mr S's best interests to live in the EMI home, and the without notice court application by the local authority was justifiable. However he listed the lessons to be learned from such a situation and recognized the exceptional nature of without notice applications.

There are dangers that misuse of these inherent powers could result in another Bournewood situation and a breach of Article 5. Failure to follow the points set by Munby J in Case Study 2.7[42] could lead to an allegation that there has been a breach of article 5.

In Case Study 2.8 the existence of inherent powers of the court was raised in relation to compelling a woman to have a caesarean section.

Case Study 2.8 shows that in deprivation of liberty cases, where the Court of Protection is prevented by Section 16A in making a declaration of deprivation of liberty because P comes under the provisions of the MHA, it would be possible for physical treatment of a person detained under the MHA to be declared lawful under the inherent jurisdiction of the High Court. The order must comply with article 5 (see previously), and it is essential that the scope, approach, and powers of the inherent jurisdiction are defined. See also the case of *NHS Trust & Ors v FG (Rev 1)* [2014][44] (where P was pregnant and suffering a schizoaffective disorder and lacked mental capacity and

Case Study 2.8 *Great Western Hospitals NHS Foundation Trust* v. *AA, BB, CC, DD* [2014].[43]

In this case AA was 38 weeks pregnant and was admitted, in a confused and disorientated state, to an obstetric ward, after her waters had broken. She was detained under Section 5(2) suffering from hypomania and puerperal psychosis, highly agitated, and exhausted by lack of sleep. The Trust made an emergency application for a caesarean. Her partner BB and her parents CC and DD and the Official Solicitor on her behalf supported the caesarean option. The judge held the court must focus on the welfare of the mother and not the fetus and look at a broader range of factors not just her medical interests. He used the inherent jurisdiction of the court to order the caesarean. He held that a welfare order cannot authorize a deprivation of liberty if AA is ineligible to be deprived of her liberty under paragraph 17 of Schedule A1 of the MCA (see Chapter 14). The treating team held that the caesarean was not treatment for mental disorder. She was under Section 2 and therefore fell within Case A of paragraph 2 of Schedule 1A as she was both subject to and detained under a hospital treatment regime. 39 Essex Chambers commented that the inherent jurisdiction of the court should only be invoked where there is a lacuna in the MCA.

the Trust applied for a transfer to an obstetric trust); Keehan J stated that where the court cannot make a welfare order depriving P of her liberty under Section 16(2)(a) of the MCA, it is able to exercise the inherent jurisdiction of the High Court to make such an order provided that it complies with Article 5 (see also Case Study 2.9 and 2.10).

Conclusions

Inevitably disputes have arisen over the interpretation of the Mental Capacity Act 2005 and the regulations enacted under it. It is the task of the courts to lay down principles to be followed, possibly to fill gaps in the statutory provisions until such time as Parliament enacts amending legislation to fill those gaps. One significant gap which has been filled is known as the Bournewood gap. The Bournewood case and Deprivation of Liberty Safeguards which have been introduced to fill the gap and the problems over interpretation which have arisen are discussed in the next chapter and in Chapter 14.

New measures to amend the DOLs and possible lacunae within the legislation are being considered by the Law Commission which is due to report with draft legislation at the end of 2016. In spite of the breadth of the Mental Capacity Act, it is clear that the inherent jurisdiction of the High Court still has a major role to play.

Case Study 2.9 *A NHS Trust* v. *Dr A* [2013].[45]

An Iranian Doctor who was detained under Section 3 of the Mental Health Act was on hunger strike, and the NHS Trust sought a declaration that he lacked capacity and that he could be given artificial nutrition and hydration. The judge held that he would not make an order under the Mental Health legislation nor under the Mental Capacity Act but under the inherent jurisdiction of the court to act in the best interests of Dr A. He declared that it would be lawful for Dr A to be provided with artificial nutrition and hydration and to use reasonable force and restraint for that purpose even though there would be deprivation of liberty. It was subsequently reported that as a result of the feeding, Dr A's mental state improved, and he recovered his capacity and returned to Iran.

Case Study 2.10 *A Local Health Board* v. *AB* [2015].[46]

AB who had a serious and life-threatening cardiac disorder was detained under Section 3 in a private hospital. The local health board sought CoP declarations in relation to AB's capacity and best interests for cardiac surgery and removal of her lower teeth with the intention that she should be placed under Section 17. HHJ Perry concluded that AB's best interests required the surgery to be carried out; she came within either case A or case B of Schedule 1A, and therefore the authorization for the medical procedures had to be made under the inherent jurisdiction of the High Court.[47]

Quick fire quiz, QFQ2

1. What is the difference between the Mental Capacity Act 2005 and the Mental Health Act 1983?
2. Does the doctrine of necessity still apply to decisions relating to those lacking the requisite mental capacity?
3. Does the Supreme Court have the power to change the law?
4. What is meant by "actionable per se"?
5. What is a trespass to the person?
6. What is the relevance of Article 5 of the European Convention on Human Rights to the detention of mentally disordered persons?

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CHAPTER 3

Human rights and statutory principles for governing decision making

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Introduction

This chapter considers the underlying principles of law which apply to the making of decisions and acting on behalf of those who are incapable of making their own choices. Some of these principles are set out in the Mental Capacity Act (MCA) 2005 itself; others are contained in the European Convention on Human Rights which has been incorporated into the laws of the United Kingdom (UK) and also in the Convention on the International Protection of Adults[1] which is given legal recognition by Section 63 of the MCA 2005. Chapter 2 of the Code of Practice gives guidance on the statutory principles and how they are applied.[2]

The Human Rights Act 1998

The United Kingdom was a signatory of the European Convention for the Protection of Human Rights and Fundamental Freedoms at the end of World War II. However, anyone who sought to bring an action for breach of their human rights, as set out in the Convention, was unable to take the case to the courts in this country but had to go to the European Court of Human Rights (ECHR) in Strasbourg. (Note that this is not the court of the European Community (i.e., the European Court of Justice), which meets in Luxembourg). It was estimated that to take a case to Strasbourg cost over £30 000 and took over 5 years. The Human Rights Act 1998 came into force in England and Wales on 2 October 2000.

It has three main effects:

- First, it is unlawful for a public authority (or an organization exercising functions of a public nature) to breach the rights set out in the Convention (see in the following text for consideration of the term *functions of a public nature*).
- Secondly, from October 2, 2000, an allegation of a breach of the rights by a public authority can be brought in the courts of this country.

Legal Aspects of Mental Capacity: A Practical Guide for Health and Social Care Professionals, Second Edition. Bridgit Dimond.

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- Thirdly, judges can make a declaration that legislation which is raised in a case before them is incompatible with the articles of the Convention. The legislation will then usually be referred back to Parliament for reconsideration.

The Act is not retrospective, but any person concerned about an infringement before October 2, 2000, could take a case to Strasbourg, depending upon time limits.

Action can be brought against a public authority or organization exercising public functions for breach of the Convention articles in the courts of this country. The House of Lords decided, in a majority decision, in June 2007 that private care homes under contract with local authorities for the provision of places were not exercising functions of a public nature for the purposes of the Human Rights Act.[3] This led to an understandable reaction from many charities concerned with the care of vulnerable adults that overriding legislation be passed. The definition of exercising functions of a public nature has subsequently been changed.

Section 145 of the Health and Social Care Act 2008 was enacted to define the provision of certain social care as a public function. Section 145 states that:

> (1) A person ('P') who provides accommodation, together with nursing or personal care, in a care home for an individual under arrangements made with P under the relevant statutory provisions is to be taken for the purposes of subsection (3)(b) of section 6 of the Human Rights Act 1998 (c. 42) (acts of public authorities) to be exercising a function of a public nature in doing so.

The relevant statutory provisions include:

> **a)** in relation to England and Wales, Sections 21(1)(a) and 26 of the National Assistance Act 1948 (c. 29),
> **b)** in relation to Scotland, Section 12 or 13A of the Social Work (Scotland) Act 1968 (c. 49), and
> **c)** in relation to Northern Ireland, Articles 15 and 36 of the Health and Personal Social Services (Northern Ireland) Order 1972 (SI 1972/1265 (NI 14)).

This provision is not retrospective and does not apply to cases prior to the coming into force of Section 145 nor can the care home itself allege a breach of human rights should the LA terminate its contract.[4]

Section 73 of the Care Act 2014 extends this provision so that the provider of care and support is exercising functions of a public nature if (a) the care or support is arranged by an authority specified in the Act and (b) the authority arranges or pays for the care or support under specified legislation. For England the specified authorities are local authorities (under s. 2, 18, 19, 20, 38, and 48 of the Care Act 2014) and Health and Social Care Trusts (under s. 51 of the Care Act 2014). The provision extends across the United Kingdom. Those funding their own care cannot claim the protection of the Human Rights Act.

An example of a declaration by a court that law is incompatible with the articles of the Convention on Human Rights is a declaration of the House of Lords,[5] which held that present marriage laws in the country which prevented a transsexual marrying following his gender change (because the law did not recognize the change of gender) were incompatible with the Convention on Human Rights. A Gender Recognition Act 2004 was then enacted which enables applicants who meet specified criteria to apply for a replacement birth certificate; they are then allowed to marry in their adopted sex.

European Convention on Human Rights[6]

Articles of the European Convention on Human Rights relevant to decision making for persons lacking mental capacity

Article 2: Right to life

> Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law. (See Protocols 6 and 13 which abolish the death penalty and were ratified by the UK.)

Diane Pretty failed in her attempt to secure an advance pardon for her husband if he should assist her in securing a dignified pain-free death. Her argument that the Suicide Act 1961 was contrary to her human rights in making it illegal for anyone to aid, abet, counsel, or procure the suicide of another or an attempt by another to commit suicide was not accepted by the English courts nor by the ECHR in Strasbourg.[7] Article 2 does not include a right to end one's life.

In other cases it has been held that ending artificial feeding or ventilation of a patient in a persistent vegetative state was not contrary to Article 2 of the European Convention on Human Rights. For example, H a female

patient had been in a permanent vegetative state for 8 years, and a declaration was made that the health trust could withdraw hydration and nutrition from her and this was not contrary to Article 2 of the European Convention on Human Rights.[8] Article 2 imposed a positive obligation to give life-sustaining treatment where that is in the best interests of the patient but not where it would be futile. Discontinuing treatment would not be an intentional deprivation of life under Article 2.

On Article 2 the House of Lords and House of Commons Joint Committee (hereafter *the Joint Committee*) stated that (Para 53):

> We are of the opinion that under the proper interpretation of Article 2, the State has a secondary obligation to protect life, but an individual can choose not to uphold that right. Accordingly the mechanisms under the draft Bill, which permit the refusal of consent to the carrying out or continuation of treatment, in accordance to the wishes of the patient, do not contravene Article 2 of the European Convention on Human Rights.

Article 3: Prohibition of torture

> No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

The MCA 2005 includes principles to be followed in respecting the autonomy of a mentally competent adult (see on pages 27–8), and these go to the heart of the underlying concept behind Article 3. In the case cited previously,[9] the court held that the discontinuation of artificial hydration and nutrition to a person in a permanent vegetative state was not torture under Article 3, provided that withdrawing treatment was in line with a respected body of medical opinion and that the patient would be unaware of the treatment and not suffering.

The Joint Committee discussed whether the provisions on the use of restraint violated Article 3 and came to the conclusion, in agreement with the Joint Committee on Human Rights, that the draft Bill provided sufficient safeguards to ensure that the right to be free from degrading treatment was protected.

The amendments to the MCA resulting from filling the Bournewood gap (see in the following) have permitted a situation where loss of liberty may result from the provisions of the Act, but there are rigid conditions, known as the Deprivation of Liberty Safeguards, to be satisfied.

In the case of *ZH* v. *Commissioner of Police for the Metropolis* [2013],[10] the Court of Appeal held that there was a breach of article 3 when an autistic young man was manhandled by the police away from a swimming pool. It held that the physical restraint of a vulnerable teenage boy who was autistic, epileptic, and lacked understanding of what was happening to him, carried out by police officers with handcuffs and leg restraints, and his detention in a cage in a police van were capable of constituting inhuman or degrading treatment contrary to article 3 and a deprivation of liberty in breach of article 5 of the European Convention on Human Rights. The boy had been taken by carers to the local swimming baths. He became fixated by the water and did not move. The manager called the police. The boy was still standing beside the pool but jumped in fully clothed when the police arrived. He was removed from the water by lifeguards, and the police took him into custody as described previously. The restraint and detention lasted about 45 min.

In *S* v. *Croatia (No 2)* [2015] ECHR 196, the ECHR held that there was a breach of Article 3 when a young woman was admitted to a psychiatric hospital and tied to a bed for 15 h on admission and her complaints of pain to her back were ignored by staff. There was also a breach of article 5 since there was a lack of procedural safeguards providing protection for P.

The Court of Appeal held that systematic and operational failures by the police in investigating serious and violent crimes by a serial rapist amounted to a breach of article 3 and inhuman and degrading treatment.[11]

Article 4: Prohibition of slavery and forced labor

1. No one shall be held in slavery or servitude.
2. No one shall be required to perform forced or compulsory labor.
3. For the purpose of this article, the term *forced or compulsory labor* shall not include:
   - **a)** Any work required to be done in the ordinary course of detention imposed according to the provisions of Article 5 of this Convention or during conditional release from such detention
   - **b)** Any service of a military character or, in case of conscientious objectors in countries where they are recognized, service exacted instead of compulsory military service

c) Any service exacted in case of an emergency or calamity threatening the life or well-being of the community

d) Any work or service which forms part of normal civic obligations

The courts have held that where trainee lawyers were required to undertake a certain amount of voluntary work as part of their training that was not a violation of Article 4. However it is possible that where persons lacking mental capacity were compelled to work against their will, Article 4 rights could be seen as infringed, depending upon the circumstances.

Article 5: Right to liberty and security

1 Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:

a) The lawful detention of a person after conviction by a competent court

b) The lawful arrest or detention of a person for non-compliance with the lawful order of a court or in order to secure the fulfillment of any obligation prescribed by law

c) The lawful arrest or detention of a person effected for the purpose of bringing him before the competent legal authority on reasonable suspicion of having committed an offence or when it is reasonably considered necessary to prevent his committing an offence or fleeing after having done so

d) The detention of a minor by lawful order for the purpose of educational supervision or his lawful detention for the purpose of bringing him before the competent legal authority

e) The lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts, or vagrants

f) The lawful arrest or detention of a person to prevent his effecting an unauthorized entry into the country or of a person against whom action is being taken with a view to deportation or extradition

2 Everyone who is arrested shall be informed promptly, in a language which he or she understands, of the reasons for his arrest and of any charge against him.

3 Everyone arrested or detained in accordance with the provisions of Para 1(c) of this article shall be brought promptly before a judge or other officer authorized by law to exercise judicial power and shall be entitled to trial within a reasonable time or to release pending trial. Release may be conditioned by guarantees to appear for trial.

4 Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.

5 Everyone who has been the victim of arrest or detention in contravention of the provisions of this article shall have an enforceable right to compensation.

An example of the impact of the European Convention on Human Rights can be seen in the Bournewood case.[12] In this case the House of Lords considered the question of whether a mentally incapacitated person, incapable of giving consent to admission, could be held at common law in a psychiatric hospital rather than being placed under the Mental Health Act 1983. It decided that Section 131 of the Mental Health Act 1983 did not require a mentally disordered person to have the capacity to consent to admission as an informal patient, and there was no breach of Article 5 of the European Convention on Human Rights when a person with severe learning disabilities was detained by common law powers and not placed under the Mental Health Act 1983. However the claimants subsequently took the case to the ECHR[13] where they succeeded, the court holding that there was a breach of Article 5(1) and 5(4) and the right to liberty. As a consequence of this decision, the UK Government was compelled to draft legislation to fill the gap revealed by the Bournewood case. The case itself, the results of this consultation and the Deprivation of Liberty Safeguards are considered in Chapter 14.

Restriction and loss of liberty

The distinction between a loss of liberty and a restriction on liberty were considered in a recent case, where the placement by a county council of a mentally incapable person in a care home was challenged as being a breach of Article 5 rights. The facts are shown in Case Study 3.1.

Since October 2007 the provisions of the MCA 2005 would apply to this situation (see the Deprivation of Liberty Safeguards (DOLs) and the Supreme Court

> **Case Study 3.1** Loss of liberty contrary to Article 5.[14]
>
> Surrey County Council (SCC) placed DE in X residential care home in September 2005 and then transferred him to Y residential home 2 months later. The local authority had justified the placement on grounds that any restriction on his liberty was in his best interests and he was not being deprived of his liberty within the meaning of Article 5. JE, his wife, claimed that DE was being held against his wishes and that SCC was in breach of DE's rights under Article 5 and also DE's and her own rights under Article 8. The judge accepted earlier precedents from cases heard by the European Court of Human Rights that the difference between deprivation of and restriction upon liberty is merely one of degree or intensity and not one of nature or substance.[15] The judge held that on the facts of the case the restrictions which SCC placed on DE (that he could not leave first X home and then Y home and return to live with JE) were in breach of his Article 5 rights. The crucial issue was whether the person was free to leave and the judge concluded that he was not.

judgment in the Cheshire case[16] which are considered in Chapter 14).

Several cases have shown that the Bournewood safeguards known as the DOLs introduced into the MCA 2005 by the Mental Health Act 2007 have caused difficulties for local authorities in ensuring that they take appropriate action in such cases as the Surrey County Council without a breach of Article 5 rights.

In the case of *X* v. *UK* [1981],[17] the ECHR held that the recall of a patient to hospital without the usual Winterwerp[18]* guarantees was lawful as it was an emergency and the further detention followed by a medical examination was also lawful, but habeas corpus proceedings were inadequate for article 5(4) purposes and the other legal machinery did not remedy the breach, in particular because the Mental Health Review Tribunal could not order discharge of restricted patients.

Mrs D, a sufferer from Huntington's Disease was awarded £27 000 for a breach of article 5 by the Court of Protection when the LA failed to allow her to return home after a 2-week stay in a care home and had not sought any authority for her continued placement for a further 6 months.[19]

Allegation of incompatibility between Ss2 and 29(4) of MHA and Article 5

In one case the Court of Appeal held that Sections 2 and 29(4) of the Mental Health Act 1983 were incompatible with Article 5(4) of the European Convention and the state had a duty to protect incompetent patients.[20] However its decision was overruled by the House of Lords[21] which was subsequently overruled in part by the ECHR. The case is shown in Case Study 3.2.

> **Case Study 3.2** *R (MH)* v. *Secretary of State for Health* (2004).
>
> MH was 32 years old and suffered from Down's syndrome. She was admitted to detention under Section 2 (which authorizes detention for 28 days) of the Mental Health Act 1983. Her mother applied for her discharge under Section 23, but this was barred by the responsible medical officer and an application was made under Section 29 to remove the mother as the nearest relative. This application had the effect of retaining the Section 2 detention beyond the 28 days until the application was heard by the court and 7 further days for formalities for admission for treatment or guardianship to be completed. MH maintained that her rights under Article 5.4 were violated since, because of her incapacity, she was unable to appeal to the Mental Health Review Tribunal under the statutory provisions. The Court of Appeal held that the state was obliged to make provision for referring to a court the case of a patient who was detained under the Mental Health Act 1983 who was incapable of exercising her right to apply to a mental health review tribunal on her own initiative. The Court of Appeal also held that Section 29(4) of the Mental Health Act 1983 was incompatible with Article 5(4) of the European Convention on Human Rights, since there was no provision for referral to court for a patient detained under Section 2 whose period of detention was extended under Section 29(4). The appeal of the Secretary of State to the House of Lords succeeded. It held that Section 2 was not

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* Winterwerp guarantees included positive answers to the following questions: (a) Was the detention lawful; (b) Was the placement justified by the severity of the disorder?; (c) Did the persistence of mental disorder justify the validity of continued confinement?; (d) Was there a right of access to a court and an opportunity to be heard in person or be represented. Special procedural safeguards may be called for in order to protect the interests of persons who, on account of their mental illness, are not fully capable of acting for themselves?

incompatible with Article 5 since a patient could apply to a tribunal within the first 14 days of the section and county court proceedings determining the removal of the nearest relative could be speedily held and S 29(4) (which extended the period of detention under Section 2) was not incompatible with Article 5 since there were remedies: the power of the Secretary of State under S.67(1) to refer the case to a tribunal and through judicial review and habeas corpus. The claimant appealed to the European Court of Human Rights[22] which held that there was a breach of Article 5(4) in respect of the first 27 days of detention (it was unreasonable to expect her to use habeas corpus when the nearest relative was barred from making an application for discharge) but there was no breach in relation to the remainder of the detention. She was awarded €4400 as compensation.

The ECHR decision illustrates the importance on ensuring that P should not only have procedural safeguards but also that steps should be taken to ensure that he/she has someone to act on his behalf to make use of such procedural protections.

Restraint and loss of liberty

Several new clauses were added to the Mental Capacity Bill to ensure that where restraint was permitted, subject to specified conditions, this restraint could not amount to a loss of liberty under Article 5 (e.g., Section 6(5) of the MCA):

> (5) But D does more than merely restrain P if he deprives P of his liberty within the meaning of Article 5(1) of the Human Rights Convention (whether or not D is a public authority).

However in order to make amendments to the MCA for the purposes of filling the Bournewood gap, the Mental Health Act 2007 Section 50(4) repealed Section 6(5) of the MCA (and the comparable sections 11(6) and 20(13)) and replaced it with new Sections 4A and 4B, which would justify the deprivation of liberty in specific circumstances. Sections 4A and 4B are set out in Statute Boxes 14.2 and 14.3, respectively, and are considered in Chapter 14.

A discussion of the human rights implications of the use of restraint can be found in Chapter 5.

As a consequence of the amendments to the MCA 2005 resulting from the need to fill the gap revealed by the Bournewood case, known as the DOLs, it would be possible for a person to lose their liberty under the MCA but only if the conditions laid down in Sections 4A and 4B and the amending Schedules are satisfied (see Chapter 14).

Article 6: Right to a fair trial

1 In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law. Judgment shall be pronounced publicly but the press and public may be excluded from all or part of the trial in the interest of morals, public order, or national security in a democratic society, where the interests of juveniles or the protection of the private life of the parties so require, or to the extent strictly necessary in the opinion of the court in special circumstances where publicity would prejudice the interests of justice.

2 Everyone charged with a criminal offence shall be presumed innocent until proved guilty according to law.

3 Everyone charged with a criminal offence has the following minimum rights:

- **a)** To be informed promptly, in a language which he understands and in detail, of the nature and cause of the accusation against him
- **b)** To have adequate time and facilities for the preparation of his defense
- **c)** To defend himself in person or through legal assistance of his own choosing or, if he has not sufficient means to pay for legal assistance, to be given it free when the interests of justice so require
- **d)** To examine or have examined witnesses against him and to obtain the attendance and examination of witnesses on his behalf under the same conditions as witnesses against him
- **e)** To have the free assistance of an interpreter if he cannot understand or speak the language used in court

The Joint Committee considered that access to the Court of Protection for persons lacking capacity was essential to ensure that they received a prompt, fair, and public hearing and that there was no breach of Article 6 (Para 54). The role of the Court of Protection is discussed in Chapter 7 and the scenarios in that chapter.

Article 8: Right to respect for private and family life

1 Everyone has the right to respect for his private and family life, his home, and his correspondence.
2 There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety, or the economic well-being of the country for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

The right to respect for private and family life is not an absolute right and there are several exceptions to it. There has to be a balancing act between the right itself and the interests of public safety, the protection of health or morals, and the other circumstances set out in Para 2. For example, it may be argued by a family where one member has severe learning disabilities that the parents are entitled to take their own decisions about the care and treatment of that family member without any public interference. However, if it can be shown that the best interests of that family member are not being appropriately protected, then intervention in the decision making on behalf of that individual could be justified. Article 8 also covers the disclosure of information held about a person and their qualified right of access to it. In one case[23] the ECHR held that the desire by a person born as a result of artificial insemination to know the details of their origin did engage Article 8 rights and placed the state under a positive obligation.

A settlement was announced in the case of Susan Hearsey who had severe learning disabilities who was abused and neglected by staff at Manor Hospital Walsall. The settlement of £65 000 included moneys for the damage to a doll which Susan treated as her baby. Her lawyer stated that the case underlined the important protections afforded by the Human Rights Act, which was relied upon to argue for these wider outcomes for Susan.[24]

In the case of *Westminster City Council* v. *Sykes*,[27] the court stated that Article 8 provides a qualified right that everyone has the right to respect for their private and family life, home, and correspondence. Any interference with Ms S's family or private life must be authorized by law, proportionate (*necessary in a democratic society*), and for a permitted purpose, for example, for the protection of her health. The court should consider

Case Study 3.3 *R (McDonald)* v. *Kensington and Chelsea Royal London Borough Council (ECHR)*[25]

The Supreme Court[26] had held that there was no breach of Article 8 rights when an LA withdrew the provision of a night time carer to assist a disabled person to use a commode when required and instead provided her with incontinence pads to wear at night (Baroness Hale dissented). The ECHR held that there was a breach of Article 8 for part of the time. However where the withdrawal had been made after a proper assessment, the interference with her right to respect for her private life had been both proportionate and justified as necessary in a democratic society and there was no breach of article 8.

The implications of this ECHR decision is that failure by the local authority to carry out an appropriate assessment before removing any assistance from or refusing to provide a service to a community client could be seen as a breach of Article 8 rights.

the nature and strength of the evidence of the risk of harm. There must, as Peter Jackson J observed in *Hillingdon LBC* v. *Neary* [2011][28] at Para 15(3), be a proper, factual basis for such concerns. Once this court has completed its analysis of Ms S's best interests under the MCA, it must satisfy itself that any infringement of her Article 5 and/or Article 8 rights which arises from its (provisional) conclusion is necessary and proportionate (see also *K* v. *LBX* [2012]).[29] (The case is considered in Case Study 5.23 and in Chapter 14.)

Article 9: Freedom of thought, conscience, and religion

1. Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.
2. Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.

Article 9 protects rights in relation to a broad range of views, beliefs, thoughts, and positions of conscience, as well as faith in a particular religion. It will be noted that in determining the best interests of a person who lacks

the requisite mental capacity, the beliefs, views, values, etc. of that person must be taken into account in determining best interests, and relevant people must be consulted over what these values etc. might be.

Article 10: Freedom of expression

1. Everyone has the right to freedom of expression. This right shall include freedom to hold opinions and to receive and impart information and ideas without interference by public authority and regardless of frontiers. This Article shall not prevent States from requiring the licensing of broadcasting, television or cinema enterprises.
2. The exercise of these freedoms, since it carries with it duties and responsibilities, may be subject to such formalities, conditions, restrictions or penalties as are prescribed by law and are necessary in a democratic society, in the interests of national security, territorial integrity or public safety, for the prevention of disorder or crime, for the protection of health or morals, for the protection of the reputation or rights of others, for preventing the disclosure of information received in confidence, or for maintaining the authority and impartiality of the judiciary.

This article has to be balanced against the qualified privacy rights recognized by Article 8. The Court of Protection has the power to determine whether a hearing involving a person lacking mental capacity should be heard in private and to make an order prohibiting any disclosure of the names (see Chapter 7).

Article 14: Prohibition of discrimination

> The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

Even though Article 14 does not explicitly mention mental capacity or age, both could be the subject of unlawful discrimination since the list of forms of discrimination is preceded by the words *such as* and ends with *or other status*. The list is not meant to be exhaustive. Article 14 does not stand in its own right: it has to be used in conjunction with the alleged violation of another article. There are however suggestions that it should be amended to this effect.

The Ministry of Justice has provided a guide to the Human Rights Act which can be downloaded from its website.[30] In 2008 it published a booklet for people with a learning disability on the Human Rights Act.

UN Convention on Rights of Persons with Disabilities

This UN Convention was signed in March 2007 and came into force in May 2008. It is monitored by the Committee on the Rights of Persons with Disabilities. The core provisions of the Convention are:

1. Respect for inherent dignity, individual autonomy including the freedom to make one's own choices and independence of persons
2. Nondiscrimination
3. Full and effective participation and inclusion in society
4. Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity
5. Equality of opportunity
6. Accessibility
7. Equality between men and women
8. Respect for the evolving capacities of children with disabilities and respect for the rights of children with disabilities to preserve their identities.

The Convention on Rights of Persons with Disabilities (CRPD) United Nations Convention came into force May 2008 and was ratified by the United Kingdom in 2009 and by the European Union in December 2010 (but the United Kingdom has not yet incorporated the convention into English law). The convention is monitored by the UN Committee of the Rights of Persons with Disabilities. Disability is defined as including:

> those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

Convention on the International Protection of Adults

Section 63 provides that Schedule 3 gives effect in the private international law of England and Wales to the Convention on the International Protection of Adults, signed at The Hague on January 13, 2000 (Cm 5881) (in so far as this Act does not otherwise do so). (Scotland implemented the Convention in Schedule 3 of the Adults with Incapacity (Scotland) Act 2000.) The Convention provides international protection for adults who cannot protect their interests. For example, it determines which jurisdiction should apply when a national of one country is in another country. The Convention on

the International Protection of Adults defines an adult with incapacity as being a person who is over 16 years (now 18 years[31]) and as a result of an impairment or insufficiency of his personal faculties cannot protect his interests. Protective measures for such adults can include the determination of incapacity and the institution of a protective regime, placing the person under the protection of an appropriate authority, guardianship, curatorship, or any corresponding system, designation, and functions of a person having charge of the adult's person or property or representing or otherwise helping him, placing the adult in a place where protection can be provided, administering conserving or disposing of the person's property and authorizing a specific intervention for the protection of the person or his or her property.

The central authority in relation to the protection of mentally incapacitated adults in England and Wales is the Lord Chancellor. Part 2 of Schedule 3 sets out the scope of the jurisdiction of the competent authority, and Part 3 considers the appropriate jurisdiction when a mentally incapacitated adult becomes habitually resident in another country. Part 4 covers the recognition and enforcement of protective measures of other Convention countries in appropriate circumstances. Part 5 covers cross-border placement of adults lacking mental capacity and requires cooperation between Convention member countries. Part 6 makes provision for a certificate given by a Convention country under Article 38 of the Convention to be regarded as proof of the matters contained in it and enables regulations to be made by the Lord Chancellor and for the commencement of the different paragraphs of the Schedule.

In the case of *Re M* [2011],[32] it was held that Section 16A and Schedule 1A to the MCA did not bar the court from recognizing and declaring to be enforceable an order of the Irish court. The Judge stated that there was a freestanding power to recognize a foreign order under paragraph 19 of Schedule 3. The court could recognize and enforce a foreign order detaining a person habitually resident overseas in an English psychiatric institution. The court was not required to consider P's best interests.

Statutory principles governing decision making under the MCA

The Joint Committee (Para 43) succeeded in its pressure for a statement of principles to be incorporated into the Mental Capacity Bill. The Joint Committee suggested five principles which could be included in the Bill, and with some minor modifications, these were incorporated into the Bill. The principles were for the most part already contained in common law rulings but were given statutory effect. The five principles are set out in Section 1 and are discussed in the following text.

Principle one: Presumption of capacity

> A person must be assumed to have capacity unless it is established that he lacks capacity. (S1(2)) MCA

A person is one over 16 years (see Section 2(5)). The presumption of capacity could be rebutted on a balance of probabilities. The burden of establishing lack of capacity would be upon a person alleging it. The presumption and determination of capacity are considered in Chapter 4 and the scenarios in that chapter. The presumption of capacity has been a basic provision at common law,[33] and Section 1(2) now puts this in statutory form. The assessment of capacity should be undertaken at regular intervals.[34]

Principle two: Practicable steps to assist capacity

> A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success. (1(3)) MCA

Interestingly, the Act uses the term *all practicable steps*. The absence of the word *reasonably* places a much higher duty on health professionals and carers to promote the capacity of the individual to make decisions. This is further discussed in Chapter 4 and the scenarios in that chapter. However the subsection does not use the words *all possible steps* so that common sense should be used in determining what measures can be taken. The Code of Practice warns of the dangers of undue pressure being used to influence P into making a specific decision.[35]

Principle three: Unwise decisions

> A person is not to be treated as unable to make a decision merely because he makes an unwise decision. (1(4)) MCA

The impact of this principle, clearly established at common law, can be seen in the case of *Re B*,[36] which is discussed in Chapter 2 (see Case Study 2.1). Miss B's refusal to accept ventilation for her paralyzed condition clearly troubled the President of the Family Division, but she accepted that since Miss B's competence had

Case Study 3.4 *D vR (Deputy of S) and S* [2010].[37]

The court considered the issue of whether an unwise gift could be upheld. R the deputy sought declarations that gifts of money made by Mr S to a Mrs D (a legal secretary employed by his solicitors) totaling over £500 000 were procured by undue influence and should be set aside. The judge Henderson J looked at 1(4) and the fact that the decision was an unwise one … does not justify conclusion of incapacity. Henderson had previously appointed a Special Visitor to consider whether Mr S had the capacity to decide whether the proceedings should continue or be compromised. The Visitor reported that Mr S lacked the requisite capacity.

39 Essex Street Chambers commented that it was "difficult to avoid the conclusion that the weight that can be placed upon the apparent lack of wisdom of the decision must be very little if the terms of S1(4) (i.e., best interests – see below) are to be respected."

been established, then it was her right to make a decision that would eventually lead to her death. It is thus a principle of law that a mentally competent person can make a decision which is contrary to his or her best interests. It follows therefore that where an individual has signed an advance decision refusing life-saving treatment, a person nominated by him to carry out his wishes does not have to act in the best interests of that individual but in accordance with the advance decision (provided it is valid and relevant) (see Chapter 9 and the scenarios in that chapter on advance decisions). See Case Study 3.4 on an unwise decision. In Chapter 4 the issue of too many unwise decisions is considered.

Principle four: Best interests

> An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests. (S1(5)) MCA

Once lack of capacity has been established, then any decisions must be made in the best interests of the person lacking the requisite mental capacity. This is further discussed in Chapter 5 and the scenarios in that chapter. If P has drawn up an advance decision which is valid and applicable to the decision to be made, then that must be followed even though the result would be contrary to P's best interests.

Principle five: Least restrictive options

> Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action. (1(6)) MCA

Examples were given in the parliamentary debates on the implications of choosing the least restrictive option, and these are discussed in Chapter 5 and the scenarios in that chapter. The House of Lords Select Committee concluded that this least restrictive principle was not routinely or adequately considered.[38] In response to the Select Committee report, the Government stated that:

> We will radically reduce the use of all restrictive practices. The Government's recent policy document "*Positive and Proactive Care*" sets out how we expect to see the use of restrictive practices minimised wherever possible. The MCA introduced into law the least restrictive principle and should be the reference point for all restrictive practices involving individuals who lack capacity. We shall align the work of our mental capacity and mental health programmes ensuring that this principle is embedded throughout and, where a deprivation of liberty is unavoidable as part of an individual's care plan, this is legally authorised (either via the Deprivation of Liberty Safeguards or the Court of Protection).[39]

The wording of Section S1(6) is that *regard must be had* to the least restrictive principle. This does not mean that it will always apply and there are cases where the best interests of P means that the least restrictive option is not followed.[40]

Disability discrimination legislation and the Equality Act 2010

The House of Commons Select Committee[41] considered the relationship between the Mental Capacity Bill and disability discrimination legislation. The point was noted in the parliamentary discussions on the Bill that there is no specific reference to the Disability Discrimination Act (DDA) in the Mental Capacity Bill, and the DDA does not specifically cover discrimination on grounds of age. However any person over 16 years who was discriminated against in relation to mental capacity would be protected by the MCA 2005, the DDA 1995, and also the Human Rights Act 1998 Schedule 1 Article 14 linked with Article 3 or any other relevant article.

The Equality Act 2006 provided for the Commission for Equality and Human Rights (CEHR) to be established in October 2007, when it took over the work of the existing three Commissions: Disability Rights Commission, Commission for Race Equality, and the Equal Opportunities Commission.[42] Trevor Philips was appointed as the CEHR chair.

In December 2006 public bodies were placed under a new disability equality duty to ensure that their organizations had a policy to identify and eradicate discrimination against disabled people. Public authorities are required to carry out six duties:

1 To promote equality of opportunity between disabled and other persons
2 To eliminate discrimination that is unlawful under the DDA 1995
3 To eliminate harassment related to their disabilities
4 To promote positive attitudes
5 To encourage participation in public life
6 To take account of their disabilities even where that involves them more favorably than other persons

The Equality Act 2010 created a framework for the protection of persons covering nine key areas of discrimination. They are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity care, race, religion or belief, sex, and sexual orientation. Further information on these characteristics can be found on the Equality and Human Rights Commission website[43] and on that of the Ministry of Justice.[44] As well as the booklet for people with learning disabilities, in June 2014 the Ministry of Justice updated as an educational resource its human rights guide: Right here, Right now.

Conclusions

The inclusion of statutory principles in the primary legislation rather than just in the Code of Practice is crucial to the protection of the interests of those who lack the requisite mental capacity. Even though many of the statutory principles were already accepted at common law (judge made or case law), setting them at the heart of the MCA with an enforceable obligation has created a new situation. The duty to obey the statutory principles which is placed on all those making decisions or acting on behalf of others should clarify the rights of and the duties to those who require protection. This clarity should be reinforced by the Code of Practice. The conservative government's to replace the UK's commitment to the European Convention on Human Rights Act with a Bill of Rights was postponed but not necessarily abandoned.

Quick fire quiz, QFQ3

1 Does the Human Rights Act 1998 gives statutory force to the full European Convention on Human Rights?
2 Why is the legislation on human rights still important after the implementation of the Mental Capacity Act 2005?
3 What is the value of incorporating statutory principles into the Act?
4 What is meant by the phrase "the presumption of capacity can be rebutted on a balance of probabilities"?
5 What is the difference between *all practicable steps* and *all reasonably practicable steps*?
6 What is the significance of the decision of the European Court of Human Rights in the Bournewood case?

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CHAPTER 4
Definition of mental capacity

THIS CHAPTER CONSIDERS THE FOLLOWING TOPICS

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Significance of mental capacity

If a person over 16 years has the necessary mental capacity to make a specific decision, then his or her right to make his or her own decisions is protected. (See qualifications on right of the 16- and 17-year-old discussed on pages 33–4 and in Chapter 12) If however he or she lacks the requisite mental capacity, then action has to be taken on his or her behalf. The existence or nonexistence of the requisite mental capacity is therefore central to the law on decision making. The adult person who has the requisite capacity can make any decisions no matter how unwise; the adult person who lacks the requisite capacity cannot make those decisions, but someone will act in his or her best interests.

Presumption that capacity exists

It was a basic presumption of law that every adult is presumed to have mental capacity, and this presumption has now been given statutory effect in the Mental Capacity Act (MCA) 2005. Section 1(2) recognizes as a basic principle that:

> A person must be assumed to have capacity unless it is established that he lacks capacity.

This presumption can however be rebutted (i.e., replaced) by evidence to the contrary, as Scenario 4.1 illustrates. The standard of proof for the rebuttal is on a balance of probabilities (S.2(4)). This is known as the civil standard

Legal Aspects of Mental Capacity: A Practical Guide for Health and Social Care Professionals, Second Edition. Bridgit Dimond.

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of proof and contrasts with the criminal standard of proof which requires the judge or jury to be satisfied beyond reasonable doubt that the accused is guilty of a crime. The civil standard is therefore a lower standard of proof and can be more easily satisfied than the criminal standard. The burden of proof is on the person alleging that P lack's capacity.

Presumption of capacity: Scenario

As a 21-year-old there would be a presumption that Bob had the mental capacity to make his own decisions, but a test may well establish that he lacks the capacity to understand the implications of not attending the dentist and the possibility that if he had an infection it could spread to the rest of his body and that, if treatment were not to be given, his situation could become extremely serious if not life threatening. If following an assessment it was concluded that Bob was incapable of realizing the seriousness of his situation and lacked mental capacity to make a decision, the presumption that he had mental capacity would be rebutted. Actions would then have to be taken in his best interests (see Chapter 5).

How is mental capacity defined?

There is a two-stage process for determining whether a person lacks the requisite mental capacity to make a specific decision. The first stage is to determine whether there exists an impairment or disturbance in the functioning of the mind or brain. The second stage is to determine if this impairment or disturbance results in an inability to make or communicate decisions.

Stage 1 Existence of an impairment, or a disturbance in the functioning of, the mind or brain

Mental capacity is defined in Section 2 of the Act and is shown in Statute Box 4.1

The factors shown in Statute Box 4.1 are illustrated in Scenario 4.2.

Scenario 4.1 The presumption of capacity is rebutted.

Bob, 21 years, has learning difficulties and has lived in residential accommodation for the past 6 years. He has been suffering very badly from toothache but hates anyone looking into his mouth. His paid carers decide that he should see a dentist and possibly have an extraction. Bob is not prepared to go to the dentist. Can he be forced to attend?

Statute Box 4.1 Section 2 of Mental Capacity Act 2005 definition of mental capacity.

Section 2 for the purposes of this Act

1 A person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

2 It does not matter whether the impairment or disturbance is permanent or temporary.

3 A lack of capacity cannot be established merely by reference to:

a) a person's age or appearance, or

b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity.

4 In proceedings under this Act or any other enactment, any question whether a person lacks capacity within the meaning of this Act must be decided on the balance of probabilities.

Scenario 4.2 Situation: A tramp.

Denis is found wandering the streets on a cold, rainy windy winter night. He is invited to take refuge in accommodation for the homeless. He accepts the offer and is given food and a bed and offered a shower. An assistant helps him prepare for the shower and notices that he has an extremely serious abscess on his ankle which looks as though it could be gangrenous. Denis agrees to see the doctor who visits the home each week and is advised that he may have to have an amputation of his leg, since the gangrene could be fatal, and that he should be examined by a specialist. Denis refuses any such examination, consultation, or treatment. Could he be compelled to undergo treatment?

Stage 1 An impairment or disturbance?

Working through the statutory definition of capacity, the following steps could be used to answer the question posed in Scenario 4.2:

- What is the decision to be made?
- The answer to this is: has Denis the capacity to make a decision on whether he should consent to or refuse possibly lifesaving treatment?

- There is a presumption that Denis has the capacity to make this decision: is there evidence that this presumption should be challenged?
- Does Denis have an impairment of, or a disturbance in the functioning of, the mind or brain?
- If so, does this impairment or disturbance mean that he is unable to make a decision for himself in relation to whether or not he should have treatment?
- Denis's state of clothing and appearance and tramp condition should be ignored for the purpose of determining whether or not he has capacity to make that specific decision.

If the conclusion is that Denis does not have an impairment or disturbance in the functioning of his mind or brain, or alternatively, he does have such an impairment or disturbance, but it does not affect his ability to make that particular decision, then the conclusion will be that Denis does not lack mental capacity and can decide himself whether to have that treatment. That conclusion means that his refusal to have the amputation could not be overruled in his best interests. As an adult with the requisite mental capacity to make that particular decision, he is entitled to make that decision and he therefore can make an unwise decision, that is, a decision which would appear to be contrary to his best interests (see page 42).

The assessment has to be made *at the material time*. This would mean that where a person is suffering from intermittent capacity which can sometimes occur with Alzheimer's disease, if there are interludes of capacity and during that time the person is able to understand the information and can make and communicate the relevant decision, then for the purposes of the MCA that person does not lack the requisite capacity. The Act specifically provides that the fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision (S3(3) See Statute Box 4.2 on page 34).

Superficial judgments

The factors set out in Section 2 for determining capacity are significant considerations in the determination of mental capacity, since it is easy to make superficial judgments based on irrelevant criteria such as "The man looks like a tramp: he must lack mental capacity".

The Joint Committee was concerned that there may be too easy an assumption of incapacity and failure to make the time and support available to enable people with learning disabilities to contribute to the decision-making process. As a result of the recommendations of the Joint Committee, the Code of Practice Chapter 4 gives specific guidance on the need for evidence of impairment or disturbance in mental functioning and of lack of capacity.

Children and young persons

Persons under 16 years are excluded from the provisions of the Act (Section 2(5)), apart from the provisions of Section 18(3), which enables the exercise of powers under Section 16 in relation to property and affairs, even though P has not reached 16 but the court considers it is likely that P will still lack capacity to make decision in respect of the matter when he is 18 years (see Chapter 12 and scenarios in that chapter).

Young persons of 16 and 17 have a statutory right to give consent to treatment.[1] However judges have ruled that at common law it is possible to overrule the refusal of a person of 16 or 17 who is refusing lifesaving treatment if that treatment is in his or her best interests.[2] In contrast, the refusal of a person over 18 years to receive even lifesaving treatment cannot be overruled, provided that they have the requisite mental capacity. This difference explains why an advance decision or living will can only be drawn up by an adult over 18 years: as the law stands at present, a young person of 16 and 17 cannot refuse life-sustaining treatment if that is in his or her best interests.

Exceptions to the rule that the MCA applies to those over 16 years:

A person must be over 18 years to be appointed as a deputy or to be given a power of attorney.

A person must be over 18 years to appoint an attorney.

A person must be over 18 years to draw up an advance decision.

The authorizations under the Deprivation of Liberty Safeguards only apply to those over 18 years (see Chapter 14).

Section 40 of the Mental Health Act 2007 amends the Mental Health Act 1983 so that a parent cannot give consent to the admission of his child of 16 or 17 to psychiatric hospital if that child has the requisite capacity

and does not consent to the making of the arrangements for admission. This may lead to a change in the law relating to overruling the refusal of a 16- or 17-year-old in other specialities apart from psychiatry (see further Chapter 12).

The new offence under Section 44 of willful neglect and ill-treatment of a person lacking mental capacity applies to all ages, but for the purposes of this offence, lack of capacity cannot be due to age.

Stage 2 An ability to make decisions

Once it has been established that there exists an impairment of, or a disturbance in the functioning of, the mind or brain, then the next stage is to determine whether this prevents P from making or communicating a specific decision.

What is meant by inability to make decisions?

The phrase *unable to make decisions for himself* used in Section 2 is subsequently defined in Section 3 and is shown in Statute Box 4.2.

This definition of being unable to make decisions contained in Section 3 and shown in Statute Box 4.2 follows very closely the common law decision set in a Broadmoor case by Thorpe J[3] and subsequently expanded by the Court of Appeal in the case of *Re MB*.[4] The case of MB was followed in a case involving a detained patient at Broadmoor Special Hospital who was refusing treatment for his bipolar affective disorder. He denied that he was mentally ill. The judge held that he lacked the mental capacity because he was not able to appreciate the likely effects of having or not having the treatment, and his decision was upheld by the Court of Appeal.[5]

In the case of *NCC* v. *PB and TB* [2014],[6] the Judge Mrs Justice Parker had to determine if PB, a woman of 79 married to a man of 50 had the capacity to decide whether to live with him. There was no dispute that both she and the husband lacked the capacity to litigate. It was agreed that she had the capacity to understand and retain the relevant information and to communicate a decision, but it was disputed whether she could use or weigh the information in making the relevant decision. The judge concluded that on the evidence, PB was unable to factor into her thought processes (i.e., using and weighing) the realities of the harm that she would suffer if she resumed contact with the husband and she was unable to weigh up the risks of her being in an unsupported environment.

Statute Box 4.2 Section 3 Mental Capacity Act unable to make decisions.

S3. (1) For the purposes of Section 2, a person is unable to make a decision for himself if he is unable:
- **a)** To understand the information relevant to the decision
- **b)** To retain that information
- **c)** To use or weigh that information as part of the process of making the decision
- **d)** To communicate his decision (whether by talking, using sign language, or any other means)

(2) A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids, or any other means).

(3) The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.

(4) The information relevant to a decision includes information about the reasonably foreseeable consequences of:
- **a)** Deciding one way or another
- **b)** Failing to make the decision

The decision of the Court of Appeal in IM v LM and others 2014[7] was also concerned with the ability to use or weigh the information and is considered in Case Study 4.7.

The issue of whether any inability to make a decision is because of an impairment of or disturbance in the functioning of the mind or brain was considered by the Court of Appeal in the case of *PC and NC* v. *City of York* [2013][8] (see Case Study 4.8). In this case the central issue was whether a woman with significant learning disabilities had the capacity to decide whether or not she was going to live with her husband.

The statutory definition covers both the actual mental inability to make decisions and also the situation where the individual may have the requisite

mental competence but be unable to communicate his or her views. However every effort must be made to facilitate communication.

Facilitating communication

What steps must be taken to assist P in having the requisite capacity, for example, in being able to communicate?

Section 3(2) would require ensuring that any appropriate technical equipment or speech therapy aids were utilized in order to facilitate communication with the patient. In addition it must be remembered that one of the basic principles of the Act (see Chapter 3 and Section 1(3)) is that:

> A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

This is of particular significance in situations such as those where a patient has brain damage which results in their only being able to communicate through technological means. There is no qualification in the section such as that only **reasonably practicable** means need be used. The consequence is that if through technology and equipment it is possible to communicate with a brain damaged/speech impaired person, then those facilities must be made available. *Appropriate to his circumstances* could therefore have significant resource implications as Scenario 4.3 illustrates.

Scenario 4.3 Situation: Capacity and communication.

Anna, aged 34 years, has cerebral palsy and has spent most of her life in residential accommodation with residents who have similar conditions. She is asked if she would like to move into a new care home that is just being opened. The decision is critical since she has several friends in the present home and there is a dispute among the carers over the move, since some feel that it would not be in her best interests. She has considerable difficulty in communicating and has in the past had regular speech therapy to assist her in using sign language. Unfortunately there is a shortage of speech therapists in the area and one is not available to assist Anna in communicating her wishes about the proposed move. The manager is proposing that the move should take place on the grounds that Anna is incapable of communicating her wishes that it is not practical to do any more and that it is in her best interests to go into the new accommodation. Some of the carers dispute these proposals. What action can be taken and what is the law?

Explanation of 'appropriate to his circumstances'

The following steps must be taken in determining whether Anna has the mental capacity to make a specific decision.

This question would be decided on a balance of probabilities. (This is the lighter test—used in civil proceedings—to determine liability and contrasts with the tougher test—beyond reasonable doubt—which is used in criminal proceedings.)

From the facts given it is clear that Anna has cerebral palsy, and this would constitute an impairment or disturbance in the functioning of her mind or brain. For Anna this is a permanent impairment or disturbance, but this does not affect the definition of mental capacity (though, if she was deemed to lack the requisite mental capacity, it could have affected how her best interests were decided—see the scenarios in Chapter 5).

In addition, in determining whether Anna had the requisite mental capacity, her age, appearance, or a specific condition or aspect of her behavior should not be used as the basis for superficial judgments about her capacity. For example, if Anna had constant uncontrollable limb movements and was continually dribbling, this should not be seen as implying that she was incapable of having the requisite mental capacity to make a decision on her accommodation.

1 Does she have an impairment or a disturbance in the functioning of her mind or brain?

2 Is Anna over 16 years? The answer to this is that she is 34 and so the powers under the Act can apply to her.

3 Does the impairment or disturbance in the functioning of the brain or mind result in Anna being unable to make a decision for herself?

The statutory test to be applied to answer this question is:

a) Does Anna understand the information relevant to the decision?

b) Does she retain that information?

c) Can she use or weigh the information as part of the process of making the decision?

d) Can she communicate her decision (whether by talking, using sign language, or any other means)?

a) Does Anna understand the information relevant to the decision?

Before this question can be answered, it must be clear what information has been given to Anna. The MCA 2005 requires her to be told information about the reasonable foreseeable consequences of deciding whether to stay in the present home, or of deciding to move to the new accommodation, or the consequences if she fails to make the decision. She should, if possible, be shown the new accommodation, where she would sleep, who would be her fellow residents, what different facilities would be available to her, how the location would be different from the existing home, and be given a good idea of her new life were she to move—that is, all the relevant information which is likely to affect her decision making, so that she would be in a position to make a realistic decision. (See the following text on guidance from the code of practice on information giving.)

Her capacity to understand this information should be checked out by the person or persons who have taken on the duty of ascertaining her ability to make this decision. There are considerable advantages in using a person for this task, whether informal or paid carer, who knows Anna well and can discern Anna's ability to understand the information given to her. The fact that the information has to be put to her in very basic terms, perhaps using simple language, visual aids, or any other means does not count against her having the necessary mental capacity. The Act makes it clear in S.3(2) (which is shown in Statute Box 4.2) that relevant information must be given in a way which is appropriate to her circumstances before any decision can be made about her capacity to understand the information.

If the answer to this first question is that Anna does seem to be able to understand the information given to her, the next question is:

b) Does she retain that information?

She needs to retain the information about the implications of moving home for as long as it takes her to make the decision. If, for example, she were to visit the new home one week and a fortnight were to elapse before she was asked by the carer or social worker or health professional whether she wanted to move, she would need to remember the information and understand the significance of her decision. The Act states in S.3(3) that:

> The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.

The information needs to be retained as long as is necessary to the making of the decision. It may be that the information would need to be repeated if any significant length of time were to elapse before Anna made the decision.

c) Can she use or weigh the information as part of the process of making the decision?

This third question requires an analysis of her cognitive skills. It might be thought that only a clinical psychologist or psychiatrist could determine this, and certainly in the event of a Court of Protection hearing, such expert evidence may be necessary for the court purposes (see Scenario 4.6). However for day-to-day matters, where there is not a dispute, the carers, whether paid or informal, would have the responsibility of deciding if Anna had the ability to weigh all the information she had received and come to a decision. It might, for example, be that Anna, having seen the wonderful facilities available in the new accommodation, decided that she would prefer to stay in the present house because she had grown fond of her fellow residents and the staff and would not want to leave them. However if she learnt that some of the existing residents and a few of the staff would be moving to the new accommodation, she might change her mind. Once again, in deciding if Anna had the cognitive skills to make this decision, the appropriate means of communication should be used.

d) Can she communicate her decision (whether by talking, using sign language, or any other means)?

This is the final question to be asked in determining whether Anna's brain or mind impairment or disturbance results in her being unable to make a decision for herself in relation to a particular matter.

On the facts given in Scenario 4.3, it would appear that Anna does have the ability to understand the information, retain, and make a decision using it, but there are problems associated with her communicating her answer. She needs a speech therapist to assist her in the communication and one is not available. Can those responsible define her as lacking the requisite mental capacity and therefore make the decision in her best interests?

The answer would appear to be *No*. The second principle to govern the implementation of the MCA is that:

> A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success. (S.1(3))

If Anna can only express her decision if she is given the assistance of a speech therapist, then the decision making may have to wait until a speech therapist can attend. This is preferable to a decision being made on the assumption that Anna lacked the capacity. Of particular significance is the wording of Section 1(3). All **practicable steps** must be taken to help her to make the decision. There is no use of the word **reasonable**. Had only reasonable steps been required, then the cost, the practicality, the delays, and other factors could have been taking into consideration in determining what was reasonably practicable. However by requiring all practicable steps to be taken, the Act is ignoring, to a certain extent, the cost, time, and other considerations. However practicable does not mean possible, so there is a limit to what is required in terms of resources. If it is practicable, then it should be done, that is, if Anna can understand and communicate with the assistance of a speech therapist, then a speech therapist's help should be secured and Anna's decision should wait until that time. If Anna is considered to have the requisite mental capacity, she can make the decision on accommodation even if that would appear to be an unwise decision (see page 42).

Temporary retention of information

Mental capacity can exist even if the relevant information is retained for only a short period. Subsection 3(3) which is shown in Statute Box 4.2 provides that:

> The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.

Clearly however the decision must be made at the time the information is still retained in the person's mind. Intermittent competence provides real problems for those assessing mental competence. This is discussed in Scenario 4.4.

Intermittent capacity

It would appear that Anna's condition in Scenario 4.3 is stable, but there are many situations where the person has fluctuating capacity. This is considered in Scenario 4.4.

It is unfortunate that Joan did not ensure that an advance decision was drawn up to reflect Amy's wishes (see Chapter 9 and the scenarios in that chapter for further discussion of this). It may be possible during a future bout of mental competence for Amy to be asked to repeat her wishes and these should be binding upon all the multidisciplinary team. Only when incapacity is clearly established is there room to apply the best interests test to the decision to be made on behalf of Amy (see Chapter 5 and scenarios in that chapter).

Scenario 4.4 Intermittent incapacity.

Amy is in the early stages of Alzheimer's and is becoming increasingly forgetful and confused. However she does enjoy lucid moments. Her daughter, Joan, is advised that Amy should have an operation for her hiatus hernia which has ulcerated. During an apparently clear thinking moment, Amy tells Joan that she would not want to have any operation. She felt that at 86 she had enjoyed her life, and did not now want to undergo such treatment. Joan felt that Amy was mentally capable and meant what she said. She told the nurses, but the surgeon was not prepared to accept such a refusal and considered that an operation was in Amy's best interests. What is the legal position?

What kind of information is relevant?

The Act further specifies that the information relevant to the decision includes:

> Information about the reasonably foreseeable consequences of a. deciding one way or another or b. failing to make the decision (S.3(4)). (See Statute Box 4.2)

The Code of Practice[9] gives the following guidance on giving relevant information to a mentally incapacitated adult to assist him or her in making a decision:

- Take time to explain anything you think might help the person make the decision. It is important that they have access to all the information they need to make an informed decision.
- Try not to give more detail than the person needs—this might confuse them. In some cases, a simple, broad explanation will be enough. But it must not miss out important information.
- What are the risks and benefits? Describe any foreseeable consequences of making the decision and of not making any decision at all.
- Explain the effects the decision might have on the person and those close to them—including the people involved in their care.
- If they have a choice, give them the same information in a balanced way for all the options.

- For some types of decisions, it may be important to give access to advice from elsewhere. This may be independent or specialist advice (e.g., from a medical practitioner or a financial or legal adviser). But it might simply be advice from trusted friends or relatives.

Relevant information and consent to medical treatment

The failure to provide relevant medical information prior to significant surgical or other treatment can render the consent which is given invalid and result in the health professional being liable in negligence for any harm which the patient has suffered. In the case of *Sidaway* v. *Board of Governors of the Bethlem Royal Hospital*,[10] the House of Lords used the *Bolam* test to determine if the appropriate information had been given and confirmed in the case of *Chester* v. *Afshar*[11] that it was sufficient for the patient to show that had she been notified of the risk, she would have had to think again about the surgery. She did not have to prove that she would not have had it.

More recently the Supreme Court awarded a boy with brain damage at birth over £5 million because doctors had failed to warn the diabetic mother of specific risks of a large baby and the possibility of shoulder dystocia because of the diabetes and the benefits of a caesarean section.[12] In this situation the Bolam test is inappropriate, since the emphasis is on what information the mother should be given personally about the risks of the birth. (See Chapter 2 on the law relating to consent and Chapter 11 on the law of negligence.)

Functional approach to mental capacity

Central to the definition of mental capacity is that a person's mental capacity is defined in terms of the decision which has to be made. Thus a person with severe learning disabilities may be able to make decisions about the food to eat, the clothes he or she wishes to wear, and social outings to be made. However that same person may be unable to make a decision about the extraction of a tooth or similar treatment. This is known as the functional approach to defining mental capacity or the specific issue approach and is considered further in Scenario 4.3 previously.

It will be noted that in discussing Scenario 4.3 and Anna's capacity to make a decision, the phrase *requisite mental capacity* has been used. This is because the MCA defines capacity in terms of a specific matter to be decided. As Section 2(1) of the MCA states:

> a person lacks **capacity in relation to a matter** if at the material time he is unable to make **a decision for himself in relation to the matter** because of an impairment of, or a disturbance in the functioning of, the mind or brain.

As can be seen from the words which the author has put in bold, capacity is decision specific. In Scenario 4.3, for example, it might be found that Anna is able to make her own decisions on what to wear or what to eat but is unable to understand the decision about moving accommodation, and therefore lacks the capacity required for that decision. In the case of *Re T (Adult: Refusal of Treatment)*,[13] the Court of Appeal emphasized that the required capacity to consent to medical treatment varied with the gravity of the decision to be made. This dictum would apply to decisions made under the MCA.

The fact that the MCA uses a functional definition of capacity has been seen as an important protection of the rights of vulnerable adults. Criticisms were made in the consultation on the draft Code of Practice that the language suggested that a person lacked mental capacity and needed to be revised to emphasize the functional and decision-specific principles that are central to the Act. The Department for Constitutional Affairs (DCA) undertook to rewrite the draft with this consideration in mind and to seek for an appropriate phrase. It could be suggested that the phrase *X has or lacks the requisite mental capacity* should cover the situation, and this is the phrase used in this book. The importance of the functional approach to the definition of capacity was also emphasized in the Joint Committee Report and by both Houses of Parliament.

Issues arising in deciding if a person lacks mental capacity

Who carries out the assessment of capacity?

On a day-to-day basis for routine decisions, it would be the health professional or carer who is deciding whether a patient/client has the requisite mental capacity to make decisions. The existence of the mental capacity to make routine decisions such as choice of food, clothing, and activities will be determined by the carer. Clearly their

training should include how such judgments are to be made. In practice the person making the assessment would be the person who is requiring the decision to be made: for example, if a care assistant in a residential home for the older person was handing out medication, then it would be the care assistant who would decide if that resident had the capacity to understand what was being offered and decide whether or not he or she should take it. For everyday situations the immediate carer would automatically be deciding on whether or not a person had the capacity to make their own decisions. (The role of the informal carer is considered in Chapter 16.)

When is help brought in for the assessment?

However it is important that where significant decisions are to be made, where there could be disputes, and where there may be formal hearings over the decisions to be made, then independent professional assistance should be brought in to determine whether a patient/client has the requisite mental capacity. Psychiatrists and clinical psychologists are the professions most frequently used to provide an expert opinion on whether the patient/client has mental capacity, but other health professions with the necessary training could also undertake this activity. In one case the judge praised the assessment of capacity undertaken by a social worker.[14] Records should be kept of any assessment relating to mental capacity. Bringing in an expert to determine capacity is considered in Scenario 4.5

Use of experts in determining if the requisite capacity exists

As noted previously, for most day-to-day decisions the determination of capacity will be carried out by the paid or informal carer. The Code of Practice lists those factors which indicate professional involvement in the assessment of capacity might be required.[15] They include situations where there is a dispute over the absence of capacity and frequent unwise decisions. In such circumstances expert opinion will be required, as illustrated in the following Scenario 4.5.

There are considerable advantages in bringing in a person who is independent of the multidisciplinary team caring for the patient but has the expertise to make a determination on whether or not capacity exists. In Scenario 4.5 a situation is considered where it would appear essential to seek the views of an expert on whether the requisite capacity exists. It would be open to the person representing Florie to ask for another expert opinion on Florie's competence to make the decision and, if that expert agreed with the psychologist, then the court could make a declaration that Florie lacked the requisite capacity and then go on to determine what action should be taken in her best interests (see Chapter 5). Since serious medical treatment is being considered, in the absence of a person who could be consulted, an independent mental capacity advocate would have to be appointed (see Chapter 8).

Scenario 4.5 Expert assessment of capacity.

Florie was pregnant and being treated for a panic attacks. She also suffered from needle phobia, which meant that she was terrified of having an injection. Her midwifery team were concerned that she might need to have a caesarean and therefore wondered whether she would be considered to have the necessary mental capacity to make a decision. The team members were divided upon whether or not she would be able to make a decision. A clinical psychologist was asked to assess Florie's mental capacity to make a decision about a caesarean, and she decided that Florie's needle phobia rendered her mentally incapable of making such a decision. Subsequently it became apparent that a caesarean section would be needed to save Florie's and the baby's lives. An application was then made by the National Health Service (NHS) Trust to court for a declaration that a caesarean could be carried out in Florie's best interests since she lacked the mental capacity to make her own decision. The psychologist gave evidence to the court of her assessment and the basis for her conclusion that Florie lacked the capacity to make that decision.

How often must the assessment be carried out?

The assessment is a functional assessment (see **Functional approach to mental capacity in page 38**) and therefore any assessment of capacity must be linked with the specific decision which is to be made. It follows that any new decision requiring a different level of capacity should lead to a fresh assessment. In addition

any change in the patient's/client's mental condition would require another assessment to determine his or her level of capacity for decision making. This poses considerable problems where a patient has fluctuating capacity. To carry out the full assessment of the requisite mental capacity for each and every decision would appear to involve considerable time and could result in a bureaucratic nightmare. Procedures and policy would have to emphasize when the full assessment was required. It would appear impracticable for a full assessment to be carried out each and every time there is a decision or action which in theory could be construed as a trespass to the person, if the patient/client/resident fails to give consent.

For example, a person with Alzheimer's disease may in the early stages ebb in and out of an understanding of their environment. At one moment they may resist having their clothes put on or their face washed and yet, at another, appear to consent to taking medication. The care plan should set out specifically how the care assistant should determine whether that person is capable of giving consent to the care and/or treatment which is being offered, and the action to be taken if the patient appears to lack the capacity to give consent to the proposed activity.

Assessment when P has fluctuating capacity is made more difficult when there is a high turnover of care staff and considerable pressure on staff because of understaffing. Unjustified assumptions might be made too easily. Strong and constant supervision and clear care planning are essential to ensure that the MCA is correctly implemented and the principles followed. In the case of *A, B, and C* v. *X, Y, and Z* [2012],[16] Hedley J was unwilling to make a general declaration of incapacity because of the fluctuating nature of P's condition but was prepared to make a qualified declaration in relation to P's power of attorney. "There will be times when undoubtedly he lacks capacity, just as there will be times when he retains it."

What if there is a dispute over the assessment?

Normally carers would make the assessment as specific decisions arose to be made or specific action required to be taken. If there is a dispute as to whether or not the resident/patient had the requisite capacity, then an independent expert able to make an assessment may have to be brought in to determine if capacity exists.

> **Scenario 4.6** Dispute over assessment of capacity.
>
> Beryl is 8 months pregnant and has made it clear that she would not want to have any surgical intervention. She believes on religious grounds that such intervention is immoral and contrary to God's will. The midwives have reasons to believe that she lacks the mental capacity to make such a decision and consider that, in the event of her lack of capacity being confirmed, she should, if necessary, have a caesarean section. The obstetrician supports the midwives. Beryl claims that she does have the capacity to refuse such intervention.

If it were decided that Anna in Scenario 4.3 did not have the requisite capacity to make the decision over accommodation, Anna might be encouraged to appeal against that decision. (The use of the Independent Mental Capacity Advocacy Service is considered in Chapter 8 and the scenarios in that chapter.) Scenario 4.6 illustrates a situation where the absence of capacity is disputed.

In such a situation as Scenario 4.6, an application should be made to the Court of Protection, where the issue of the presence or absence of mental capacity can be heard. Clearly both Beryl and the NHS Trust will require expert witnesses who can give evidence on the issue of her capacity. Beryl's relatives may also wish to be represented at the hearing. (See the scenarios in Chapter 7 for discussion over a Court of Protection application and hearing, and see the scenarios in Chapter 8 for a discussion of the role of the Independent Mental Capacity Advocate.)

Difficulties can arise when there is a dispute between health professionals over whether a patient has the requisite capacity. For example, a doctor might assess P an elderly patient as having the mental capacity to consent to discharge, but P's main nurse might say that P has no understanding of where he is, believes his relatives are nearby when they live abroad, thinks he is very wealthy when he is dependent on his state pension, and has no understanding of how he could cope on his own. In such a conflict the nurse must stand his or her ground and might be able to suggest that an independent assessment be carried out.

What role do relatives play in the assessment?

Often relatives are the main carers of the adult whose capacity is in question, and they would therefore be determining capacity on a day-to-day basis. However for critical decisions such as serious medical treatment, accommodation decisions, and other significant decisions, they may be encouraged to bring in experts to carry out the assessment. This would depend upon the mental condition of the person, since in some situations there may be no doubt as to the presence or absence of capacity. The implications of needing to determine capacity in everyday situations is illustrated in Scenario 4.7, which shows that it is imperative that care assistants or healthcare support workers receive a basic understanding of the legislation.

Scenario 4.7 Who determines capacity?

Angela, 75 years, was admitted to hospital following a fall at home. She had recovered, but it was considered inadvisable for her to return to live on her own and a place was being sought in a care home. There were times on the ward when she appeared to be lucid and able to make her own decisions. At other times she appeared to be confused and disorientated. The healthcare support worker bringing the tea trolley to the ward shouted at the door asking if anyone wanted a drink. One person responded. Angela had a friend Dawn with her. Dawn asked her if she would like a drink. Angela seemed confused but was persuaded that it seemed a good idea, and Dawn chased after the trolley and obtained a cup of tea for Angela. Angela drank it in one go and was clearly very thirsty. It was apparent to Dawn that Angela was unable to identify when she was thirsty or hungry and, had Dawn not been present, Angela would have been incapable of obtaining a drink for herself. Whose responsibility should it have been to ensure that Angela had food and drink?

Assessment of capacity in an everyday situation

As discussed previously there will be situations where experts are brought in to assess whether an individual is capable of making a specific decision, but often in a day-to-day context, it will be those persons who are in regular attendance on the patient/client who have to make decisions over a person's capacity. This is illustrated in Scenario 4.7.

The simple answer to the question posed in Scenario 4.7 is that the care home staff should on Angela's admission and on a regular basis thereafter have decided on Angela's ability to take reasonable care of herself and ensure that she received appropriate drinks and food. The care assistant should have been briefed as to which patients should be helped to have drinks. Where a patient was assessed as lacking the capacity to determine her own thirst, the support worker should have been told not to rely upon the patient responding. It is essential that all staff who have contact with patients are aware of the basic provisions of the MCA 2005. Unfortunately Scenario 4.7 is all too common in the NHS. A survey by Age Concern reported in August 2006 that nurses were often too busy to assist patients who need help with eating. It surveyed 500 nurses and found that 90% said that they did not always have the time to help, despite evidence that malnutrition is common among older patients.[17] In March 2007, it was reported that Age Concern was seeking an army of volunteers to feed elderly patients who might otherwise go hungry because nurses are too busy to sit with them at mealtimes.[18]

Has guidance been provided on the assessment?

The Code of Practice, as recommended by the Joint Committee,[19] has provided general guidance on the assessment of capacity and suggested several methods of supporting a person in making his or her own decisions. These include reducing the stress level of P; if it is a situation of temporary loss of capacity, then waiting for capacity to be recovered; using specialist persons such as a speech therapist or family members to assist in communication with P; and being aware of any cultural, ethnic or religious factors which may have a bearing on the person's way of thinking, behavior, or communication.[20]

The British Medical Association and the Law Society have published a guide to the assessment of mental capacity for health and legal professionals, carers, and all those involved in looking after people with suspected mental impairment.[21]

Is the assessment a medical one or does it involve social and other types of assessment?

Since capacity is determined on a specific issue basis, it is important to ensure that the correct experts are brought in to determine P's capacity in the light of the type of decision to be made. The more serious the decision, the more formal the assessment of capacity may need to be. The assessor must be prepared to justify findings and clearly records must be kept.

What happens if P does not accept the assessment of a lack of capacity?

It may be that P challenges a decision that he or she is lacking the requisite capacity. In such circumstances, P should be assisted in refuting that assessment and if necessary taking a case to the Court of Protection. Scenario 4.6 considers a situation where there is a dispute over the assessment of capacity.

Unwise decisions

The fact that making unwise decisions is not conclusive of a lack of mental capacity has now been given statutory effect in Section 1 of the MCA 2005, where the basic principles are set out. Principle No. 3 is:

> A person is not to be treated as unable to make a decision merely because he makes an unwise decision. (S1(4) MCA)

Self-determination is the opposite of paternalism. Health professionals may find it difficult to accept when a mentally competent patient refuses lifesaving treatment but that is the competent adult's right in law. It follows therefore that provided the patient is defined as having the mental capacity to make a specific decision, according to the approved tests, the fact that the decision is irrational or unwise or contrary to the best interests of the patient is not relevant.

This principle was brought out clearly by the President of the Family Division, Dame Elizabeth Butler Sloss, in the case of *Re B*[22] (See Case Study 2.2):

> It was most important that those considering the issue should not confuse the question of mental capacity with the nature of the decision made by the patient however grave the consequences. Since the view of the patient might reflect a difference in values rather than an absence of competence the assessment of capacity should be approached with that in mind and doctors should not allow an emotional reaction to, or strong disagreement with, the patient's decision to cloud their judgment in answering the primary question of capacity.

The Law Commission in its report in 1995[23] recommended (Para 3.19):

> A person should not be regarded as unable to make a decision by reason of mental disability merely because he or she makes a decision which would not be made by a person of ordinary prudence.

On the issue of making unwise decisions, the Joint Committee stated that:

> We considered carefully the dilemma created when a person with apparent capacity was making repeatedly unwise decisions that put him/her at risk or resulted in preventable suffering or disadvantage. We recognise that the possibility of over-riding such decisions would be seen as unacceptable to many user groups. Nevertheless, we suggest that such a situation might trigger the need for a formal assessment of capacity and recommend that the Codes of Practice should include guidance on:
>
> - whether reasonable doubt about capacity and the potentially serious consequences of not intervening indicated the need for an appropriate second opinion
> - circumstances in which the statutory authorities should be responsible for providing a level of support as a safeguard against abuse and
> - where there was genuine uncertainty as to capacity and an urgent decision was required to prevent suffering or to save life, the benefit of doubt would be exercised to act in that person's best interests in relation to any assessment of capacity (Para 78).

The Code of Practice points out that a person who was hitherto extremely rational but who is repeatedly making unwise decisions may be demonstrating a lack of capacity, and this should be explored. This is considered in Scenario 4.8, which is taken from the Code of Practice.

The fact that unwise decisions should not be regarded as evidence of mental incapacity is an extremely important provision, and it determines the order in which the assessment must be made:

> Firstly there must be a definition following reasonable criteria on whether a person satisfies the statutory definition of mental competence.

> Secondly if the requisite mental capacity is established according to that definition, then the person can make their own decision, no matter how foolish they would appear to the majority of persons.

The dangers of making an assessment of incapacity on the basis of the wisdom of the decision making is obvious. To those who see blood transfusions as a basic natural part of lifesaving medicine, the refusal by Jehovah Witnesses to accept blood transfusions may seem very unwise, but to say such lack of wisdom is therefore evidence of mental incapacity would be contrary to the human rights of those who held that belief.

In the case of *Nottinghamshire Healthcare NHS Trust* V. *RC* [2014][24] where a Jehovah's Witness refused a blood transfusion, Mostyn J said that "It would be an extreme example of the application of the law of unintended consequences were an iron tenet of an accepted religion to give rise to questions of capacity under the MCA." The case is considered in Chapter 13.

In the case of *Newcastle upon Tyne Foundation Trust* v. *LM*[25] Peter Jackson J found that a woman with a history of depression and paranoid schizophrenia had the requisite mental capacity when she told the doctors that as a Jehovah's Witness she would not wish to have treatment with any blood products and granted a declaration that it was lawful to withhold blood transfusions. She died before the reasons for the declaration was handed down. The judge saw her declaration as constituting a form of advance decision, even though it did not comply with the MCA requirements, but stated that if he were wrong to take that view, her wishes, feelings, and long-standing beliefs and values should be taken into account in determining her best interests—see Chapter 5.

The Code of Practice considers the problem of a person constantly making unwise decisions and the possibility that this might become evidence of a lack of capacity.[26]

There may be cause for concern if somebody:

- Repeatedly makes unwise decisions that put them at significant risk of harm or exploitation
- Makes a particular unwise decision that is obviously irrational or out of character

These things do not necessarily mean that somebody lacks capacity. But there might be need for further investigation, taking into account the person's past decisions and choices. For example, have they developed a medical condition or disorder that is affecting their capacity to make particular decisions? Are they easily influenced by undue pressure? Or do they need more information to help them understand the consequences of the decision they are making?

Scenario 4.8 Too many unwise decisions?[27]

Cyril, an elderly man with early signs of dementia, spends nearly £300 on fresh fish from a door-to-door salesman. He is very fond of fish but there is far too much to fit into his freezer. Before the onset of dementia, he was always very thrifty and careful with his money and would never have dreamt of buying such a quantity of expensive fish or spending this amount in one go.

This decision alone may not automatically mean he now lacks capacity to manage all aspects of his property and affairs, but his daughter makes further enquiries and discovers Cyril has overpaid his cleaner on several occasions (something he has never done in the past). He has also made payments from his savings that he cannot account for.

His daughter decides it is time to use the registered Lasting Power of Attorney her father made in the past. This gives her the authority to manage Cyril's property and affairs whenever he lacks the capacity to manage them himself. She takes control of Cyril's cheque book to protect him from possible exploitation, but she can still ensure he has enough money to spend on his everyday needs.

Dangers in making assumptions

In psychiatric care there has been a tendency in day-to-day care and treatment to assume that if the patient agrees with what is proposed, then the patient has the necessary mental capacity, but if the patient disagrees with what is proposed, then that disagreement brings the issue of capacity into question, and at that point an assessment is made. There should be an awareness of a person's mental capacity at all times. However the presumption that mental capacity exists can be rebutted if there is evidence to the contrary. That evidence must be more than the mere fact that the patient has refused to cooperate with treatment schemes. The European Court of Human Rights held that there was a breach of article 8 rights when the courts failed to follow the appropriate procedure in hearing a challenge by a woman with cerebral palsy who argued that the assessment of lack of the requisite capacity to manage her affairs was incorrect.[28]

Since the MCA came into force in 2007, there have been many judicial decisions dealing with the issue of mental capacity, and cases on specific issues are discussed in the following. The Court of Appeal warned of the danger of lawyers trawling through previous cases looking for factual similarities or analogies and then debating these in their skeleton arguments, involving a substantial waste of costs and time.[29] Each case must be decided on its own individual facts, and the Court of Appeal has been reluctant to overturn any finding of fact by the initial judge. The following cases are given as examples of the reasoning of the courts in specific issues.

Cases illustrating different kinds of decision making

Assessing capacity

Case Study 4.1 *RB* v. *Brighton and Hove Council* [2014].[30]

In January 2007 RB sustained a serious brain injury in an accident. He was treated for eight months in hospital and then transferred to a care home, S house. In 2011 RB ceased participating in rehabilitation programs and proposed leaving S house. The staff held that he was not capable of independent living. The Council granted a standard authorization (under the Deprivation of Liberty Safeguards in Schedule A1 of the MCA (see Chapter 14)), and RB applied under S 21A of the MCA to terminate the standard authorization. The district judge Glentworth accepted that although RB's wish to consume alcohol predated his brain injury, he was unable to weigh up the information to make a decision because of his brain injury and was therefore in a different position to a nonbrain injured alcoholic. It was in his best interests to remain in the care home. On appeal HHJ Horowitz refused to interfere with the District Judge's reasoning and conclusions on either capacity or best interests.

RB appealed to the Court of Appeal contending that the mental capacity and the best interests requirement for the standard authorization had not been made out.

The Court of Appeal dismissed RB's appeal. "The decisions which RB wishes to make required a process of using and weighing up relevant information. On the basis of expert evidence and of the District judge's findings of fact, RB is not capable of carrying out that mental process.... RB is unable to appreciate and weigh up the risks which he will run if he resumes his former way of life and goes out on drinking bouts. Applying MCA Section 3(1)(c) RB does not have capacity to make this decision."

This case can be contrasted with that of Case Study 4.2

Case Study 4.2 *X* v. *A local Authority and an NHS Trust* [2014].[31]

A retired lawyer suffered from Korsakoff's syndrome, a mental illness related to the overconsumption of alcohol. He was held to have the capacity to make decisions as to residence, care, and medical treatment and his compulsory detention came to an end. The fact that he may relapse and resume drinking did not mean that he lacked capacity at that time.

See also the case of a *Primary care trust* v. *LDV, CC, and B Healthcare Group* [2013][32] where Baker J gave guidance on determining the nature of the information which P must be given so that his ability to understand, retain, use, and weigh it could be assessed in deciding if P had capacity.

The capacity to litigate

Case Study 4.3 *Dunhill* v. *Burgin (Nos 1 and 2).*[33]

The Supreme Court ruled on the definition of mental capacity in March 2014 in a case following a road accident. The defendant motor cyclist had knocked down the claimant who was crossing the road. An initial agreement had been reached whereby the claimant received £12 500 with costs. That was a gross undervaluation of the claim which was assessed as £2 million by the claimant's advisers and about £800 000 by the defendant. The Supreme Court held that the claimant lacked the capacity to commence and conduct proceedings. She should have had a litigation friend from the outset, and the settlement should have been approved by the court under rule 21(10)(1) of the civil procedure rules. The consent order was set aside and the case was to go to trial. The test of capacity to litigate is whether or not a party to the legal proceedings is capable of understanding , with the assistance of such proper explanation from legal advisers and experts in other disciplines as the case requires, the issue on which his consent or decision is likely to be necessary in the course of the proceedings. He needs to be able to understand the relevant issues and be able to give instruction thereon.

> **Case Study 4.4** *Zarbafi and others* v. *Zarbafi*.[34]
>
> The Court of Appeal held that a party could not bring an action both on her own behalf and as the litigation friend of a necessary party who lacked capacity in circumstances where there was a serious conflict of interest between them. The father had suffered a severe disabling stroke in 2001 and was a protected party under rule 21.1(2)(d) of Part 21 of the Civil Procedure Rules. He was represented in the proceedings by his only daughter and youngest of his three children. She had appointed herself as his litigation friend without a court order under rule 21.4. She was also a claimant in her own right because she claimed to be a 40% beneficial owner of the relevant properties. The Court of Appeal held that she should have joined her father as a defendant to the claim rather than as a coclaimant. The court allowed the appeal against summary judgment and removed the daughter as her father's litigation friend.

Capacity and finance

> **Case Study 4.5** *Simon* v. *Byford*[35] [2014].
>
> The Court of Appeal heard an appeal by R against the decision that his mother had the requisite testamentary capacity when she made a second will which was less advantageous to him compared with his siblings than her previous will. The CA held that a first instance judge's findings about testamentary capacity and knowledge and approval are findings of fact, based on his appreciation of the evidence as a whole, such that an appeal court should be wary of interfering with them. The correct tests of testamentary capacity had been applied and the fact that the mother did not remember why she had favored R in her previous will or the implications of the change for R's shareholding in the family company did not mean that she lacked the testamentary capacity in relation to the disputed will. The CA quoted Mummery LJ in the case of *Hawes* v. *Burgess*.[36]
>
> > "The basic legal requirement for validity are that people are mentally capable of understanding what they are doing when they make their will and that what is in the will truly reflects what they freely wish to be done with their estate on their death."

Capacity to marry

In the case of *Sheffield City Council* v. *E*[37] Munby J laid down a test of capacity to marry as requiring that a party to the marriage understood the nature of the marriage contract and was capable of mentally understanding the duties and responsibilities which are normally attached to marriage. He stated that the contract of marriage is in essence a simple one which does not require a high degree of intelligence to comprehend. It has been accepted that the MCA does not change this test. In the case of *D Borough Council* v. *B* [2011][38] Munby J stated that the test of capacity to marry was status specific and not spouse specific.

> **Case Study 4.6** *London Borough* v. *BB & Ors*.[39]
>
> BB was a 32-year-old woman who suffered from schizoaffective disorder. She was born in 1979 and was first diagnosed with an acute personality disorder in 1989. By 1993 she had been diagnosed with early onset schizophrenia. She had severe communication difficulties and was prelingually profoundly deaf and had a learning disability.
> At the time of the hearing, BB was living at a specialist residential unit in Birmingham known as Polestar. On February 10, 2000, BB went through a ceremony of marriage with MA in Bangladesh. At the time MA was living and resident in Bangladesh and BB was resident in England but on a family holiday in Bangladesh. There were no known children of the marriage although BB had periodically referred to children who may have been born to her. MA joined BB in London in 2001 and they lived together until 2004. On November 9, 2007, MA filed a petition for divorce citing BB's unreasonable behavior and in that way matrimonial proceedings first came before the court. The court had to consider:
>
> **i)** Whether it was in BB's best interests to be married
> **ii)** Whether BB's liberty was deprived at Polestar
> **iii)** Where BB should live
> **iv)** Whether and if so when she should have contact with her extended family if she is not living with them
>
> It was held that it was common ground that BB lacked the capacity to conduct this litigation or to make any of the decisions which needed to be made about her life including where she should live, with whom she should have contact, who should provide her with care, or the nature of care to be provided including her medical care and her marriage. Furthermore, she lacked that capacity at the time of her marriage. All parties were agreed that it was in BB's best interests for her marriage with MA to be annulled pursuant to section 12(c) of the Matrimonial Causes Act 1973 on the ground that she did not validly consent to the marriage as she lacked capacity to consent at the relevant time. MA had agreed through solicitors to an annulment. With the agreement of the parties, the court gave leave for the present proceedings to be treated as an application for a forced marriage protection order and for such an order to be made as being demonstrably in BB's best interests.

Capacity and sexual relations

Case Study 4.7 *IM* v. *LM and others*.[40]

In this case the Court of Appeal in reviewing earlier cases confirmed that the test of capacity to consent to sexual relations is general and issue specific and not person or event specific. LM was 41 years, had three children, and had an extensive history of drug and alcohol abuse and convictions for offences related to prostitution. She suffered a hypoxic brain injury which had caused her problems with her memory. A consultant psychiatrist advised that she lacked capacity to consent to sexual relations because she could not weigh up foreseeable risks to her and potential children from becoming pregnant. Nor was LM able to weigh up the risks of acquiring a sexually transmitted disease. Peter Jackson J concluded that she had the capacity to consent to sexual relations. The fact that pregnancy would be an extremely serious state of affairs did not lead to the conclusion that she lacked capacity but that she should receive continued safeguarding and help, advice, and explanation as and when the question of sexual activity might become a reality. The Court of Appeal dismissed the appeal against the first instance decision holding that capacity to consent to future sexual relations can only be assessed on a general and nonspecific basis. This contrasted with the person-specific basis nature of a decision to consent to sexual relations in criminal cases.[41] The Court of Appeal held that LM's ability to use or weigh information, although limited, was not beneath the low level called for in the context of a *visceral* decision rather than a *cerebral* one.

A consequence of this decision is that local authorities cannot use the MCA to protect persons from sexual activity unless there is clear evidence of lack of capacity to consent, and the test for this is lower than in a charge of rape.

Case Study 4.8 *PC and NC* v. *City of York* [2013].[42]

In this case the Court of Appeal had to decide whether a married woman, PC, with significant learning disabilities had the capacity to decide whether or not to live with her husband, NC. Hedley J in the Court of Protection decided that she lacked the capacity to decide to cohabit, and he declared that her best interests were served by resuming cohabitation with NC within a scheme of monitoring and support provided by the LA as approved by the Court of Protection. (NC had been convicted and sentenced for serious sexual offences.) PC appealed against that ruling claiming among other points that the judge should not have applied a person-specific, rather than an act-specific, test in determining capacity. McFarlane LJ in the Court of Appeal accepted the test used by Munby J in the case of *Sheffield County Council* v. *E*[43] that capacity to marry is to be assessed in general and as a matter of principle and not by reference to any particular prospective marriage. The Court of Appeal held that she did have the capacity to decide to cohabit. She failed to satisfy the diagnostic test under Section 2(1) and therefore there could be no finding of incapacity for the purpose of the Act. Lewison LJ said that to resume cohabitation was probably not a wise decision, but she had the capacity to make it. Once again MCA is not to be used as a protective paternalistic device for those making unwise decisions.

In the case a contrast was drawn between consent to sexual relations under Section 30 of the Sexual Offences Act 2003 and the case of *R* v. *Cooper*[44] where the House of Lords had held that the Court of Appeal had unduly limited the scope of S. 30(1) of the 2003 Act by holding that a lack of capacity to choose whether or not to agree to sexual activity cannot be person or situation specific. This contrasts with the test of capacity to consent to sexual relations under the MCA which is act specific and not partner specific.

Undue influence and capacity

Case Study 4.9 *V Hackett* v. *CPS and D Hackett* [2011].[45]

This case provides a summary of the law on undue influence and the vulnerable. It involved a severely deaf woman of 83 who was unable to speak, read, and write but was able to do some basic hand signs and who had transferred ownership of her house to her son. This son had been charged with involvement in smuggling activities, and the CPS claimed that the house was purchased with moneys from these illegal activities. Judge Silber held that the house was probably purchased from savings made by her deceased husband and not part of criminal proceeds. He also held that the Crown Prosecution Service had not disproved the presumption of undue influence by the son on his mother. Nor could the transaction be set aside on grounds of non est factum (i.e., a party can avoid being tied to an agreement on grounds that he or she was unable to have any real understanding of the purport of the document). The Judge was not prepared to hold that the woman lacked capacity.

Mental capacity: Holiday case

Case Study 4.10 *Cardiff County Council* v. *Ross and Davies* 2011.[46]

Mrs Ross, an 82-year-old woman with a diagnosis of dementia had decided with her partner of 20 years to go on a cruise. They had both been on cruises together in the past. She had moved to a care home a few months before the planned cruise but spent weekends with her partner in his home. The local authority formed the view that she lacked the capacity to decide to go on the cruise and it was not in her best interests. She would not be able to appreciate the risks to her well-being. Judge Mastermann heard the case at short notice without oral expert evidence on capacity and decided that there was insufficient evidence to rebut the presumption of capacity, but even if he were wrong on that, it was not contrary to her best interests to go on the cruise. The local authority had failed to balance the benefits against the risks of the trip to her well-being. An application should have been made to the court by the local authority rather than using the Deprivation of Liberty Safeguards regime (see Chapter 14 on DOLs).

Case Study 4.11 *Wandsworth CCG* v. *LA and TA* [2014].[47]

In this case IA, a 59-year-old diabetic man with serious side effects from diabetes, requiring regular dialysis; anemia; chronic leg ulcers; cellulitis; and neuropathy, suffered a violent criminal assault which left him with cognitive impairment and problems with memory, inflexibility of thought, impulsivity, and mood control There was a dispute between the official solicitor and the local authority over whether he had the capacity to make decisions about (a) his ongoing medical treatment, (b) his future residence and care, and (c) the management of his property and affairs. Mr Justice Cobb judge started with the presumption of capacity, applied the fourfold *functionality* test set out in Section 3 of the MCA, and accepted that the threshold of capacity to understand should not be set unduly high (citing Baker J in *PH v A Local Authority and Z limited and another* [2011][48]). He then reviewed the evidence given on capacity and concluded that the assumption of capacity has not been replaced in respect of any of the three decisions which he had to make. He was aware that IA had made a number of unwise decisions in the past about his medical treatment and home living conditions; these were not demonstrative of lack of capacity and were more reflective of his somewhat challenging personality and antedated his acute brain injury.

Capacity and residence

Case Study 4.12 *LBX* v. *K. L and M* [2013].[49]

In this case Theis J had to decide whether a man with learning disabilities would achieve the capacity to make decisions about his residence and contact. She warned against adopting a too high threshold for testing capacity and set out the criteria relevant to capacity to decide where to live, with whom to have contact, and the sort of care to receive.

Conclusions

The determination of capacity is at the heart of the MCA 2005. Once it is concluded that an individual has the requisite mental capacity to make a specific decision, then at that point carers, relatives, and health and social services professionals must be prepared to leave that specific decision to the individual. There is no room in the law for paternalism where a person can exercise his or her own autonomy. In taking Anna's situation in Scenario A3, we came to the conclusion that she did have the requisite mental capacity to make her own decision about accommodation. However if the conclusion of the assessment is that the person lacks the requisite mental capacity, then actions and decisions must be taken in the best interests of that individual, and it is to this that we turn in the next chapter.

Quick fire quiz, QFQ4

1. What are the two stages for determining whether a person has the requisite mental capacity?
2. Could a person's mental capacity be determined merely by reference to a person's age or appearance?
3. In determining mental capacity does it matter if the impairment or disturbance or the mind or brain functioning is permanent or temporary?
4. What four criteria are used to determine if a person is able to make a decision?
5. Does the Act specify what information must be given to a person in assessing their mental capacity?
6. What is meant by the functional approach to the determination of mental capacity?

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CHAPTER 5

Making decisions in the best interests of others

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Introduction

Once it is reasonably established that P lacks the requisite mental capacity to make a specific decision, then action may be taken in his best interests. This chapter considers the statutory steps to be taken in determining what are P's best interests and considers the protection provided by Section 5 and exclusions from the decision-making process. It also considers the conditions which must be followed when P is kept under restraint. Finally some of the specific kinds of decisions with examples from decided cases are discussed.

Best interests—the fourth principle

Where decisions have to be made on behalf of a person who lacks the requisite mental capacity, then they must be made in the best interests of that person (unless there have been instructions by the person before he or she

Legal Aspects of Mental Capacity: A Practical Guide for Health and Social Care Professionals, Second Edition. Bridgit Dimond.
© 2016 John Wiley & Sons, Ltd. Published 2016 by John Wiley & Sons, Ltd.

lost capacity, e.g., in an advance decision or in appointing a donee under a lasting power of attorney (LPA)).

It is the fourth principle of the Mental Capacity Act (MCA) 2005 (S.1(5)) that:

> An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.

An exception to acting in the best interests is the situation where P has drawn up an advance decision which applies to the situation which has arisen. In this case the advance decision will prevail, even though this may be contrary to P's best interests (see Chapter 9). Similarly, if in an LPA P has given the donee specific instructions about personal welfare or property or financial decisions, these must be followed, even if they are contrary to P's best interests (see Chapter 6).

Who makes the decision on best interests?

For most day-to-day matters it will be the carer, whether paid or informal, who is deciding both whether P has the requisite capacity to make a specific decision and, if not, what are in P's best interests. However for more significant decision making, there will be a need to bring in the experts. In the case of *C* v. *A Local Authority* [2011],[1] which involved a boy of 18 years with severely challenging behavior, Mr Justice Ryder commented on the dangers of using common sense rather than expert professional guidance.

What is meant by best interests?

Best interests is not defined in Section 4, but this section provides a checklist of the considerations which must be taken into account in determining what are P's best interests. An example of how the courts have determined *best interests* in the case of a boy of 18 years with severe learning disabilities and renal failure who may need a kidney transplant is shown in Case Study 5.1.[2]

Section 4 sets out the steps to be taken in deciding best interests and is shown in Statute Box 5.1. These steps include briefly:

- Do not make unjustified assumptions (4(1)).
- Consider all the relevant circumstances (4(2)).
- Consider whether capacity is likely to be recovered (4(3)).
- Support P's ability to participate (4(4)).
- In lifesaving treatment, a desire to bring about death should not be the motivation (4(5)).
- Consider P's wishes and feelings, beliefs, and values and other factors P would consider (4(6)).
- Consult views of specified others about what is in P's best interests and P's wishes, feelings, etc. (4(7)).
- Do not deprive P of his liberty unless it is authorized by the court or it is authorized by the Deprivation of Liberty Safeguards (DOLs) (Section 4A) (see Chapter 14) or is necessary for life-sustaining treatment under Section 4B.

These specified steps also apply to others taking decisions on behalf of P, such as those exercising an LPA (see Chapter 6) and deputies of the Court of Protection (CoP) (see Chapter 7).

Section 4 is set out in full in Statute Box 5.1

The criteria used to determine best interests

1 Unjustified assumptions (4(1))

The person who is making the decision must not make it merely on the basis of the person's age or appearance or a condition of his or an aspect of his behavior which might lead others to make unjustified assumptions about what might be in his best interests. In other words, just as in the determination as to whether or not someone lacks mental capacity, so in the determination of what is in that person's best interests a superficial judgment cannot be made (see Scenarios 5.1 and 5.2). There is evidence from research that has been carried out by the Disability Rights Commission[3] that those with learning disabilities are likely to have higher rates of unmet health needs and higher rates of respiratory disease and are likely to be more obese than the rest of the population and that generally their access to health provision is poorer than those without disabilities.

Often the recording in primary care of those with learning disabilities is inadequate, and the proportion of people with learning disabilities who are known to the service is estimated at around one-quarter of actual prevalence. People with learning disabilities are less likely to receive health interventions, for example, in the treatment of diabetes. This research would suggest that too often those making decisions on behalf of those who lack the requisite capacity are making unjustified assumptions about their best interests and not taking the necessary action to ensure that they are not disadvantaged in the receipt of healthcare. These conclusions

Statute Box 5.1 Section 4: Best interests.

4. Best interests

1 In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of—
  a) the person's age or appearance, or
  b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests.
2 The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.
3 He must consider—
  a) whether it is likely that the person will at some time have capacity in relation to the matter in question, and
  b) if it appears likely that he will, when that is likely to be.
4 He must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.
5 Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.
6 He must consider, so far as is reasonably ascertainable—
  a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),
  b) the beliefs and values that would be likely to influence his decision if he had capacity, and
  c) the other factors that he would be likely to consider if he were able to do so.
7 He must take into account, if it is practicable and appropriate to consult them, the views of—
  a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,
  b) anyone engaged in caring for the person or interested in his welfare,
  c) any donee of a lasting power of attorney granted by the person, and
  d) any deputy appointed for the person by the court, as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).
8 The duties imposed by subsections (1) to (7) also apply in relation to the exercise of any powers which—
  a) are exercisable under a lasting power of attorney, or
  b) are exercisable by a person under this Act where he reasonably believes that another person lacks capacity.
9 In the case of an act done, or a decision made, by a person other than the court, there is sufficient compliance with this section if (having complied with the requirements of subsections (1) to (7)) he reasonably believes that what he does or decides is in the best interests of the person concerned.
10 "Life-sustaining treatment" means treatment which in the view of a person providing health care for the person concerned is necessary to sustain life.
11 "Relevant circumstances" are those—
  a) of which the person making the determination is aware, and
  b) which it would be reasonable to regard as relevant.

4A and 4B are set out and considered in Chapter 14 (Statute Boxes 14.2 and 14.3) in relation to DOLs.

Scenario 5.1 Unjustified assumptions.

Ralph had been sleeping on the streets for several months and was dishevelled and dirty. He was brought to a Salvation Army hostel and seen by a doctor, who considered that he was suffering from severe kidney failure and would require immediate dialysis and possibly ultimately a kidney transplant. Ralph made it clear that he was refusing any such treatment.

Scenario 5.2 Too old for treatment.

Angela is 84 years old and has been in a care home for 5 years. One winter, following her *flu injection*, she appeared to be suffering from a severe chest infection. Her relatives, who seldom visited her, advised the home manager that at her age they did not consider that there was any point in a doctor being called or in antibiotics being prescribed. The manager was uncertain what action to take.

were reinforced by more recent evidence from the Confidential Inquiry into premature deaths of people with a learning disability (2013).[4]

Advocacy clearly has a very important role to play in such situations (see Chapter 8). Unfortunately however the advocate is only likely to be involved when serious medical treatment is already being considered. There may be no advocate when a hip replacement is a possibility but is not raised by the surgeon, because of the perceived lack of capacity of the patient. The disability equality duty, placed on public bodies in December 2006 to eradicate institutional discrimination against disabled people, should lead to clearer identification and meeting of the health needs of disabled people (see Chapter 3).

The first question which arises here is, does Ralph have the mental capacity to make the decision for himself, after being given all the relevant information? If the answer to that is yes, then he is entitled to refuse any treatment. If however it is determined according to the principles set out in Section 1 and in relation to the definition of mental capacity set out in Sections 2 and 3 that he lacks the requisite mental capacity (see Chapter 4), then the decision must be made in his best interests. In deciding what is in his best interests, the fact that he has been a tramp for some time and does not appear to enjoy a very high quality of life is irrelevant. However his ability to keep to the strict posttransplant regime of antirejection medication would be relevant to the priority assigned to him for a transplant operation.

The first issue to arise in Scenario 5.2 is the question of Angela's mental capacity. Is she able to understand the information given to her, retain it, and make a decision in the light of it? If Angela is reasonably believed to have the requisite mental capacity, then she can decide for herself what treatment to have. On the other hand, if the manager and the relatives decide that Angela does not have the requisite mental capacity, then action has to be taken in her best interests.

Section 4(1) makes it clear that the determination of her best interests must not be made merely on the basis of her age, appearance, or any condition or behavior of hers. The fact that Angela is 84 years old, lacks mental capacity, and is in a care home is irrelevant for the purposes of determining her best interests. (It could be, of course, that the relatives are thinking of their best interests were Angela to die in the near future and they would benefit financially from her death.) In addition, where the decision relates to life-sustaining treatment, the decision maker must not, in considering whether the treatment is in Angela's best interests, be motivated by a desire to bring about her death. Life-sustaining is defined as:

> Treatment which in the view of a person providing health care for the person concerned is necessary to sustain life. (S.4(10))

It is highly probable that the doctor called in to examine Angela would consider that in her situation antibiotics are a life-sustaining treatment. Such treatment could therefore not be withheld on the grounds that it was in Angela's best interests to die, and antibiotics should therefore not be prescribed and administered.

Example of a case which decided what were 'best interests'

The MCA sets out the factors to be taken into account in determining what are the best interests, but it does not actually give a definition of the term. The courts have held that the list of factors set out in section 4 does not create a hierarchy[5] and each case must be considered as unique and a unique solution found.[6] In medical decision making, courts have sometimes used the balance sheet approach balancing benefits against disadvantages.[7] Guidance on how the courts have determined best interests is useful but should not be followed slavishly in the implementation of the MCA. One example of the balance sheet approach is shown in Case Study 5.1, where in a potentially lifesaving situation the court had to decide whether it was in the best interests of a boy of 18 years to be given a kidney transplant. In certain situations the balance sheet approach might lead to recognition that certain factors have a magnetic importance in determining best interests. See Case Study 5.10 *A NHS Trust* v. *DE* [2013].[8]

Other cases where judges have used the balance sheet approach to determine what are the best interests of P include the case of Re G(TJ) [2010][11] (see Case Study 5.15) where the balance sheet approach was used by Mr Justice Morgan to determine whether it was in the best interests of P for a gift (in the form of continuing maintenance) to be made to an adult daughter C. He held that substituted judgment could be taken into account in the balance sheet. "However it is absolutely clear that the ultimate test for the court is the test of best interests and not the test of substituted judgment." He concluded that the gifts could be made, since that would have been her wishes, had she had the capacity to make the decision.

2 Consider all the relevant circumstances (4(2))

It is a statutory requirement that all the relevant circumstances must be taken into account. Relevant circumstances are defined as

> those of which the person making the decision is aware and which it would be reasonable to regard as relevant.

Case Study 5.1 Is a transplant in the best interests? *A Hospital National Health Service (NHS) Trust v S* [2003].[9]

S was born with a genetic condition, velocardiofacial syndrome, and had a number of major problems including severe learning disabilities and bilateral renal dysplasia. He was 18 at the time of the court hearing in 2003. He had been admitted to hospital in 2000 with acute renal failure and had been on hemodialysis ever since. There was a dispute between some of the health professions and the parents over his continuing treatment, including whether a kidney transplant should eventually be carried out.

Dame Elizabeth Butler-Sloss, President of the Family Division, had to decide how S's best interests were to be determined. She quoted her statement in *Re A (Male Sterilisation)*[10]:

"best interests encompasses medical, emotional and all other welfare issues." She also quoted Thorpe LJ in the same case, where he suggested that the judge with the responsibility to make an evaluation of the best interests of a claimant lacking capacity should draw up a balance sheet. This is set out in Case Study 5.23.

In deciding what was in S's best interests, the judge accepted the principle that just because a person cannot understand treatment it is wrong to say that he cannot have it. If there is a quality of life then, even if it is necessary to go through a traumatic period, it would be worthwhile in the long term. She noted that all parties agreed that hemodialysis should continue and if necessary be followed by peritoneal dialysis. In addition she concluded that AV fistula should be attempted if medically indicated, even though he disliked needles, since it was not at all clear that he was seriously afraid of needles and there was no evidence that S had a needle phobia. In relation to the kidney transplant, which at the present time was hypothetical, the mother was prepared to offer her kidney. The judge ruled that while there were significant medical difficulties, that his severe learning disability militated against explanations about the transplant, and that the hospital were concerned about the consequences of emergency surgery on an autistic boy, she considered that it should be possible to manage him postoperatively. She stated that:

On balance, if the medical reasons for a kidney transplantation are in his favour, and alternative methods of dialysis are no longer viable, in my judgement, a kidney transplantation ought not to be rejected on the grounds of his inability to understand the purpose and consequences of the operation or concerns about his management.

What is relevant will vary from person to person and the kind of decision which has to be made: financial decisions will require different kinds of information than medical or social ones. Clearly health and social services professionals must ensure that full documentation is completed on the relevant circumstances that they have taken into account in making a decision on behalf of P. There would also be advantages if the informal carer also kept records as to the basis of some of the significant decisions they might have to make on a person's behalf (see Chapter 16 and the scenarios in that chapter). Relevant circumstances would also include P's human rights under Article 8 of the European Convention on Human Rights[12] (see Chapter 3).

3 Consider whether capacity is likely to be recovered (4(3))

Temporary or permanent

There is a statutory requirement (S.4(3)) that the decision maker must consider whether it is likely that the person will at some time have capacity in relation to the matter in question and, if it appears likely that he or she will, when that is likely to be. (See Scenario 5.3 and contrast this with Scenario 5.4.)

Scenario 5.3 Road accident 1.

Following a road traffic accident, Mike, aged 33 years, is brought unconscious into Accident and Emergency (A&E). His right arm is badly injured and surgeons believe that although they could save it, in the long term Mike might be better served with a prosthesis. It is likely that Mike will recover consciousness in a few hours, and the surgeons consider that they could wait to discuss all the options with him then before any decision to amputate is made.

Scenario 5.4 Road accident 2.

Mavis, aged 33 years, comes into A&E following a road accident. She is unconscious. She has severe learning difficulties and would be unable to understand that her right arm is so badly injured that it might have to be amputated and would therefore be unable to make a decision about amputation. The surgeons discuss all the options with her parents and the manager of the care home in which she lives and decide that it is in her best interests that the amputation should take place immediately and there would be little justification in waiting until she regained consciousness.

While the temporary or permanent nature of the person's condition is irrelevant to the definition of mental capacity for making a specific decision, it is relevant in determining the best interests of the patient. In determining what are in the best interests of the person lacking the required mental capacity, the decision maker must decide if the person is likely to recover mental capacity in relation to the matter in question and if so, when that recovery is likely to be. It follows that if the making of a serious decision can be delayed without harm to the person until such a time as that individual can decide for himself or herself, then the delay would be in the best interests of the individual. The two situations are illustrated by Scenarios 5.3 and 5.4. The Code of Practice provides guidance on factors which indicate that a person may regain or develop capacity in the future.[13] These include P learning a new form of communication and where incapacity has resulted from alcohol or drugs.

The situation in Scenario 5.3 contrasts with that in Scenario 5.4.

The length of the delay until the requisite mental capacity is restored is of course relevant, and if in Scenario 5.3 the doctors decided that an operation on the arm could not wait till the recovery of Mike's mental capacity, then action would have to be taken in his best interests while he was still unconscious. In contrast in Scenario 5.4 even when Mavis recovered consciousness, she would not be able to make the required decision.

4 Support P's ability to participate (4(4))

Participation

It is a statutory requirement that the decision maker should, so far as is reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.

Participation may require mechanical aids. There may be considerable resource implications in facilitating participation of the client in decision making.

Reasonably practicable however enables cost, value, time, and other considerations to be taken into account in achieving that participation. Had the word *reasonable* not been included, then if participation was scientifically or practically possible, it would have to take place. This contrasts with the second principle contained in Section 1(3) that:

> A person is not to be treated as unable to make a decision unless **all practicable steps** to help him to do so have been taken without success.

where there is no *reasonable* (see Scenario 5.5).

In determining Glen's mental capacity to make a decision about his transfer to another home, all practicable steps must be taken to help him achieve the necessary capacity and the ability to communicate (see Scenario 4.3). *Practicable* does not mean *possible* and is a lesser duty. Once it is concluded that Glen does not have the requisite capacity, then reasonably practicable steps must be taken to assist him in having the requisite mental capacity to participate in the decision-making process:

> He (the decision maker) must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him. (S.4(4))

What should health and social services do for Glen which would be seen as "so far as reasonably practicable?" In answering this question, the cost, the time, the value to Glen, and other priorities could be taken into account. Each organization may come up with a different answer depending upon their resources and the demands upon those resources. They must act reasonably, which would mean it would be unjustified to treat two clients with identical needs in different ways. Documentation would be required of how a particular decision was reached, as well as all the considerations which were taken into account in deciding what facilities and services Glen would be able to have and what facilities and services were refused.

Scenario 5.5 Reasonably practicable support.

Glen received severe injuries at birth, as a consequence of which he is unable to communicate effectively. He has been cared for at home by his elderly parents, but there is now a possibility that he could be transferred to a home for young people with physical disabilities. It is possible that he could participate in the decision making but only with extremely expensive high-tech equipment which neither health nor social services consider they have the resources to provide. What is the law?

The basic questions to be answered by health and social services are as follows:

1 Does Glen have the requisite mental capacity?
2 If not, could any practicable steps be taken to assist in his having the requisite mental capacity?
3 If the answer to 2 is *yes*, then those steps must be taken.
4 If the answer to 2 is *no*, then the decision must be taken by others.
5 How could Glen be assisted so that he could participate in the decision-making process?
6 Is this assistance available?
7 If so, what is the cost of this assistance, and is the expenditure justified in terms of the benefit that it would bring to Glen's active participation and in comparison with other priorities? It could be, for example, that there were available a highly expensive computer activated by touch, but it would take considerable time for Glen to be taught how to use this equipment and the decision over accommodation would have to be made in the near future.

5 In lifesaving treatment, a desire to bring about death should not be the motivation (4(5))

Continuation of life

It was of concern to those debating the bill that the decision maker could make life-and-death decisions and decide that the mentally incapacitated adult could be allowed to die while notionally acting in the best interests of the patient/client. If life-sustaining treatment is being considered, then the decision maker must begin by assuming that it will be in the person's best interests for his life to continue. Life-sustaining treatment is defined in Section 4(10) as:

> Treatment which in the view of a person providing health care for the person concerned is necessary to sustain life.

If the mentally incapacitated person had drawn up, when mentally capacitated, an advance decision which applied to the particular circumstances, then this would take precedence in the decision making (see Chapter 9). There may be circumstances where letting die is in the best interests of the patient. For example, where the patient is in the terminal stages of cancer and suffers a cardiac arrest, doctors treating the patient may consider that resuscitation is not in the best interests of the patient. The statute does not require health professionals to carry out treatment which in their professional judgment is not in the best interests of the patient, and this is in accordance with the common law, the decision by the UK Court of Appeal in the Burke case.[14] This case is considered in Chapter 9 (Case Study 9.7).

Nor does the statute permit voluntary euthanasia to take place. A doctor would be permitted in law to provide pain relieving treatment for the patient, even though this may, incidentally, shorten the patient's life, but the doctor cannot give an overdose of pain relieving medication to bring about the patient's death. This is in keeping with existing statute (Suicide Act 1961 as amended) and common law (the law of murder) and will continue to be the law for the foreseeable future unless the Parliament passes an assisted dying bill (see Chapter 11). In a situation where a patient is in a persistent vegetative state, it would be lawful to allow the patient to die, that is, to let nature take its course as the Tony Bland case[15] shows which is considered in Chapter 11 (Case Study 11.7). This case preceded the implementation of the MCA but would still be followed. A case determined after the MCA came into force where it was considered to be in the best interests for treatment to be withheld[16] is also considered in Chapter 11 (Case Study 11.8) together with the Supreme Court decision in the Aintree case[17] where it ruled on withholding treatment from a patient (Case Study 11.9).

6 Consider P's wishes and feelings, beliefs, and values and other factors P would consider (4(6))

Modified best interests

The effect of the statutory provisions of determining best interests is a modified best interests test, close to what has been described as a substituted judgment test. Scenario 5.6 illustrates the difference between a simple best interests test and a modified one.

This modified best interests test is possible when a person once had the mental capacity and evidence of their earlier wishes and feelings can be provided. However if a person has never had the requisite mental capacity, such as those with severe learning disabilities or serious brain damage from birth, then it is difficult to apply any test other than the simple best interests test. The courts have been clear that the duty under the MCA is to determine the best interests of P

and not provide a substituted judgment. In the case of Re G(TJ) [2010] (see Case Study 5.15), Morgan J said it is absolutely clear that the ultimate test for the court is the test of best interests and not the test of substituted judgment. Nonetheless, the substituted judgment can be relevant and is not excluded from consideration.[18]

Circumstances to be taken into account

There could have been a requirement that best interests were determined on an objective basis: what would any reasonable person wish to be decided for them, or what action would any reasonable person want? However the statutory provisions allow for the particular characteristics of the client/patient to be taken into account in determining what is in their best interests.

Past and present wishes and feelings

The decision maker must consider, so far as is reasonably ascertainable, the person's past and present wishes and feelings. Where P once had the requisite mental capacity, there would be evidence of how they once acted, their values, beliefs, feelings, and wishes. A profile can be built up of that person's personality and character. Where P has never had mental capacity for this kind of decision, it is more difficult to ascertain what he or she would want if they now had the capacity to decide. Scenarios 5.6 and 5.7 provide examples of how this statutory provision would work.

If an objective test were used to determine the best interests of a person lacking the required mental capacity, then their past and present wishes and feelings, what they once believed in, and their earlier values before they lost mental capacity could be ignored for the purposes of determining their best interests. However the MCA 2005 requires a subjective assessment of what is in P's best interests and enables a consideration of how would P decide if he or she now had the capacity to make the specific decision, but this is not necessarily the deciding factor.

> **Scenario 5.6** Modified best interests test.
>
> Mavis was by family background a strong member of the Jehovah's Witness faith and had always made it clear that in the event of her requiring a blood transfusion and her lacking the capacity or ability to make a decision, she would not want to be given blood. She had not however completed the Jehovah's Witness card to that effect. In her late 60s she suffered dementia and was moved to a residential home. Her physical health weakened and she was diagnosed as suffering from chronic leukemia and required a blood transfusion. She lacked the mental capacity to make any decision about having a blood transfusion.

> **Scenario 5.7** Previous wishes and feelings.
>
> Audrey has severe Alzheimer's and has been in a residential home for several years. The home is due to be demolished and residents are being moved to other homes. There are two principal choices for Audrey: an inner-city home with close access to shops, restaurants, and cinemas and a rural home surrounded by gardens and fields. Audrey's daughter explains to the home manager that Audrey had always lived in the city and would prefer to be close to public activities and city life than to be banished to the countryside.

If a simple best interests test is used in the case of Mavis in Scenario 5.6, then it could be argued that Mavis would die without a blood transfusion, and therefore it is in her best interests to have a transfusion. However if a modified best interests test is used, then account can be taken of what she would have said had she still retained the mental capacity to make a decision. On this basis, assuming that she still kept her beliefs and had not changed her mind about having a transfusion, then the blood transfusion could be withheld on the grounds that looking at her previous wishes and feelings, she would have refused it when she had the mental capacity, and therefore would continue to have refused it at a time when she lacked the capacity.

Clearly Audrey's life and preferences made at an earlier time when she had capacity should be taken into account in making the decision over which home would be in her best interests. Closely linked with past and present wishes and feelings are the beliefs and values which she once had and would be likely to influence her decision if she now had capacity. In the situation in Scenario 5.6, account has been taken of the previous beliefs and values of Mavis. The Code of Practice uses the example of a young girl, brain injured in a road accident, who had previously been politically active and whose father, when making investment decisions on her behalf,

was able to take into account to what investment choices her beliefs and values would have led her.[19]

In Case Study 5.2 there was concern that the costs of payment for a nanny could deplete the funds necessary for P's upkeep and whether that would be in her best interests.

Beliefs and values

The decision maker must also take into account any beliefs and values that P once had. This is discussed in Scenario 5.7. The fact that these beliefs and values are contrary to those held by the decision maker is irrelevant, as Scenario 5.9 shows.

Case Study 5.2 *Re X, Y and Z* [2014].[20]

The facts of the case were that a divorced woman following domestic violence (for which her husband was imprisoned) with three children was catastrophically injured in a road accident where the other three occupants were killed. The compensation included moneys for the employment of nannies. An application was made to court to determine whether it was in her best interests for moneys from her fund to be used for the nanny. P's deputy was concerned that this may not be in her best interests because of a shortfall between P's income and expenditure on her own needs. The best interests of P is what she would have wanted for children. Baker J concluded that the proposed payments to S from P's estate were in P's best interests.

Case Study 5.3 *Ashan* v. *University Hospitals Leicester NHS Trust* [2006].[21]

This is an example of a case where Judge Hegarty took account of the fact that P, who was in a persistent vegetative state, was a member of a family of devout Muslims and in determining her best interests he could take into account the wishes and beliefs of her family and those which she would have held had she had capacity. He held that it was in her best interests to be cared for at home rather than in a private nursing and rehabilitation center funded by the Trust.

Morgan J considered the factors influencing the weight to be attached to the wishes and feelings of P in the case of Re M[22] holding that the weight to be attached to P's wishes and feelings is issue specific. Eldergill J quoted from this case in *Westminster* v. *Sykes*[23] (Case Study 5.23).

Any other factors

Any other factors that the client/patient would be likely to consider if he or she were able to do so may include a wide variety of topics. For example, it may be that the client was a very altruistic person, generous with charities. The fact that he or she always contributed to a particular charity could be taken into account in decisions relating to the use of his income or capital. It may be that the person once had particular hobbies and interests, and this fact may be taken into account in determining his accommodation or his expenditure.

Scenario 5.8 illustrates a situation where risks to P are an important factor in determining best interests.

Risk taking

Scenario 5.8 first raises the question: has Harry the capacity to make his own decision about going swimming? If the answer to that is *no*, then the decision must be made in his best interests. The decision maker must follow the steps set out above and also carry out a risk/benefit analysis taking into account Harry's own wishes and feelings. Harry's quality of life would obviously be improved if he were able to undertake those activities he enjoys, and the decision maker would have a duty to see if the risks could be managed to reduce the possibility of harm arising in the water: more staff in attendance, the use of harnesses (see Scenario 5.12), and other methods of ensuring Harry's safety while he is the water should be considered. The assumption that it would be safer for him to stay at home should not be made without rigorous examination.

7 Consult views of specified others (4(7))

Consultation with others

The decision maker is obliged to take into account the views of others who are specified in the Act. This requirement is qualified by the words

> if it is practicable and appropriate to consult them.

Scenario 5.8 Risk taking.

Harry has severe learning disabilities and also suffers from epilepsy, which is not entirely under control with medication. He loves swimming but has been told that because of the risk of his suffering an epileptic fit while in the water, it is too dangerous.

Interestingly there is no *reasonably* qualifying practicable. This means that every practicable (this is less stringent than possible) effort must be made to contact the specified persons. However the use of the word *appropriate* signifies that the decision maker could decide that certain persons need not be consulted. This may include a person with whom the client/patient had fallen out or with whom they have not had contact over a long period. Those that the Act requires to be consulted include:

A nominated person

It may be that the client/patient has named a person as someone to be consulted on the matter in question or on matters of that kind. The decision maker would need to clarify the fact of the nomination, as well as the area over which they could be consulted. Thus a relative may have been nominated to be consulted over the client's care and treatment, but not over any financial matters.

Carer

"Anyone engaged in caring for the person or interested in his welfare" must be consulted by the person making the decision (S.4(7)(b)).

The Act does not specify whether or not the carer is paid, and therefore the views of both informal and paid carers could be obtained over what is considered to be in the best interests of the mentally incapacitated person. The Court of Appeal held that a person is caring for another where the services provided are more than minimal and they need not have been provided for the long term.[24] In this case the court had to decide on the definition of *cared for* under Section 26(4) of the Mental Health Act (MHA) 1983 in order to determine the nearest relative of the patient. (The nearest relative is one who ordinarily resides with or is cared for by one or more of his relatives.) Lord Justice Otton stated that *cared for* meant that the services provided were not merely minimal. They were services which were substantial and sustained. See also the discussion of carer in Chapter 16.

Donee of an LPA and deputy appointed for the person by the court

If either of these appointments has been made, then the decision maker has a duty to consult them if he or she considers it practical and appropriate. The donee of an LPA may, for example, have had a long acquaintance with P prior to P's loss of mental capacity and can provide the decision maker with information about P's wishes and feelings, beliefs, and values. It is not the views of those who are consulted which are relevant to the decision on P's best interests.

Content of consultation

Scenarios 5.9 and 5.10 illustrate situations dealing with consultation in the determination of best interests.

It is probable that social services would take the lead in determining how this decision was to be made and what was in Ruth's best interests. Let us assume the following.

Brenda Thomas is the social worker appointed to carry out an assessment of Ruth:

- She has evidence from the home manager and from the general practitioner (GP) who attends Ruth at the home that Ruth lacks the mental capacity to decide for herself where she should live.
- She therefore obtains all the relevant information necessary to determine Ruth's best interests.
- This would include finding out whether it was possible to assist Ruth in participating in the decision. For example, could a speech therapist or a specialist in the care of the elderly be of any assistance?

Scenario 5.9 The views of others on P's best interests.

Ruth has been in a care home for 2 years and seems unsettled and unhappy. She appears to lack short-term memory and is diagnosed as being in the early stages of dementia. However she is able to work the key pad for the door locks and frequently walks out of the front door onto a busy road. She has four children. Three of them visit her when they can. The fourth lives abroad and only sees Ruth once a year. Her younger daughter, Jane, is proposing to move to a larger house and turn the garage into a downstairs self-contained flat for Ruth. The other siblings who are not on good terms with Jane are opposed to this move. They consider that it is in Ruth's best interests to remain in the care home, where they feel that she is well cared for. They do not consider that she is capable of living in self-contained accommodation and do not believe that the younger sister would be able or would be prepared to give Ruth the time and support that she needs. They also suspect that Jane is more interested in Ruth's personal assets and would exploit her financially. There is no evidence that Jane visits Ruth more frequently than the other two siblings who live in this country.

- She would take medical advice in deciding if Ruth was likely to recover capacity so that she could make her own decisions. If there was no such likelihood, she would have to make the decision in Ruth's best interests.
- She would ascertain if it were appropriate to arrange for the appointment of an independent mental capacity advocate (see Chapter 8 and Scenario 8.1).
- She would consult with the three members of the family who visited Ruth and ascertain when the fourth child was likely to be in the country, so he or she could also be consulted on their views on what is in Ruth's best interests.
- She would also ascertain if there were other relatives who would have relevant views as to what was in Ruth's best interests.
- She would also consult with the carers in the home, the GP, and others involved in her present care and treatment.
- All these people would be asked what they knew of Ruth's past and present wishes and feelings and if Ruth has any written statements (made when she had the requisite mental capacity) which are relevant to her future accommodation.
- They would also be asked about any beliefs and values that would have influenced Ruth had she had the requisite mental capacity and any other factors which Ruth would have considered had she been able to do so.

In the light of these views as to what was in Ruth's best interests and the views of the independent mental capacity advocate (if appointed), Brenda would make her decision over what was in Ruth's best interests, probably following the balance sheet method discussed in Case Study 5.1 and in Re G(TJ) [2010][25] (Case Study 5.15).

Let us assume that Brenda decided in the light of the information that she had obtained that it was in Ruth's best interests to remain in the care home. She may have discovered, for example, that Ruth had never been very close to her younger daughter Jane but that Ruth had always been meticulous in treating each of her children equally. Brenda also found out that Jane was in serious financial difficulties and that Ruth paid the full home fees from the considerable capital that was left to her from the death of her husband and the sale of her house. Brenda also found out that Ruth appeared to be friendly with several fellow residents in the care home and would sit with them for meals and when watching television. Ruth also appeared to enjoy the outings from the home.

Brenda's decision that Ruth should remain in the care home was challenged by Jane, who was prepared to apply to the CoP for an order enabling Ruth to be transferred to her house. It is possible that a deputy would be appointed by the CoP to make the decision (see Chapter 7 and Scenario 7.1).

Brenda should have the records which show the views that she had received and all the data which informed her decision. It is important that those she has consulted give their views on what would appear to be in Ruth's best interests and their views as to Ruth's wishes and feelings, beliefs, and values rather than their own views as to what they would want. Even in this apparently simple decision, there is a lot to be taken into consideration, and there are considerable resource issues for social services in this decision-making process, particularly where there are disputes within a family or between clinicians and informal carers.

Scenario 5.10 presents another situation comparable to Scenario 5.9, when the views of others may prevent the best interests of P taking priority.

The starting point in this Scenario is Geoffrey's mental capacity to decide if he wishes to take part in these activities and, ultimately, if he wishes to leave home. Only if an assessment is made which confirms that Geoffrey lacks the requisite mental capacity, is it necessary to determine what is in his best interests. There is a danger here that his parents, who have seen the dependent, disabled side of Geoffrey, have not taken on board the potential he has for developing his independence and

Scenario 5.10 A sexual relationship.

Geoffrey suffered brain damage at birth and has always been cared for by his parents. They gave up work at his birth and spent their lives devoted to him. A speech therapist has worked with Geoffrey in developing his communication and encouraged him to participate in activities outside the home. He enjoys going to the pub and has met up with a girl in similar circumstances with whom he would like to have a sexual relationship. His parents are horrified at this development and do not consider it is in Geoffrey's interests to have these outside interests, since false expectations may be set up and he may eventually want to move into other accommodation, where he would be unable to cope.

for enjoying activities outside the home. Geoffrey may well find it difficult to represent himself against the wishes of his parents to whom he owes so much. He may need support from an advocate in such a situation (see Chapter 8).

Case illustrating consultation duty

Case Study 5.4 *R(W)* v. *London Borough of Croydon* [2011] EWHC 696 (Admin).

An application for judicial review was made on behalf of W who was autistic with learning disabilities because of LA's failure to consult with W's parents and staff at his current placement before deciding to move him. Part of the reason was the expense of the current placement. Although finances could be taken into account, LA was under a duty to consult under NAA Choice of Accommodation Directions 1992, the Community Care Assessment Directions 2004, and the MCA Code of Practice with W his carers, his family, and care providers.

The criteria used to determine best interests

These statutory requirements on how best interests is to be decided must be followed by anyone exercising powers under an LPA or any other powers exercised on behalf of a person who is reasonably believed to lack capacity (S.4(8)). (An exception to this would be where an LPA specifies action which must be taken by the donee of the power, which could be contrary to P's best interests.)

Thus, whenever decisions are to be made on behalf of a person who lacks capacity the principles set out in Section 4 must be applied. However where an advance decision (see Chapter 9) has been drawn up, is relevant, and applies to the decision, then the best interests criteria would not be relevant. Those acting under the advance decision must carry out the refusal of P (if it is valid and relevant to the circumstances), since those wishes were recorded at a time when P had the requisite mental capacity.

It must be emphasized that the use of the best interests criteria only comes into play when the decision has been made that P lacks the requisite mental capacity to make a specific decision. As long as P has the mental capacity, P can make his or her own decisions, whether or not they are in his or her best interests.

Who decides? What role does the family play?

For day-to-day decisions the immediate carer would be deciding whether a person lacks the requisite capacity and, if so, what is in the person's best interests. However for more serious decisions, such as medical treatment or accommodation, the health professionals and social services personnel would be making the decision but would involve informal and paid carers and family members in the decision-making process. Where there is no such person to be consulted, an independent medical capacity advocate would be appointed (see Chapter 8).

Disputes over what is in a person's best interests

The Department for Constitutional Affairs (now the Ministry of Justice) published a consultation paper[26] which provides guidance on resolving disputes over what is in P's best interests. These include appointing a mediator, using an advocate, getting a second opinion in medical disputes, and using informal or formal complaints procedures. Where there is no local resolution of the dispute, then an application could be made to the CoP which might appoint a deputy to assist in the resolution of the problem (see Chapter 7). The CoP is more likely to appoint a deputy where property and affairs decisions are required than in the case of personal welfare issues (see Chapter 7).

Standard of compliance: Section 5

Section 5 provides protection for a person acting in the best interests of a person lacking the requisite capacity. It is shown in Statute Box 5.2.

Where an act is done or decision made (in connection with the care or treatment of another person) by a person other than the court, then there is sufficient compliance with Section 4 (best interests) if the person complies with steps to be taken in determining best interests and in taking into account all the specified considerations (S.4(1) to (7)), and he or she reasonably

Statute Box 5.2 Section 5: Acts in connection with care or treatment.

1 If a person ("D") does an act in connection with the care or treatment of another person ("P"), the act is one to which this section applies if—
 a) before doing the act, D takes reasonable steps to establish whether P lacks capacity in relation to the matter in question, and
 b) when doing the act, D reasonably believes—
  i) that P lacks capacity in relation to the matter, and
  ii) that it will be in P's best interests for the act to be done.
2 D does not incur any liability in relation to the act that he would not have incurred if P—
 a) had had capacity to consent in relation to the matter, and
 b) had consented to D's doing the act.
3 Nothing in this section excludes a person's civil liability for loss or damage, or his criminal liability, resulting from his negligence in doing the act.
4 Nothing in this section affects the operation of sections 24 to 26 (advance decisions to refuse treatment).

believes that what he or she does or decides is in the best interests of the person concerned (S.4(9)).

The following stages must take place:

1 A person (D) has taken reasonable steps to determine if P lacks capacity in relation to the matter in question.
2 He reasonably believes that P does lack capacity.
3 He reasonably believes that it will be in P's best interests for the act to be done.

Then D (the person carrying out the activity) does not incur any liability in relation to the act that he would not have incurred if P had the capacity to consent in relation to the matter and had consented to D's doing the act.

In other words, if the statutory provisions are followed, the absence of consent by P does not create a trespass to the person in relation to D's actions. This section puts in statutory form the protection recognized at common law and set out in the case of *Re F*[27] (see Case Study 2.3). The section provides legitimacy for all those activities by laypersons and health and social services professionals taken out of necessity in the best interests of a mentally incapacitated adult. They are not making decisions on behalf of the incapacitated person: they are acting in his or her best interests out of necessity. Only two conditions are required: firstly that there should have been reasonable steps taken to ascertain that P lacks capacity and that these steps led to the conclusion that P was mentally incapable in relation to that matter and secondly that the acts should be in the best interests of P. The principles set out in Section 1 apply to this situation, as does the definition of capacity in Sections 2 and 3 and the definition of best interests in Section 4.

This means that any civil or criminal proceedings brought against the decision maker in relation to their acting without consent can be defended on the grounds that there was compliance with the statutory provisions. However in the event of a dispute the decision maker would have to produce evidence that the statutory provisions were followed, and therefore documentation on the persons who have been consulted, the information which has been taken into account, and what has been decided as relevant would be essential evidence. Records of such information are essential for health and social services professionals, but they would also be of great value to the unpaid carer. Thus even informal carers and decision makers would be well advised to keep records of some of the significant decisions made on behalf of the person lacking the requisite mental capacity (see Chapter 16).

Activities protected under Section 5

The Code of Practice[28] lists those activities which could come under Section 5 covering personal care and healthcare and treatment. The list includes help with personal hygiene, eating and drinking, communication mobility, etc., but the list is not intended to be exhaustive.

Where the carer is following an advance decision, Section 5 does not apply (S5(4)) (see page 66).

There could be compliance with the MCA but still evidence of criminal behavior or negligence, which could be followed by civil proceedings for compensation, as Scenario 5.11 illustrates.

Under Section 5 the bathing of Ruth would be considered to be an act in connection with the care and treatment of P.

Scenario 5.11 Consent but negligence.

Ruth had severe learning disabilities and was cared for in a community home. She was incapable of giving consent to even the basic forms of care. Every Thursday afternoon she was bathed by a care assistant. Unfortunately, at one bathing session, the care assistant failed to test the water before putting Ruth in the bath, and Ruth screamed out in pain and was scalded.

The care assistant, manager, or supervisor would have assessed Ruth's inability to give consent to having a bath and determined that it was in Ruth's best interests to have a bath. These activities would have been protected by Section 5. However the protection provided under Section 5 is limited, since Section 5(3) explains that nothing in Section 5 excludes a person's civil liability for loss or damage, or his criminal liability, resulting from his negligence in doing the act (see Chapter 11) as illustrated by the example in Scenario 5.11. The failure to ensure that the water was of the correct temperature and the harm that it caused to Ruth would be both an act of negligence in civil law (a breach of the duty of care which caused harm to the person; see Chapter 11 and Scenarios 11.3 and 11.4) and also a criminal offence. Were Ruth to die as a result of the scalding, the care assistant or her managers could be prosecuted for manslaughter.

Exclusions from Section 5

Section 6 places limitations on the scope of Section 5 and is shown in Statute Box 5.3.

The power recognized in Section 5 to take action in relation to the care and treatment of a mentally incapacitated adult does not authorize a person to act contrary to a donee of an LPA granted by P or a deputy appointed for P by the court (S.6(6)). However this would not prevent a person providing life-sustaining treatment or doing an act which he reasonably believes to be necessary to prevent a serious deterioration in P's condition while awaiting a decision from the courts (S.6(7)).

Restraint—Section 6

Under Section 6 (which is shown in Statute Box 5.3) where the decision maker acts with the intention of restraining the client/patient, it does not come under the protection of Section 5 unless two further conditions are satisfied.

These are:

- That the decision maker must reasonably believe that it is necessary to do the act in order to prevent harm to the client/patient
- That the action is a proportionate response

Proportionate means that the act of restraint is proportionate to both the likelihood of harm to the client/patient and the seriousness of the harm.

The use of restraint is defined as including the decision maker using or threatening to use force to secure the doing of an act which the client/patient resists, or resisting P's liberty of movement, whether or not P resists. This is illustrated in Scenario 5.12. Scenario 5.14 considers a situation where an intimate procedure was carried out under anesthetic at the same time as surgery for a fractured ankle.

The Department of Health has published guidance on positive care for persons to reduce the need for restrictive interventions.[29] Examples of justifiable interventions to prevent harm to P are listed in the Code of Practice.[30]

As a consequence of the amendments to the MCA included in Section 50 of the MHA 2007 in relation to deprivation of liberty safeguards (see Chapter 14), Section 6(5) of the MCA is repealed. (Section 6(5) is shown in Statute Box 5.3.) The DOLs now provide authorization for the deprivation of liberty of those lacking the requisite mental capacity. The MHA 2007

Statute Box 5.3 Section 6: Section 5 acts: limitations.

1 If D does an act that is intended to restrain P, it is not an act to which section 5 applies unless two further conditions are satisfied.
2 The first condition is that D reasonably believes that it is necessary to do the act in order to prevent harm to P.
3 The second is that the act is a proportionate response to—
 a) the likelihood of P's suffering harm, and
 b) the seriousness of that harm.
4 For the purposes of this section D restrains P if he—
 a) uses, or threatens to use, force to secure the doing of an act which P resists, or
 b) restricts P's liberty of movement, whether or not P resists.
5 *But D does more than merely restrain P if he deprives P of his liberty within the meaning of Article 5(1) of the Human Rights Convention (whether or not D is a public authority). This subsection was* repealed by S 50(4)(a) MHA 2007 (see Chapter 14 and the DOLs).
6 Section 5 does not authorise a person to do an act which conflicts with a decision made, within the scope of his authority and in accordance with this Part, by—
 a) a donee of a lasting power of attorney granted by P, or
 b) a deputy appointed for P by the court.
7 But nothing in subsection (6) stops a person—
 a) providing life-sustaining treatment, or
 b) doing any act which he reasonably believes to be necessary to prevent a serious deterioration in P's condition, while a decision as respects any relevant issue is sought from the court.

repealed Section 6(5) of the MCA and replaced it with new Sections 4A and 4B, which would justify the deprivation of liberty in specific circumstances (see Chapters 3 and 14). Sections 4A and 4B are set out in Statute Boxes 14.2 and 14.3, respectively.

Scenario 5.12 illustrates the use of proportionate restraint.

Taking Bob shopping is an act in connection with the care and treatment of Bob and therefore comes within Section 5 provisions. If reasonable steps have been taken to assess Bob's mental capacity to go shopping and it is concluded that he lacks the ability to make a decision, but it would be in his best interests to go, then the use of the reins would come within the provisions of Section 6 and the use of restraint.

The carers must answer the questions:

1 Does Bob lack the requisite mental capacity to make his own decisions?
2 If the answer to Q. 1 is *yes*, do they reasonably believe that it is necessary to restrain Bob in order to prevent harm to him?
3 Is the use of the reins a proportionate response to the likelihood of Bob suffering harm and the seriousness of that harm?
4 Are there alternative arrangements which could be made which are less restrictive of him such as his always being accompanied by two carers?

In addition they must ensure that the principles set out in Section 1 are followed, that it is in the best interests of P to go shopping, and that the least restrictive option is being taken.

On the assumption that Bob lacks the requisite mental capacity, the next two questions must be answered. Since the use of the reins is to prevent Bob running into the road and possibly being killed, it would seem that questions 2 and 3 could be answered in the affirmative.

Scenario 5.12 Restraint or loss of liberty?

Bob had received a serious head injury in a road traffic accident and had little thought for his own safety. He enjoyed shopping but would dart across roads in front of traffic. His carers decided that they could only take him shopping safely if he were to wear a harness. He disliked this restraint and fought to have it taken off, but the carers insisted he wore it when he went out. Could he argue that it was unlawful?

Other alternatives could be not going at all, and thus reducing the quality of life of Bob, or of taking more than one carer, with resource implications which may lead to no further or much fewer shopping trips.

NHS England commissioned a report from Sir Stephen Bubb on the use of restraint for those with learning problems and autism. It was published in 2015 and concluded that mechanical restraint or seclusion has no place in the twenty-first century. If the restraint amounts to a deprivation of liberty, then an authorization should be sought (see Chapter 14).

Restraint and LPA

The donee of an LPA giving powers in relation to personal welfare is only authorized to restrain P if the three conditions laid down under Section 11 are satisfied. See Chapter 6 for further discussion of this.

Payment for necessary goods and services

Under Section 7 (see Statute Box 5.4) if necessary goods and services are supplied to a person who lacks capacity to contract for the supply, he or she must pay a reasonable price for them. *Necessary* is defined as meaning suitable to a person's condition in life and to his actual requirements at the time when the goods or services are supplied (see Chapter 11, Scenario 11.3). Section 7 gives statutory effect to the situation at common law (or judge-made law).[31]

Reimbursement of expenditure

Under Section 8 (see Statute Box 5.5) if an action relating to care and treatment (covered by Section 5) involves expenditure, then it is lawful for D to pledge

Statute Box 5.4 Section 7: Payment for necessary goods and services.

1 If necessary goods or services are supplied to a person who lacks capacity to contract for the supply, he must pay a reasonable price for them.
2 "Necessary" means suitable to a person's condition in life and to his actual requirements at the time when the goods or services are supplied.

Statute Box 5.5 Section 8: Expenditure.

1 If an act to which section 5 applies involves expenditure, it is lawful for D—
   a) to pledge P's credit for the purpose of the expenditure, and
   b) to apply money in P's possession for meeting the expenditure.
2 If the expenditure is borne for P by D, it is lawful for D—
   a) to reimburse himself out of money in P's possession, or
   b) to be otherwise indemnified by P.
3 Subsections (1) and (2) do not affect any power under which (apart from those subsections) a person—
   a) has lawful control of P's money or other property, and
   b) has power to spend money for P's benefit.

Scenario 5.13 Reimbursement.

Max was subject to extreme bouts of mood, from severe depression to hypermania. In the latter mood he became very extravagant and spent wildly. Subsequently he regretted his generosity and wild spending and refused to pay the bills. His carer Sally bought, out of her own money, food and household goods for Max. He then refused to reimburse her.

P's credit for the purpose of the expenditure and to apply money in P's possession for meeting the expenditure. If D bears the expenditure on P's behalf, then it is lawful for D to reimburse himself out of money in P's possession or to be otherwise indemnified by P. These subsections do not affect any power under which a person has lawful control of P's money or other property and has power to spend money for P's benefit.

Whether D is a paid or informal carer, it would be wise for records to be kept of any moneys taken from P by D to reimburse himself, so that if challenged D can provide evidence of the justification for the reimbursement. See Scenario 5.13 on reimbursement.

If the act of care and treatment involves the expenditure of money, then Section 8 permits P's credit to be used for such expenditure and any money spent by D in connection with P's care and treatment to be reimbursed. These sections apply even though D does not have an LPA. Scenario 5.13 illustrates the principle of reimbursement.

Sally is entitled to have her expenditure reimbursed. She would have to produce receipts and also be able to show that the expenditure was on Max's behalf. It is hoped that local discussion, negotiation, or mediation would resolve the dispute, but if not she could apply to the CoP for a declaration that Max owed moneys to her, which she was entitled to receive.

Decisions relating to organ and tissue removal and retention are considered in Chapter 15.

Decisions excluded from the Act

The MCA excludes some decisions being made under the Act on the basis that these are so personal to the person making them that they cannot be delegated to another person and that specific mental capacity is required for these kinds of decisions to be made. The excluded decisions are specified in Section 27 and shown in Statute Box 5.6.

Statute Box 5.6 Excluded decisions (S.27)

1 Nothing in this Act permits a decision on any of the following matters to be made on behalf of a person:
   a) consenting to marriage or a civil partnership
   b) consenting to have sexual relations
   c) consenting to a decree of divorce being granted on the basis of two years' separation
   d) consenting to a dissolution order being made in relation to a civil partnership on the basis of two years' separation
   e) consenting to a child's being placed for adoption by an adoption agency
   f) consenting to the making of an adoption order (as defined in the Adoption and Children Act 2002)
   g) discharging parental responsibilities in matters not relating to a child's property
   h) giving a consent under the Human Fertilisation and Embryology Act 1990.
2 "Adoption order" means—
   a) an adoption order within the meaning of the Adoption and Children Act 2002 (including a future adoption order), and
   b) an order under section 84 of that Act (parental responsibility prior to adoption abroad).

In certain of these specified situations there will be lawful alternatives to the giving of consent. For example, under Section 27(1)(e) and the consenting to a child being placed for adoption, if the birth mother lacked the capacity to give consent to that adoption taking place, the rules on dispensing with consent in the adoption legislation would apply. The possibility of the CoP giving consent or giving a deputy powers to consent on behalf of the mentally incapacitated person is precluded by Section 27(1)(e).

A marriage is void if one or other parties to the marriage lacks the capacity to give consent, and thus Section 27(1)(a) prevents consent being given on behalf of a mentally incapacitated person.

Exclusion of MHA matters (S28(1))

> Nothing in this Act authorises anyone to give a patient medical treatment for mental disorder, or to consent to a patient's being given medical treatment for mental disorder, if, at the time when it is proposed to treat the patient, his treatment is regulated under the MHA 2007. (Medical treatment and mental disorder and patient have the same meaning as in that Act, except that the qualifications on learning disabilities being a mental disorder under the MHA 1983 are disregarded.)

This exclusion is considered further in Chapter 13 on mental health and mental capacity and is discussed in Case Study 5.5.

It is a principle of the MCA that where the provisions of the MHA apply in relation to a detained person's treatment, then the MCA does not authorize treatment (Section 28 of the MCA; see Chapter 13). However treatment under the MHA only covers treatment for mental disorder, and a case heard in 2006 and shown in Case Study 5.5 illustrates what happens when a detained patient who lacks capacity requires treatment for a physical disorder.

Since October 2007 following the implementation of the MCA, were a similar situation to Case Study 5.5 to arise, the MCA would govern the decision making: the definition of mental capacity in Sections 2 and 3 of the Act (see Chapter 4) would be applied, and the criteria for best interests as set down in Sections 4 of the Act would also be applied. See Chapter 13 for consideration of whether the MCA or the MHA is relevant to P's situation.

Case Study 5.5 Detained patient requiring treatment for a physical disorder.[32]

A primary care trust and NHS trust applied to court for a declaration that H, a detained patient under Section 3 of the Mental Health Act 1983, could be treated for her ovarian cyst (which appeared to be cancerous) with a hysterectomy. H refused the operation because she wished to have children. She also refused more limited surgery for the removal of the cyst. Medical experts were of the view that it was in her best interests to undergo the proposed surgery. Declarations were sought that she lacked the capacity to make decisions, that it was in her best interests to undergo a total hysterectomy, and that it was lawful to provide sedation and reasonable physical restraint in order to administer treatment.

The President of the Family Division of the High Court granted the application. He reiterated the principle that no medical treatment could be given without the consent of a mentally competent adult. A person lacked capacity if some impairment of mental function rendered that person unable to make a decision whether to consent to treatment. He decided that H had delusional beliefs about her circumstances. It was clear that she did not appreciate the seriousness of her condition and the sense of threat to life that it presented if unalleviated. She therefore lacked the capacity to decide. The court was not tied to the clinical assessment of what was in a patient's best interests. It was obliged to take into account a broad spectrum of medical, social, emotional, and welfare issues before reaching its own conclusion. In balancing the benefits and disadvantages of the proposed treatment, the judge decided that the hysterectomy was in her best interests.

The judge made the declarations sought but also declared that forcible administration of postoperative chemotherapy was not covered by these declarations.

Exclusion of voting rights (S29(1))

> Nothing in this Act permits a decision on voting at an election for any public office, or at a referendum, to be made on behalf a person.

The definition of referendum is as set out in Section 101 of the Political Parties, Elections and Referendums Act 2000 and means a referendum or other poll held in pursuance of any provision made under an Act of Parliament on one or more questions specified in or in accordance with any such provision. The decision on how to exercise the right to vote is intensely personal and is nondelegable. It is a right which is effectively lost in the event of a person losing mental capacity and could not be covered by an advance decision.

Advance decisions

Where P had created a valid advance decision, then Section 5 would not apply to any care and treatment specified in the advance decision. The best interests test does not apply where a person has the mental capacity to make their own decisions or where they have by means of an advance decision made clear, at a time when they had the requisite mental capacity, what care and treatment they would not want if they were in the future to lack that capacity (see Chapter 9). The Code of Practice suggests that under Section 5 an advance directive cannot exclude basic care for the patient: it can only cover treatment. However there is no statutory definition of care, and the definition of treatment states that *treatment* includes a diagnostic or other procedure. Case law will ultimately be required to determine what comes within the definition of care (and therefore cannot be refused by an advance decision) and what comes within the definition of treatment (and therefore can be refused by an advance decision) (see Chapter 9 and Scenario 9.10.)

Accountability is considered in Chapter 11.

Decisions which should go to the CoP

The Code of Practice[33] recommends that the following situations should be referred to the court:

Withdrawing or withholding artificial nutrition or hydration from patients in PVS

Donation of organs or bone marrow from a person lacking the requisite capacity

Nontherapeutic sterilization

Disputes over what is in a person's best interests

Decision making in specific areas

Illustrative cases

The CoP has warned that the determination of capacity and of best interests is case and fact specific and there is a danger in finding a case with similar facts and following the outcome slavishly. The following cases are therefore given as illustrations of the issues that have been considered by the court but like the scenarios should not restrict the conclusions which can be reached in other situations. The important point is the logic applied by the court and how it interprets the statutory provisions. Different facts may lead to different outcomes.

Decisions about sexual activity

If the principles of *Valuing People*[34] (rights, independence, choice, and inclusion (see Chapter 11)) are followed, as updated in 2007[35] the care plan for a person with learning disabilities may include the achievement of a sexual relationship. This may present difficulties for those paid carers who have strong beliefs in sexual relations only taking place within marriage. Scenario 5.14 illustrates some of the potential problems.

The circumstances in Scenario 5.14 are perhaps a little extreme, but it is a well-recognized fact that a care plan for a person with learning disabilities should include sexual health and activity where that is appropriate. While Ken may have had the capacity to consent to having sex with a prostitute, he may not have been able to appreciate some of the risks which went with that such as venereal disease, and the care workers would have a duty to ensure that all reasonable care was taken to prevent that. Brenda's personal beliefs and values are irrelevant in determining what is in Ken's best interests. Only if what is proposed is contrary to the law or an affront to public decency would she be justified in protesting against the planned trip. Following the implementation of the MCA she could of course seek a declaration from the CoP that what is being proposed for Ken was contrary to his best interests. The chances of her succeeding are by no means certain.

Scenario 5.14 Sexual activity.

Ken had been in a care home for over 10 years. He had mild learning disabilities. Staff discussed with him a care plan following the principles of *Valuing People*[36] (Department of Health (2001)).

Ken made it clear that he wanted to experience a sexual relationship. Brenda, his key worker, stated that she was not prepared to assist him in this. In particular, she believed such an intimate relationship should not be encouraged with any of the women who lived in the care home. John, a care assistant, suggested that they should arrange to take Ken to Amsterdam to visit a prostitute. It was agreed by the care team that Ken would be able to give consent to having sex but would be incapable of organizing the trip. By a majority decision, with Brenda dissenting, it was agreed that Ken would be taken to Holland by a single care worker, and the costs would come out of Ken's personal moneys.

Intimate care

Problems can arise in the care of those who lack the capacity to give consent over their intimate care. Screening breasts for lumps, cervical screening, washing of the genitalia, and similar procedures can all pose problems when the patient/client is unable to understand the justification for what is proposed, is unable to give consent, and furthermore may resist any intimate touching of his or her person. A typical situation is discussed in Scenario 5.15.

Scenario 5.15 presents an example of the everyday activities necessary for the care and treatment of those incapable of giving consent to what could be seen (in the absence of the statutory provisions) as a trespass to their person. Nail cutting, hair washing, and such hygienic procedures can all present difficulties, especially when the client resists any such care. Individually their lack is not a life-and-death question, but over time a lack of hygiene or nail cutting can become a lifesaving necessity. Where the client is incapable of giving consent and physically resisting any intervention, the restraint provisions of the MCA must be complied with and all reasonable care taken. Documentation is essential to show the circumstances and the fact that what was done was in the best interests of the client. Withholding or withdrawing treatment is considered in Chapter 11.

Serious medical treatment

Where the decision relates to whether serious medical treatment should be undertaken, the possibility of appointing an independent mental capacity advocate should be considered (see Chapter 8). This only arises where there is no appropriate person who could be consulted on behalf of the patient/client to determine what was in his or her best interests. The question however arises as to whether other treatments, not normally seen as serious, could be carried out at the same time. Scenario 5.16 provides an example.

There would appear to be no problem in ensuring that the operation to repair the ankle took place in the best interests of Barbara. What however of the cervical smear? Could it be done while Barbara was under the anesthetic? The first question to be asked is: did Barbara

Scenario 5.15 A necessary protocol.

Karl had Down's syndrome and was cared for by his elderly parents. When they were in their 70s, they agreed that Karl should move to a care home, where he could get to know people of his own age. He visited the care home several times for short stays for respite and then moved in. The care staff were concerned that he resisted any attempt to have intimate areas washed, and he was not prepared to wash himself. They were particularly concerned at the possibility of infections developing under his foreskin. His key worker Fred discussed the problems with his mother, who said that she alone bathed him and made sure that all areas were properly cleaned, but she could understand that Karl would not want anyone else to interfere with him. The care team discussed the problem with Karl's GP, who said that it was not his concern and he could not help. The care team considered the possibility of inviting his mother to come once a month to wash Karl, but this was considered inappropriate and a lapse of their own professional duties. They then devised a protocol which stated that once a month, Karl should have a full cleaning session: two members of staff were required to be present, and all efforts would be made to persuade Karl to wash himself and to assist him. If necessary minimal restraint would be used. The care would be documented and reviewed as appropriate.

Scenario 5.16 What treatments?

Barbara had mild learning disabilities and lived in a community home. She was a very keen walker and on one trip stumbled and fractured her ankle badly. She needed to have surgery with a general anesthetic. It was not clear that she understood what was required, and an expert was brought in to determine her ability to give a valid consent to the operation. The expert was of the view that while she wanted her ankle to heal, she did not understand the nature and effects of the anesthetic and could not give a valid consent. It was therefore decided that she should be seen as a person lacking the specific capacity to give consent to the treatment, and the MCA would therefore apply. Her mother was consulted about Barbara's views, beliefs and values, and she said that she considered that it was in Barbara's best interests to have the surgery. An independent mental capacity advocate was not required, since the mother could be consulted. The mother also asked if Barbara could have a cervical smear at the same time, as she had been unable to get her to agree to a smear in the clinic and the doctor was not prepared to use force.

have the requisite mental capacity to give or refuse consent to the cervical smear? If the answer to that question is *yes*, then it could not be done without her consent. If on the other hand the answer was *no*, she did not have the requisite capacity to make a decision about a cervical smear, and then taking the smear while she was under the anesthetic would appear to be in her best interests. The alternative would be to carry it out while she was conscious and therefore possibly resisting, which would be more traumatic for her. Unfortunately the easy way out is to fail to take the cervical smear, which probably accounts in part for the low health screening undertaken on those with learning disabilities (see page 50 and the Confidential Inquiry into premature deaths of people with a learning disability (2013)[37]).

Case illustrating decision about serious medical treatment

Case Study 5.6 *A NHS Trust* v. *(1) K (2) Another Foundation Trust* [2012] EWHC 2292 CoP.

A woman K had cancer of the uterus and could be potentially cured by a lifesaving operation, but because of comorbidities she could die during the operation. The medical team and her sons felt that she should have the operation. Holman J had to determine whether it was in her overall best interests to have the op. He decided that it was and also decided that it was also in her best interests to receive sedation prior to the op (justifying his decision on the basis of *DH NHS Foundation Trust* v. *PS* [2010][38] where a hysterectomy was held to be in P's best interests plus covert sedation in advance). Judge Holman said that the anesthetist, surgeon, and the intensivist should all have powers of veto of the operation going ahead if the circumstances changed.

See also the case of *Tracey R (on the application of)* v. *Cambridge University Hospital NHS Foundation and others* [2012][39] for a judicial review of the failure to treat claimant's late wife and the DNACPR order. The Court of Appeal allowed the appeal against the refusal of judicial review.[40] The case is discussed in Chapter 11 (Case Study 11.11).

See also the case of *Sandwell and West Birmingham Hospitals NHS Trust* v. *CD and others*[41] where there was a dispute between Trust and parents over the treatment to be provided to their daughter AB who was 20 with cerebral palsy and as a result of septic poisoning suffered brain damage and lacked capacity. Mrs Justice Theis was concerned about procedure for out-of-hours application and gave guidance on what steps should be taken prior to such an application.

Obstetric case and caesarean

Case Study 5.7 *Re AA* [2012].[42]

This was the first CoP decision on caesarean section since MCA came into force.

A NHS trust applied under the MCA for a declaration that an expectant mother lacked capacity to consent to medical treatment relating to the delivery of her baby, as well as in relation to her antenatal and postnatal treatment. The application was granted. AA, an Italian on a short visit to this country (but the court had jurisdiction on the basis of para 7(1)(c) of Schedule 3 of MCA), was detained under Section 3 of the MHA and represented by the Official Solicitor who did not oppose the application and considered that a caesarean to be in her best interests since she risked uterine rupture with a natural vaginal birth. Mostyn J held that the case came within the guidelines of Re MB[43] and declared that it was in her best interests that her child should be born alive and healthy. The court must have regard to the principle of the least restrictive action but that principle does not seek to define the expression *best interests*. He said that it would be heavy handed for the police to remove the child under S. 46 of the Children Act 1989 but suggested that the LA applied for an interim care order where the mother could be represented. This subsequently took place and a care and placement order was made. A later hearing took place on reporting restrictions.[44]

Case Study 5.8 *Re SB* [2013].[45]

This was the first bipolar case to be reported where the sufferer was found to have the capacity to decide to terminate her pregnancy. 39 Essex suggested the value of professionals considering better ways for patients with bipolar to secure respect for their wishes in the event of their mental health deteriorating during pregnancy (patients often failed to take medication because of the effect on the fetus).

See also *NHS Trust and Ors* v. *FG (Rev 1)* [2014][46] which was concerned with the obstetric care of FG and which should be read in conjunction with *X County Council* v. *M and others* [2014].[47] The case sets out guidance to be followed in four categories of obstetric cases and medical intervention. (The case is considered in Chapter 2 on inherent jurisdiction of the court.)

See also *Great Western Hospitals NHS Foundation Trust* v. *AA, BB, CC, DD* [2014] EWHC 132 Fam which is considered in Chapter 2 on the interface between the MCA MHA and inherent jurisdiction (see Case Study 2.8).

Sterilization

Case Study 5.9 *A Local Authority* v. *K (by the official solicitor), Mr K, Mrs K and a NHS trust* [2013].[48]

K was 21 years old suffering from Down's syndrome with associated learning difficulties and her parents wanted her to be sterilized. A local authority sought a declaration from the Court of Protection (CoP) regarding the best interests of K. Her parents wished her to be sterilized. A best interests meeting between the parents, LA, and staff from the NHS trust decided that a nontherapeutic sterilization was not in her best interests. The parents indicated that they were taking K abroad. The LA brought proceedings seeking a declaration in relation to contraception and sterilization and an injunction not to remove K from the jurisdiction. The LA and Official Solicitor commissioned a report from a gynecology expert who stated that sterilization was not in K's best interests and was not the least restrictive option. The CoP laid down the principles and procedure which should apply when nontherapeutic sterilization was being considered. Such a decision was so serious that the CoP should make it. In the actual case the CoP stated that any issue of nontherapeutic sterilization should be brought back before the court so that those who were responsible for K's care were clear about the requirements going forward.[49]

Where medical conditions could change, it is important for an early application to be made to the CoP as illustrated in the case of *NHS Trust* v. *Mr and Mrs H and others* [2012][50] where KH had a medical condition which could become very serious. Peter Jackson J identified the treatment issues that needed to be determined and that were not likely to change over time and in respect of which declarations could be made.

Case Study 5.10 *Re DE* [2013].[51]

This was the first reported case where court found that it was in the best interest of an incapacitated learning disabled adult to have a vasectomy as a method of contraception.

The case was quoted in IMCA 6th annual report to show the importance of maximizing capacity and duty of IMCA to ensure least restrictive option is followed as far as is possible (see also Chapter 14).

In the case of the Mental Health Trust/the Acute Trust and the Council v. *DD (by her litigation friend the Official Solicitor), BC (Number 5)* [2015],[52] Cobb J had to determine whether it was in the best interests for DD (autistic with mild learning difficulties who had had six pregnancies with all children in care) to have a coil fitted or to have a laparoscopic sterilization. He stated that best interests were not confined to medical interests but covered wider issues. He undertook a balancing exercise between the two options and concluded in favor of the sterilization taking into account 2 factors of magnetic importance: the risks to her life of future pregnancies and the fact that sterilization would enable her to lead a normal life without intrusion by health and social services.

Anorexia

Case Study 5.11 *The NHS Trust* v. *L and others* [2012].[53]

A 29-year-old with severe anorexia + OCD detention under S. 3 rescinded after all treatment options exhausted. Trust sought declaration that it was not in her best interests to be the subject of forcible feeding or medical treatment, notwithstanding that she would die without it.

Judge Eleanor King J held that Ms L lacked capacity and it was in her best interests not to be force fed and made a declaration that it was in Ms L's best interests to provide nutrition, hydration, and medical treatment, where she complied with its administration; to administer dextrose to immediately save life, with minimal force if necessary; not to provide nutrition and hydration if she resisted after all reasonable steps had been taken to gain her cooperation; and to provide palliative care should she enter the terminal stage of her illness. This case contrasts with Case Study 5.12. In Case Study 5.11 there was no hope of her recovering. In Case Study 5.12 there was a 20% chance of recovery after treatment.

Case Study 5.12 *A Local Authority* v. *E and others* [2012].[54]

The court decided that it was in E's best interests to be fed by force if necessary and that the resulting interference with her article 8 and 3 rights was proportionate and necessary to protect her right to life under article 2.

Best interests and contact

Case Study 5.13 *PS* v. *LP* [2013].[55]

This case raised an issue over contact where the preincapacity views were not clear. LP left home to live with PP and claimed that she had been subjected to abuse and domestic violence. Then she had a cerebral aneurism and was in a care home requiring 24-h support. Her daughter PS wished to have contact with her and claimed that letters purporting to say that LP did not wish to have contact were written under the influence of PP and did not express LP's real wishes. The judge decided that LP's wishes not to see her family were genuine and of her own volition at a time when she had capacity. He concluded that it was not in LP's best interests to see PS and her family unless there was a change in LP's situation at some point in the future. This case can be compared with that of *RGB* v. *Cwm Taf Health Board and others* [2013][56] which is considered in Chapter 9 (Case Study 9.1) and illustrates the difficulties which arise when an advance decision has not been recorded.

Best interests and conflict within family

Case Study 5.14 *HN* v. *FL and Hampshire County Council* [2011].[57]

HN was sister of FL who suffered from MS and lacked the capacity to make decisions about her case, residence, and contact with others. She had lived in a care home for 8 years. Two previous sets of proceedings which led to HN's power of attorney for financial affairs being cancelled and welfare proceedings concerned with care, residence, and contact culminated in a 2009 consent order. HN had disagreements with the care home and LA. After a 4-day fact-finding hearing the judge found that HN had acted vexatiously in FL's affairs including waging a war of groundless complaints. The judge ruled it was in FL's best interests to remain in the care home and there were restrictions on HN's contact with her, supported by penal notices. The judge said the court would step in to resolve disputes if necessary, ideally with as little intervention as possible.

Best interests and property

Case Study 5.15 *Re G(TJ)* [2010].[58]

The judge had to decide if it was in Mrs G's best interests for the deputy to make payments to her adult daughter by way of maintenance to her. He analyzed section 4 and said there is no definition, but clearly altruistic gifts could be seen as part of best interests in P's balance sheet of factors. However it is absolutely clear that the ultimate test for the court is the test of best interests and not the test of substituted judgment. Nonetheless, the substituted judgment can be relevant and is not excluded from consideration. He concluded that the continuation of maintenance payments to the daughter is in P's best interests.

Selling the Pissarro

Case Study 5.16 *In the matter of RGS (No 3)* [2014].[59]

This was third case: the earlier ones had dealt with the son with mental health problems wishing to remove father RGS from care home, financial mismanagement, sale of a Pissarro painting, and issues relating to the media. P was an 84-year-old man with dementia. His son wanted him removed from care home after he had been attacked by another resident with mental health problems. The court decided that it was in his best interests to stay there on the basis of a best interests report prepared by a General Visitor (the resident had been placed under MHA and removed). The son had published information about the father on the website, but the court decided not to take contempt of court action against him. The son's contact with father could continue under supervision by LA. The judge also looked at the pros and cons of publicly naming parties in the proceedings. Earlier case of Re RGS (No 2) [2013][60] (Case Study 7.8) concerned the sale of the Pissarro to meet care home costs (see Chapter 7).

Best interests and residence

Case Study 5.17 *LB Haringey* v. *FG and others* [2011].[61]

The case was concerned with determining the best interests of HG and whether she should continue in care or return to live with mother. The judge met up with HG. It was a case which started under Children Act proceedings but was then transferred to CoP (see Chapter 12).

Case Study 5.18 *HT* v. *CK* [2012].[62]

A case where K 60 with Down's syndrome lived with her mother till the latter's death and then in a care home. There was regular contact with her sister HT who complained about her care at C home. HT moved and wanted K to be moved to a home nearer her. HT complained to CQC. LA decided K's continued residence in C home was appropriate. HT applied to CoP seeking order to be appointed as K's personal welfare deputy and property and affairs deputy and an interim order for K to be moved to residence closer to HT.

The LA opposed the application. Judge DJ Eldergill held that there was no suitable placement within 20-mile radius of HT's home. It was in her best interests to remain in C home. The independent social worker held that while family relationships are important, the balance weighed in favor of maintaining the stable, consistent high-quality care that K was receiving opted in favor of a final order to bring finality to a lengthy process. The interference with Article 8 rights of K and HT was lawful, proportionate, and justified.

39 Essex commented that this was an example of case where the court has to balance the rights of family members with P's interests in continuity of care. It is not the only case where the court has decided in favor of P staying in existing home, rather moving to be nearer a family member who has just relocated.

Case Study 5.19 *K* v. *LBX* [2012].[63]

In this case the father opposed the son with learning disabilities being moved to supported living and away from family home. The father quoted Munby in Re S [2003][64] 1 FLR 292 that although there was no presumption in law that P should stay with his family, usually a mentally incapacitated adult will be better off with a family than in an institution.

CA rejected father's appeal. The right approach under the MCA is to ascertain the best interests of the mentally incapacitated adult by applying section 4 best interests checklist. Then is the conclusion a violation of article 8 rights, and if so is the violation necessary and proportionate? Black LJ pointed out that there could be a conflict between a private life (personal self-development and establishing relationships with others) and family life by continuing to exist in family home. See also *London Borough of Hillingdon* v. *Neary and another* [2011][65]; see Case Study 14.8.

Case Study 5.20 *FP* v. *HM and A Health Board* [2011].[66]

Hedley J had to consider whether GM should return home on a trial basis or whether he should be permanently admitted into EMI care. He had been detained under S 2 of MHA and then discharged from section and made subject of an urgent, followed by standard DOLs authorization which was challenged by his partner FP.

39 Essex commented on this case to remark that the judgment represents a master class in best interests decision making. Determining the residence issue through an article 8 lens ensured that the significant component of best interests analysis was not overshadowed by its physical counterpart. It showed too how efficient and effective the CoP can be. There is a tension between para 1.14 of Code of Practice and not using an extension of DOLs due to delays in moving people between care or treatment settings. In the case of *A County Council* v. *MB and others* [2010],[67] Charles J said the best interests assessor needs to take timings of a move into account.

Case Study 5.21 *PCT* v. *P, AH and a Local Authority* [2009].[68]

This is one of the first cases of the newly constituted CoP. There were two issues: (a) capacity of P in relation to medical treatment, his best interests, residence, and what kind of contact he has and the ability to conduct litigation and (b) determination of his best interests especially residence. Hedley J held that it is only where best interests of P compellingly require placement away from the family environment that such placement can be justified as a proportionate interference with the rights of both P and the relevant family members under article 8. The judge recognized that restrictions upon contact could give rise to a situation of deprivation of liberty.

Best interests and marriage

Case Study 5.22 *A London Borough* v. *BB, AM SB and EL Trust* [2011].[69]

BB had learning disabilities and was deaf. Her marriage with MM was annulled on the ground that she did not validly consent to it. The judge held that the arrangements of her placement amounted to a deprivation of liberty.

Best interests and the balance sheet approach

Case Study 5.23 *Westminster City Council* v. *Sykes* [2014].[70]

The facts of this case which involved the validity of a deprivation of liberty authorization are considered in Chapter 14. Ultimately the decisive issue in the case was whether it was in the best interests of MS to be deprived of her liberty by living in a care home rather than at home with a package of care. District Judge Eldergill considered the issues relating to the determination of best interests.

The best interests test is an objective test, concerned with the best interests of MS and not the best interests of another person. The following passage concerning the need for a balance sheet approach to best interests comes from the then President's judgment in the case of *Re S (Adult's lack of capacity: carer and residence)* [2003][71]:

> … The question … is: which outcome will best serve her interests? … [It] is clear that the court goes about deciding that question by drawing up the balance sheet identified by Thorpe LJ in Re A (Male Sterilisation) [2000].[72]
>
> Pending the enactment of a checklist or other statutory direction it seems to me that the first instance judge with the responsibility to make an evaluation of the best interests of a claimant lacking capacity should draw up a balance sheet. The first entry should be of any factor or factors of actual benefit … Then on the other sheet the judge should write any counter-balancing disbenefits to the applicant … Then the judge should enter on each sheet the potential gains and losses in each instance making some estimate of the extent of the possibility that the gain or loss might accrue. At the end of that exercise the judge should be better placed to strike a balance between the sum of the certain and possible gains against the sum of the certain and possible losses. Obviously only if the account is in relatively significant credit will the judge conclude that the application is likely to advance the best interests of the claimant.

District Judge Eldergill having conducted a balancing exercise concluded that it was his view that it was in Ms S's best interests to attempt a 1-month trial of home-based care. Factors he looked at included the following: her age, 89 years; that it is her life; value of a few months in her own home balanced against the trauma of her being removed to institutional care; the risks of the failure of a home care package; the action which can be taken to minimize those risks and reduce any distress at home; the purpose of a trial at home; the role of RS, her attorney for property and affairs; her safety as a consideration in determining her welfare but not an overriding consideration; and the powers (S.115 and 135) under the MHA to enable a speedy response in an emergency.

In balancing the various factors to determine a person's best interests, forcing P to remain in a care home and not return to her own house could not be justified purely on the basis of prolonging her life.[73]

Guidance on best interests

In Case Study 5.23 of *Westminster* v. *Sykes*,[74] Eldergill J quoted the following paragraphs from the case of *in the matter of the MCA and in the matter of M*; *ITW* v. *Z* [2009],[75] Munby J (as he then was) had to determine the contents of a statutory will to be drawn up on behalf of M. He gave the following guidance with regard to the different considerations listed in Section 4 which the decision maker must have in mind.

i) The first is that the statute lays down no hierarchy as between the various factors … beyond the overarching principle that *what* is determinative is the judicial evaluation of what is in P's "best interests."

ii) The second is that the weight to be attached to the various factors will, inevitably, differ depending upon the individual circumstances of the particular case. A feature or factor which in one case may carry great, possibly even preponderant, weight may in another, superficially similar, case carry much less, or even very little, weight.

iii) The third, following on from the others, is that there may, in the particular case, be one or more features or factors which, as Thorpe LJ has frequently put it, are of "magnetic importance" in influencing or even determining the outcome.

The weight to be given to an incapacitated person's own wishes was to be determined as follows:

i) First, P's wishes and feelings will always be a significant factor to which the court must pay close regard: see *Re MM; Local Authority X* v. *MM (by the Official Solicitor) and KM* [2007][76]

ii) Secondly, the weight to be attached to P's wishes and feelings will always be case-specific and fact-specific. In some cases, in some situations, they may carry much, even, on occasions, preponderant, weight … it all depends … upon the individual circumstances

of the particular case [and] … the weight to be attached to their wishes and feelings must depend upon the particular context ….

iii) Thirdly, in considering the weight and importance to be attached … the court must … have regard to all the relevant circumstances. [These] will include [but are not] limited to such matters as:

a) the degree of P's incapacity, for the nearer to the borderline the more weight must in principle be attached to P's wishes and feelings: *Re MM; (See above)*

b) the strength and consistency of the views being expressed by P;

c) the possible impact on P of knowledge that her wishes and feelings are not being given effect to: see again *Re MM (see above)*

d) the extent to which P's wishes and feelings are, or are not, rational, sensible, responsible and pragmatically capable of sensible implementation in the particular circumstances; and

e) crucially, the extent to which P's wishes and feelings, if given effect to, can properly be accommodated within the court's overall assessment of what is in her best interests.

Eldergill J stated that:

The "best interests requirement" is in reality four requirements masquerading as one. It is satisfied only if all of the following four conditions are satisfied:

1. MS is being detained in the care home for the purpose of being given care or treatment in circumstances which amount to a deprivation of her liberty;
2. This is in her best interests;
3. This is necessary in order to prevent harm to her; and
4. Her detention in the care home for the purpose of being given care or treatment in circumstances which amount to a deprivation of her liberty is a proportionate response to the likelihood of her suffering harm, and the seriousness of that harm (if she were not so detained).

If one or more of these conditions is not satisfied, the person does not meet the best interests requirement; and, because a standard authorisation may only be given if all six requirements are satisfied, Ms S may not be deprived of her liberty under that scheme. (This is considered in Chapter 14.)

Eldergill J concluded that in his view it was in Ms S's best interests to attempt a 1-month trial of home-based care.

Working within the funding available

Case Study 5.24 *Bedford Borough Council* v. *(1) Mrs LC and (2) Mr LC* [2015].[77]

In this case Judge Eldergill had to consider whether it was in the best interests of Mrs LC to return to the matrimonial home with a restricted care package of £700 per week or to continue to reside at the care home or reside in a different care home. The case arose following an assault by Mr C on Mrs C who had been married for over 50 years. Mrs C who suffered from dementia, diabetes, and stroke related illness was transferred to a care home. Contact gradually resumed between husband and wife and Mr C wished her to be returned home. The LA would not fund a 24-h package for Mrs C in the matrimonial home but only 50 h of care or 25-h of double-handed care. The judge decided that it was in her best interests to remain in the care home because Mrs C's needs had increased and the £700 would not cover the care at home she required. See also the case of in the matter of M (Adult) [2015][78] discussed in Chapter 7 where Sir James Munby stated that the Court of Appeal had no greater powers to obtain resources for P than P would have had himself had he had capacity.

Use of funds for a sibling

Case Study 5.25 *Re A* [2015].[79]

Senior Judge Lush agreed that £17 000 of the £5 million compensation awarded to A as a result of negligence at birth could be used to fund the private schooling of her brother. It was in her best interests because the payment was reasonably affordable; A's interests, needs, and well-being were inextricably linked with those of the family; the official solicitor's opposition to the application was unnecessarily cautious, paternalistic, and risk averse; and it was absurd to expect the parents to work to pay for the brother's fees and buy in help for A; this would cost more than double the family's current outgoings. He found the best interests checklist set out in Section 4 of little help. He warned against this case setting a precedent for the payment of a sibling's school fees, since it was *tailored to A's circumstances*.

Conclusions

Once a person has been assessed as lacking the requisite mental capacity, the concept of best interests is at the heart of decision making under the MCA, and the Act provides no simple test for defining best interests. It sets out the steps to be taken and the considerations to be used in determining it. It is highly subjective and, as case law develops over the outcome of the test in individual cases, we have seen a move away from the medical model which has dominated decision making in care and treatment disputes since the case of *Re F*. Those cases where the outcome of determining the best interests of P involves a deprivation of liberty are considered in Chapter 14.

Checklist for determining best interests on behalf of P

- Is there a reasonable belief that P lacks the requisite mental capacity for the decision in question?
- If the answer is *yes*, have superficial factors—such as age, appearance, condition, or aspects of behavior—been discounted as the sole basis for making the decision?
- Is the mental incapacity temporary or permanent, and if temporary, how long before capacity is likely to be recovered, and if so, could the decision making await, without harmful effects for P, that recovery, so that P could make his or her own decisions?
- Have all relevant circumstances, of which the decision maker is aware and which it would be reasonable to regard as relevant, been taken into account?
- What reasonably practicable steps to encourage P to take part in the decision making exist?
- Have these reasonably practicable steps been taken?
- Is lifesaving treatment under consideration?
- If so, is it clearly understood that the decision maker must not be motivated by the desire of bringing about P's death?
- Have the following been taken into account:
  a) P's past and present wishes and feelings and any written statements of P?
  b) P's beliefs and values that would have influenced his decision had he had the capacity?
  c) Other factors that P would have taken into account had P been able to do so?
- Have the following (if practical and appropriate) been consulted:
  a) Anyone named by P as someone to be consulted on the matter in question or matters of this kind?
  b) Anyone engaged in caring for P or interested in his welfare?
  c) Any donee of a lasting power of attorney granted by P?
  d) Any deputy appointed for P by the court?
- Have records been kept of the answers to the above questions and the action and discussions which have taken place?
- What is the balance of the risks and benefits of the proposed action?

In addition to the above, if restraint has been used, the following questions should also be asked:

- Does D reasonably believe that it is necessary to do the act in order to prevent harm to P?
- Is the proposed act a proportionate response to the likelihood of P's suffering harm and the seriousness of that harm?

Quick-fire quiz, QFQ5

1. What steps must be followed in determining the best interests of a person lacking the requisite mental capacity?
2. In what circumstances does the decision maker not have to follow the best interests of the person who lacks the mental capacity to make decisions?
3. How is life-sustaining treatment defined?
4. What is meant by drawing up a balance sheet in determining the best interests of a person who lacks the requisite mental capacity?
5. What is the difference between a best interests test and a modified best interests test?
6. Which people must the decision maker consult with in determining best interests?

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CHAPTER 6

Lasting powers of attorney

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Legal Aspects of Mental Capacity: A Practical Guide for Health and Social Care Professionals, Second Edition. Bridgit Dimond.
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Introduction: Statutory provisions

The original power of attorney, whereby a person appointed an attorney or donee to act on his behalf in a matter of property or finance, was of limited value since it ended whenever the person appointing the attorney became mentally incapable of handling his or her affairs. For many this would be the very point at which an attorney would be required. The Enduring Power of Attorney Act 1985 was therefore enacted to cover this gap. The person had to have the requisite mental capacity to draw up the enduring power, which would continue in spite of the fact that the donor had lost his or her mental capacity, at which point the attorney could exercise the powers granted on behalf of the donor. There was one major limitation however about the enduring power of attorney (EPA) as provided for under the 1985 Act: it only covered property and financial decisions. It did not cover matters of personal welfare. As a consequence one of the significant creations of the Mental Capacity Act 2005 was provision for a lasting power of attorney (LPA), under which the donor, when mentally capable, could grant powers of attorney covering care and treatment decisions, as well as, or instead of, property and finance decisions. The Law Society has published a practice note on LPAs[1] and guidance is available online from the Office of Public Guardian including a note on "Avoiding invalid provisions in your LPA."[2]

The statutory provisions relating to LPAs are set out in Sections 9–14 of the MCA 2005 as amended by the Mental Health Act 2007 and are shown in Statute Box 6.1.

Statute Box 6.1 Sections 9–14 MCA 2005 (as amended by MHA 2007 and regulations).

9 Lasting powers of attorney

1 A lasting power of attorney is a power of attorney under which the donor ("P") confers on the donee (or donees) authority to make decisions about all or any of the following—
- **a)** P's personal welfare or specified matters concerning P's personal welfare, and
- **b)** P's property and affairs or specified matters concerning P's property and affairs, and which includes authority to make such decisions in circumstances where P no longer has capacity.

2 A lasting power of attorney is not created unless—
- **a)** section 10 is complied with,
- **b)** an instrument conferring authority of the kind mentioned in subsection (1) is made and registered in accordance with Schedule 1, and
- **c)** at the time when P executes the instrument, P has reached 18 and has capacity to execute it.

3 An instrument which—
- **a)** purports to create a lasting power of attorney, but
- **b)** does not comply with this section, section 10 or Schedule 1, confers no authority.

4 The authority conferred by a lasting power of attorney is subject to—
- **a)** the provisions of this Act and, in particular, sections 1 (the principles) and 4 (best interests), and
- **b)** any conditions or restrictions specified in the instrument.

10 Appointment of donees

1 A donee of a lasting power of attorney must be—
- **a)** an individual who has reached 18, or
- **b)** if the power relates only to P's property and affairs, either such an individual or a trust corporation.

2 An individual who is bankrupt [or is person to whom a debt relief order is made][3] may not be appointed as donee of a lasting power of attorney in relation to P's property and affairs.

3 Subsections (4)–(7) apply in relation to an instrument under which two or more persons are to act as donees of a lasting power of attorney.

4 The instrument may appoint them to act—
- **a)** jointly,
- **b)** jointly and severally, or
- **c)** jointly in respect of some matters and jointly and severally in respect of others.

5 To the extent to which it does not specify whether they are to act jointly or jointly and severally, the instrument is to be assumed to appoint them to act jointly.

6 If they are to act jointly, a failure, as respects one of them, to comply with the requirements of subsection (1) or (2) or Part 1 or 2 of Schedule 1 prevents a lasting power of attorney from being created.

7 If they are to act jointly and severally, a failure, as respects one of them, to comply with the requirements of subsection (1) or (2) or Part 1 or 2 of Schedule 1—
- **a)** prevents the appointment taking effect in his case, but
- **b)** does not prevent a lasting power of attorney from being created in the case of the other or others.

8 An instrument used to create a lasting power of attorney—
- **a)** cannot give the donee (or, if more than one, any of them) power to appoint a substitute or successor, but
- **b)** may itself appoint a person to replace the donee (or, if more than one, any of them) on the occurrence of an event mentioned in section 13(6)(a)–(d) which has the effect of terminating the donee's appointment.

11 Lasting powers of attorney: restrictions

1 A lasting power of attorney does not authorise the donee (or, if more than one, any of them) to do an act that is intended to restrain P, unless three conditions are satisfied.
2 The first condition is that P lacks, or the donee reasonably believes that P lacks, capacity in relation to the matter in question.
3 The second is that the donee reasonably believes that it is necessary to do the act in order to prevent harm to P.
4 The third is that the act is a proportionate response to—
a) the likelihood of P's suffering harm, and
b) the seriousness of that harm.
5 For the purposes of this section, the donee restrains P if he—
a) uses, or threatens to use, force to secure the doing of an act which P resists, or
b) restricts P's liberty of movement, whether or not P resists, or if he authorises another person to do any of those things.
6 (*But the donee does more than merely restrain P if he deprives P of his liberty within the meaning of Article 5(1) of the Human Rights Convention* repealed by MCA 2005) (see Chapter 14).
7 Where a lasting power of attorney authorises the donee (or, if more than one, any of them) to make decisions about P's personal welfare, the authority—
a) does not extend to making such decisions in circumstances other than those where P lacks, or the donee reasonably believes that P lacks, capacity,
b) is subject to sections 24–26 (advance decisions to refuse treatment), and
c) extends to giving or refusing consent to the carrying out or continuation of a treatment by a person providing health care for P.
8 But subsection (7)(c)—
a) does not authorise the giving or refusing of consent to the carrying out or continuation of life-sustaining treatment, unless the instrument contains express provision to that effect, and
b) is subject to any conditions or restrictions in the instrument.

12 Scope of lasting powers of attorney: gifts

1 Where a lasting power of attorney confers authority to make decisions about P's property and affairs, it does not authorise a donee (or, if more than one, any of them) to dispose of the donor's property by making gifts except to the extent permitted by subsection (2).
2 The donee may make gifts—
a) on customary occasions to persons (including himself) who are related to or connected with the donor, or
b) to any charity to whom the donor made or might have been expected to make gifts, if the value of each such gift is not unreasonable having regard to all the circumstances and, in particular, the size of the donor's estate.
3 "Customary occasion" means—
a) the occasion or anniversary of a birth, a marriage or the formation of a civil partnership, or
b) any other occasion on which presents are customarily given within families or among friends or associates.
4 Subsection (2) is subject to any conditions or restrictions in the instrument.

13 Revocation of lasting powers of attorney etc.

1 This section applies if—
a) P has executed an instrument with a view to creating a lasting power of attorney, or
b) a lasting power of attorney is registered as having been conferred by P, and in this section references to revoking the power include revoking the instrument.
2 P may, at any time when he has capacity to do so, revoke the power.
3 P's bankruptcy [or the making of a debt relief order (under Part 7A of the Insolvency Act 1986) in respect of P,][4] revokes the power so far as it relates to P's property and affairs.
4 But where P is bankrupt merely because an interim bankruptcy restrictions order has effect in respect of him, [or where P is subject to an interim debt relief restrictions order (under Schedule 4ZB of the Insolvency Act 1986)],[5] the power is suspended, so far as it relates to P's property and affairs, for so long as the order has effect.
5 The occurrence in relation to a donee of an event mentioned in subsection (6)—
a) terminates his appointment, and
b) except in the cases given in subsection (7), revokes the power.
6 The events are—
a) the disclaimer of the appointment by the donee in accordance with such requirements as may be prescribed for the purposes of this section in regulations made by the Lord Chancellor,
b) subject to subsections (8) and (9), the death or bankruptcy of the donee or, if the donee is a trust corporation, its winding-up or dissolution,
c) subject to subsection (11), the dissolution or annulment of a marriage or civil partnership between the donor and the donee,
d) the lack of capacity of the donee.
7 The cases are—
a) the donee is replaced under the terms of the instrument,
b) he is one of two or more persons appointed to act as donees jointly and severally in respect of any matter and, after the event, there is at least one remaining donee.
8 The bankruptcy of a donee does not terminate his appointment, or revoke the power, in so far as his authority relates to P's personal welfare.
9 Where the donee is bankrupt merely because an interim

bankruptcy restrictions order has effect in respect of him, his appointment and the power are suspended, so far as they relate to P's property and affairs, for so long as the order has effect.

10 Where the donee is one of two or more appointed to act jointly and severally under the power in respect of any matter, the reference in subsection (9) to the suspension of the power is to its suspension in so far as it relates to that donee.

11 The dissolution or annulment of a marriage or civil partnership does not terminate the appointment of a donee, or revoke the power, if the instrument provided that it was not to do so.

14 Protection of donee and others if no power created or power revoked

1 Subsections (2) and (3) apply if—

a) an instrument has been registered under Schedule 1 as a lasting power of attorney, but

b) a lasting power of attorney was not created, whether or not the registration has been cancelled at the time of the act or transaction in question.

2 A donee who acts in purported exercise of the power does not incur any liability (to P or any other person) because of the non-existence of the power unless at the time of acting he—

a) knows that a lasting power of attorney was not created, or

b) is aware of circumstances which, if a lasting power of attorney had been created, would have terminated his authority to act as a donee.

3 Any transaction between the donee and another person is, in favour of that person, as valid as if the power had been in existence, unless at the time of the transaction that person has knowledge of a matter referred to in subsection (2).

4 If the interest of a purchaser depends on whether a transaction between the donee and the other person was valid by virtue of subsection (3), it is conclusively presumed in favour of the purchaser that the transaction was valid if—

a) the transaction was completed within 12 months of the date on which the instrument was registered, or

b) the other person makes a statutory declaration, before or within 3 months after the completion of the purchase, that he had no reason at the time of the transaction to doubt that the donee had authority to dispose of the property which was the subject of the transaction.

5 In its application to a lasting power of attorney which relates to matters in addition to P's property and affairs, section 5 of the Powers of Attorney Act 1971 (c. 27) (protection where power is revoked) has effect as if references to revocation included the cessation of the power in relation to P's property and affairs.

6 Where two or more donees are appointed under a lasting power of attorney, this section applies as if references to the donee were to all or any of them.

What about existing EPAs

The Enduring Power of Attorney Act 1985 is repealed by Section 66(1)(b) of the Mental Capacity Act (MCA) and no EPA within the meaning of the 1985 Act could be created after the commencement of the MCA on October 1, 2007 (S.66(1)(b) and S.66(2)). However Schedules 4 and 5 to the Act apply to any EPA that was created before then. In addition Regulation 23 and Schedule 7 to the Regulations[6] set out the form of notice to be given to the donor and to his relatives, when an attorney under an enduring power intends to apply for registration. Regulations 24–28 and Schedule 8 to the Regulations specify other requirements applying to the registration process for EPAs.

Thus existing EPAs created before the repeal of the 1985 Act are still valid and integrated into the new scheme as a result of Section 66(3) and Schedule 4. Schedule 4 applies to any EPA created under the 1985 Act and before the commencement of the Mental Capacity Act 2005 (S.66(3)).

Schedule 5 also contains transitional provisions in relation to the 1985 Act (see Chapter 17 on implementation of the MCA).

It would always be open to a person who has set up an EPA to end it and create instead an LPA, provided he or she still has the requisite mental capacity. However this is not necessary if he or she only wishes to delegate property and financial matters and, under the transitional provisions, the EPA will continue to be effective. Of course if the donor of the EPA no longer has the requisite mental capacity, it is not possible for him to replace it with an LPA.

Section 44 creates a criminal offence if a donee of an EPA (and also a donee of an LPA) ill-treats or wilfully neglects P (see Chapter 11).

The Office of the Public Guardian (OPG) (see Chapter 7) has provided guidance on the transitional provisions relating to EPAs.[7] A leaflet on the differences between an EPA and an LPA is available from the Public Guardianship website. It emphasizes that an EPA must be made before October 1, 2007, and covers the differences in the decisions which can be made by an attorney under an EPA in contrast to an LPA, the duties of the attorney under an EPA compared with an LPA, and registering the powers and revoking the powers of each.

What is an LPA?

An LPA is a new statutory form of power of attorney recognized in Section 9 of the MCA (see Statute Box 6.1). By means of this power of attorney, the donor (P) confers on the donee (or donees) or the attorney(s) authority to make decisions about all or any of the following:

a) P's personal welfare or specified matters concerning P's personal welfare, and
b) P's property and affairs or specified matters concerning P's property and affairs.

This includes authority to make such decisions in circumstances where P no longer has capacity.

Different forms are available for the two kinds of LPA, that is:

a) a property and affairs LPA and
b) a personal welfare LPA

The "donor" is the person granting the power (known in the legislation as "P"); and the "donee" or the "attorney" is the person who is given the power. The "instrument" is the document granting the power and the conditions on which it is given.

The power only comes into force, for care and welfare decisions, when the donor no longer has the mental capacity to make his or her own decisions. This contrasts with the donation of powers in relation to finance and property, where the actual delegation can take place when the donor still has the requisite mental capacity.

To create a valid LPA, the conditions laid down in Section 10 must be complied with.

Firstly, it must be registered in accordance with the provisions of Schedule 1.

Secondly, it must be registered at the time when P:

- executes the instrument
- has reached 18, and
- has capacity to execute it.

These conditions are considered in more detail in the following.

Any instrument which purports to convey authority but does not comply with Section 9 or 10 or Schedule 1 confers no authority. The authority conferred by the LPA is subject to the provisions of the MCA and in particular the principles laid down in Section 1 (see Chapter 3), Section 4, and the definition of best interests (see Chapter 5). In addition any conditions or restrictions specified in the instrument must be complied with.

Following extensive consultation forms and guidance for making an LPA were issued on July 17, 2006. The fees payable when registering an LPA were subject to a separate consultation.

Forms for LPAs

Two prescribed forms are in use: one for making an LPA in relation to property and affairs and one for making an LPA in relation to personal welfare. It is accepted that there would be people who wished the same person to act in relation to both their personal welfare and their property and affairs. However two separate forms (and two separate certificates) are required, one for each area of delegation. A single form for both types of LPA could be misleading, since an LPA for property and affairs can be used both when the donor has capacity and also when the donor lacks capacity, whereas an LPA for personal welfare can only be used when the donor lacks capacity.

Following the consultation, regulations relating to LPAs, EPAs, and the Public Guardian were placed before Parliament on April 17, 2007, and came into force on October 1, 2007.[8] They can be accessed through the Ministry of Justice[9] or legislation website.[10]

Who can make LPAs?

A person over 18 years can grant an LPA but must have the requisite mental capacity at the time of its signature or execution.

How would capacity be defined?

The definition of mental capacity set out in Sections 2 and 3 of the MCA would be used to determine whether P had the necessary mental capacity to set up and execute an LPA. Earlier case law on defining the requisite capacity, such as the case of *Re K; Re F*[11] where it was held that a person could have the necessary mental capacity to execute an EPA even though he or she did not have the mental capacity to manage his or her own property and affairs will continue to be valid, until overruled. Schedule 1 Para 2(e) requires a certificate to be provided to state that (i) the donor understands the purpose of the instrument and the scope of the authority conferred under it, (ii) no fraud or undue pressure is being used to induce the donor to create an LPA, and (iii) there is nothing else which would prevent an LPA being created by the instrument.

How are they drawn up?

Usually a person would seek legal advice in drawing up an LPA to ensure that all the required formalities are complied with and that it is sufficiently clear what the donor intended. The statutory forms are in Schedules to the Regulations and can be accessed from the website.[12]

Scenario 6.1 considers the setting up of an LPA.

The requirements for Christine to be able to establish an LPA are that:

- she must be at least 18 years at the time of the execution of the instrument setting up the LPA,
- she must have the requisite mental capacity at the time of the execution, and
- the donee must be at least 18 years.

In Scenario 6.1 Christine could plan for the drawing up of the LPA and hope that she survives with the requisite mental capacity, so that when she becomes 18 she can execute the instrument and appoint her older sister as the donee. Until the time that she reaches adulthood, she could come under the provisions of the Children Act 1989. She could of course draw up a statement of her wishes which would constitute neither an LPA nor an advance decision (because for both of these she needs to be over 18 years). This statement should however influence those who are purporting to act in her best interests, since it may set out her wishes, feelings, beliefs, and values, that is, factors which should be taken into account in determining her best interests under Section 4 of the Act (see Chapter 5).

Scenario 6.1 Requirements for setting up an LPA.

Christine, aged 17 years, was chronically ill with cystic fibrosis. She knew that unless she had a transplant she was unlikely to survive for very long, and she was almost reaching the stage of becoming too ill to cope with a transplant. Her parents were divorced and she lived with an older sister and her nieces and nephews. She was anxious that her sister, with whom she had a very close relationship, should make the decisions relating to her care and treatment, if she became too ill to make them herself. She explored whether she could arrange for her sister to be appointed to be the donee under a lasting power of attorney, to make decisions for her personal welfare.

What could an LPA cover?

General

An LPA could be general in the sense that it grants a power to the donee to make all welfare, property, and affairs decisions on behalf of the donor, at the point at which the donor lacks mental capacity. The donee would be bound to act according to the principles of the MCA and in particular Section 1 (see Chapter 3) and Section 4 (see Chapter 5).

Specific

Alternatively the LPA could grant a specific power in relation to property or affairs or treatment and welfare. The donee would only have the powers granted in the instrument, and if the donee were to make decisions or take action on matters not included in the LPA, the donee would be acting *ultra vires*, that is, outside the powers granted.

Who could the donee be?

The donor has the complete choice over whom he or she wishes to be appointed as a donee. The only legal requirements are that the donee should be over 18 years and have the requisite mental capacity. Alternatively for property and affairs decisions, the donee could be a trust corporation. There are special rules about bankrupts (see "Bankruptcy" on page 99).

Trust corporation

A trust corporation can be appointed as donee to make decisions on property and affairs. Section 64 of the MCA uses the definition given in Section 68(1) of the Trustee Act 1925 as the Public Trustee or a corporation appointed by the court in any particular case to be a trustee, or entitled by rules made under Section 4(3) of the Public Trustee Act 1906, to act as custodian trustee. Only an individual can be appointed a donee for a personal welfare LPA.

What if the donee did not know of the appointment?

It would not be possible for an LPA to be created with a specified person identified as a donee, but without the knowledge and consent of that person. Schedule 1

states that the instrument must include a statement by the donee (or, if more than one, each one of them) that he or she has read the prescribed information and understands the duty imposed on a donee of an LPA under Section 1 and Section 4 on the best interests.

What if the donee changes his or her mind?

The donee is entitled to disclaim the power of attorney and, if that person is the only nominated donee, the LPA will come to an end, unless there is a power in the LPA for another donee to be appointed. If the donee decides to change his or her mind, before the LPA comes into effect, the donor, if he or she still retains the necessary mental capacity, would have the opportunity of replacing the donee within the instrument. Para 20 and Schedule 6 of the Regulations[13] cover the disclaimer of appointment by a donee of an LPA (drawn up by the Lord Chancellor under his powers given by Section 13(6)(a) of the MCA).

The Regulations require the donee to complete the form (LPA 005) contained in Schedule 6 and send it to the donor, with a copy to the Public Guardian and to any other donee who, for the time being, is appointed under the power.

What conditions are required for a valid LPA?

The conditions for a valid LPA are set out in Section 10 (see Statute Box 6.1).

Firstly the donee must be *an individual who has reached 18 years*. This is the age of majority, and while for some purposes (such as the giving of consent under the Family Law Reform Act 1969) a young person of 16 and 17 years is recognized as having specific powers, for most legal situations a person is an adult at 18 years. Where the individual is over 18 years, then the powers under the LPA can cover both welfare decisions and property and affairs (see Chapter 12 on children). Scenario 6.2 considers the implications of this.

Since the donee must be over 18 years at the time of the appointment, Brian will be unable to accept the appointment. Section 10(1)(a) stipulates that where the donee is an individual he or she must have reached 18 years. In addition Schedule 1 Para 2(d) requires the donee to state that he or she has read the prescribed information and understands the duties imposed upon the donee of an LPA. As a consequence it would be impossible for Brian's mother to draw up an LPA appointing Brian at age 17 as a donee, which would come into effect when he is 18 years.

Scenario 6.2 Setting up a lasting power of attorney.

When Brian was 17 years old, his mother, Ada, was diagnosed with a cancerous brain tumor. He had a brother and sister of 10 and 13, respectively. Ada was a widow and was concerned about how her family would cope when she died. She wished to set up a lasting power of attorney (LPA), so that she would be able to arrange for a person to make decisions for her, in the event of her becoming mentally incapacitated, including decisions not only about her property and affairs but also her welfare. She wished Brian to be the donee of the LPA and to make the decisions for her. Is this legally possible?

Could she appoint her sister until such time as Brian became 18 years?

Ada cannot in the instrument creating the LPA appoint her sister as her donee and give powers for her sister to appoint Brian when he becomes 18 years. (Giving the power to a donee to appoint a substitute or successor is prevented by Section 10(8)(a).)

It is possible for the instrument creating the LPA to appoint a person to replace the donee, on the occurrence of an event mentioned in Section 13(6)(a)–(d) (i.e., the disclaimer of the appointment by the donee, the death or bankruptcy of the donee, the dissolution of marriage or civil partnership between donee and donor, or the lack of capacity of the donee). However these exceptions do not cover the situation outlined here.

The simple answer therefore is that Brian cannot be appointed as a donee of an LPA until he is 18 years old.

The donor must have the requisite mental capacity to sign the LPA

Mental capacity would be defined according to Sections 2 and 3 of the MCA and Schedule 1 Para 2(e) (see preceding text) sets out the content of the certificate which must be completed by a person at the time of the execution of the LPA.

If the LPA relates to P's property and affairs, *the donee must not be bankrupt*. This does not apply where the LPA relates to personal welfare.

Can more than one donee be appointed?

Section 10(4)–(7) covers the situation of two or more donees acting together.

The donees can act jointly or jointly and severally, or the instrument may appoint them to act jointly in respect of some matters and severally in respect of others.

Jointly means that the donees always act together in any decision and if one fails to meet the criteria in the Act, then a valid LPA will not be created.

Severally means that each donee can act independently.

Jointly and severally means that the donees can act together or independently.

If the LPA does not itself specify whether they are to act jointly or jointly and severally, the instrument is to be assumed to appoint them to act jointly.

It is possible for the instrument to grant certain powers to be exercised jointly and other powers to be exercised jointly and severally.

If donees are to act jointly, a failure as respects one of them to comply with the requirements of Section 10(1) or (2) or Part 1 or 2 of Schedule 1 prevents an LPA from being created.

If they are to act jointly and severally, a failure as respects one of them to comply with the requirements of Section 10(1) or (2) or Part 1 or 2 of Schedule 1 prevents the appointment taking effect in his case, but does not prevent an LPA from being created in the case of the other or others.

What happens if there are several donees who disagree?

In such a situation, it is likely that there would be an application to the Public Guardian or the Court of Protection to determine the dispute. Scenario 6.3 considers a dispute between donees.

> **Scenario 6.3** Dispute between donees.
>
> Mark drew up a lasting power of attorney appointing his son Matthew and his brother Harry to act as donees in decisions relating to his care and treatment. They both accepted the appointment. Mark subsequently suffered from dementia and was assessed as being unable to make decisions about his care and treatment. A dispute then arose between Matthew and Harry in relation to Mark's admission to a residential care home. Matthew considered that Mark should stay in the family home supported by carers. Harry was of the view that Mark should be admitted to a residential care home where he would have a better quality of life. He personally believed that Matthew was afraid that his inheritance would be lost in care home fees as the family home would have to be sold to pay the fees. How would such a dispute be resolved?

Clearly there would be evidence from social services and others as to what was seen to be in Mark's best interests. If the general view was that it was in Mark's best interests to be transferred to a residential care home, then if Matthew failed to agree to that, an application could be made initially to the OPG who could appoint a visitor to report on the situation and if necessary an application could be made to the Court of Protection for the dispute to be resolved. The court may make a declaration as to what is in Mark's best interests. If Mark has not specified in the LPA whether the two are appointed to act jointly or severally, it will be presumed that a joint appointment is intended. This would mean that Matthew and Harry must act together.

What formalities must be followed?

The donor must make a statement to the effect that he or she has read the prescribed information and intends the authority conferred by the instrument to include authority to make decisions on his or her behalf in circumstances where he or she no longer has capacity. The donor must also name a person(s) whom he or she wishes to be notified of any application for the registration of the instrument or state there are no such persons (Schedule 1 of the MCA).

Execution of the LPA

The *execution* means the signing by the donor of the document which sets up the LPA. Regulation 9 sets out how the instrument is to be executed:

- The donor must read (or have read to him) all the prescribed information.
- As soon as reasonably practicable after reading the information, the donor must complete the provisions of Part A of the instrument and then sign Part A in the presence of a witness.

- The person (or persons if two are required) giving an LPA certificate must complete the LPA certificate at Part B of the instrument and sign it.
- The donee(s) must read or have read to him all the prescribed information and must complete the provisions of Part C of the instrument and sign in the presence of a witness.
- If the instrument is to be signed by a person at the direction of the donor or donee, the signature must be done in the presence of two witnesses.
- The donor may not witness any signature nor may the donee, apart from that of another donee.
- A person witnessing a signature must sign the instrument and give his full name and address.

Registration

An LPA must be registered with the OPG before it can be used. An unregistered LPA will not give the attorney any legal powers to make a decision for the donor. The donors can register the LPA while they are still mentally capable, or the attorney can apply to register the LPA at any time.[14] A helpline for registering an LPA has been set up.[15]

The donor can identify persons who are entitled to receive notification of the application to register the LPA. Relatives will not automatically be notified of the application to register the LPA unless the donor has named them as being persons who should be given notice.

Objections to registration

The donor, where he or she is not the applicant to register, the attorney, and persons named as entitled to be notified of the application to register are all entitled to object to the LPA being registered. This is covered by Regulation 14,[16] which sets out time limits for making an objection to registration. Regulation 15 covers an application to the court over an objection to registration.[17] In one case[18] the Public Guardian refused to register an LPA because of the conditions imposed by the donor to regulate its use. Lush SJ held that the Public Guardian could only refuse to register an LPA if the provisions could not take effect legally (e.g., a term giving voting rights).

What do the registration provisions mean?

When the LPA is first drawn up?

Unless an LPA has been registered with the OPG, a valid LPA instrument has not been created. As a consequence no powers are given to the attorney once the donor lacks capacity (Sections 9(2)–(3)).

If the donor has failed to register the LPA, the donee can still apply for registration and must ensure that it has been effectively registered before attempting to exercise any of the powers under the LPA. The Code of Practice advises that if the LPA has been registered but not used for some time, the attorney should tell the OPG when they begin to act under it, so that the attorney can be sent relevant, up-to-date information about the rules covering LPAs.[19]

Schedule 1 provisions

Schedule 1 lays down the detailed requirements as to the making of instruments establishing LPAs. Additional requirements have been enacted by regulations made by the Lord Chancellor.[20] These regulations include the forms which are to be completed for registration. They can be downloaded from the Ministry of Justice website or the Office of Public Guardian website.[21]

The donor must make a statement to the effect that he or she has read the prescribed information and intends the authority conferred by the instrument to include authority to make decisions on his or her behalf in circumstances where he or she no longer has capacity. The donor must also name a person(s) whom he or she wishes to be notified of any application for the registration of the instrument or state there are no such persons.

The maximum number of persons the donor can name is five.[22] Where the donor states that there are no persons whom he or she wishes to be notified of any application for the registration of the instrument, then the instrument must include two LPA certificates (see Page 86) and each certificate must be signed by a different person.[23]

The donee(s) must make a statement that he or she has read the prescribed information and understands the duties imposed upon a donee of an LPA under Section 1 (the principles) and Section 4 (best interests).

A ***prescribed person*** must provide a ***lasting power of attorney certificate*** that in his opinion at the time when the donor executes the instrument:

- the donor understands the purpose of the instrument and the scope of the authority conferred under it,
- no fraud or undue pressure is being used to induce the donor to create an LPA, and
- there is nothing else which would prevent an LPA from being created by the instrument.

Schedule 1 Para 3 sets out the effects of failure to comply with the prescribed form.

Under Regulation 8 the persons who are able to provide an LPA certificate are:

a) a person who has known the donor personally for at least two years, which ends immediately before the date on which the LPA certificate is signed, and

b) a person chosen by the donor who on account of his professional skills and expertise, reasonably considers that the donor is competent to make the judgments necessary to certify the matters set out in Para 2(1)(e) of Schedule 1 to the MCA. (The following are cited as examples of such a person: a registered health care professional; a barrister, solicitor or advocate; a registered social worker, or an independent mental capacity advocate.)

Certain persons are disqualified from being able to give the LPA certificate, and these include:

- A family member of the donor
- A donee of the LPA or a donee of any other LPA executed by the donor
- A family member of the donee
- A director or employee of a trust corporation acting as a donee
- A business partner or employee of the donor or donee
- An owner, director, manager, or employee of any care home in which the donor is living when the instrument is executed
- A family member of any of these persons

Schedule 1 Part 2 of the MCA registration provisions

An application to the Public Guardian for registration of the instrument intending to create an LPA must comply with the requirements set out in Part 2 of Schedule 1 of the MCA and the regulations.[24]

Notice of the intention to apply for registration of an LPA must be on form LPA 001, found in Schedule 2 to the Regulations.[25] An application for registration must be on form LA 002 found in Schedule 3 to the Regulations. Form LPA 003A, on which the Public Guardian must notify the donees when he or she receives an application for registration, is found in Part 1 of Schedule 4 to the Regulations, and Form LPA 003B (found in Part 2 of Schedule 4 to the Regulations) is the form of notice to the donor when an application for registration is received by the Public Guardian.

Schedule 1 Part 3 of the MCA: Cancellation of registration and notification of severance

This part sets out the circumstances in which the OPG is obliged to cancel the registration of the LPA and the circumstances in which the Court of Protection can order the OPG to cancel the registration.

Schedule 1 Part 4 of the MCA: Records of alterations in registered powers

The OPG must attach a note to the instrument of the LPA if the specified circumstances arise. In such a situation, Regulation 18 applies,[26] and the OPG is required to give notice to the donor and the donee(s) requiring them to deliver the original of the instrument, any office copy, and any certified copy. The Public Guardian will then attach the required note and return the document.

Nonregistration

Where the Public Guardian is unable to register the instrument as an LPA, he or she must notify the person who applied for registration of that fact.

Fees in respect of the LPA and Court of Protection

The Consultation Paper on the fees for the Court of Protection and OPG[27] suggested that to register an LPA should cost £150, payable on application. Where an LPA

has been drawn up to cover personal welfare as well as property and finance, both registrations will attract the fee, since there are separate registers for property and affairs and another for personal welfare LPAs. The fee for searching the Register should be £25. The fee of £25 also applies to a search of the Register to see if a deputy has been appointed. These are now set out in the Regulations.[28] The current fees (October 2014) are £110 to register each LPA unless you get a reduction or exemption or your form has been returned because of mistakes in which case you can reapply within 3 months for £55. Registering a property and financial affairs LPA and a health and welfare LPA costs £220.

Limitations on an LPA

The appointing of a replacement donee

An instrument used to create an LPA cannot give the donee (or, if more than one, any of them) power to appoint a substitute or successor.

However it may itself appoint a person to replace the donee (or, if more than one, any of them) on the occurrence of specified events.

These events are:

a) the donee disclaiming his appointment in accordance with regulations[29] drawn up by the Lord Chancellor (S.13(6)(a));

b) the death or bankruptcy of the donee (where the LPA relates to property or affairs an interim bankruptcy order merely suspends the LPA power as long as it lasts), or if the donee is a trust corporation, its being wound up (S.13(6)(b));

c) the dissolution or annulment of marriage where donor and donee are married, unless the LPA made specific provisions that in such circumstances the donee's power would not cease (S.13(6)(c));

d) the lack of capacity of the donee (S.13(6)(d)).

Where the donor is detained under the Mental Health Act 2007

The MCA expressly excludes the donee under an LPA having power to consent or refuse treatment for a mental disorder where the donor is detained under the Mental Health Act 2007 (Section 28 MCA and see Chapter 13). However if decisions relating to physical disorders are required (and therefore do not come within the aegis of the Mental Health Act 2007), then the donee under an LPA with powers relating to welfare decision would be able to make them on behalf of the mentally incapacitated donor.

Section 28 of the Mental Capacity Act is shown in Statute Box 6.2.

Statute Box 6.2 Section 28 of MCA 2005: Mental Health Act matters.

28(1) Nothing in this Act authorises anyone—
a) to give a patient medical treatment for mental disorder, or
b) to consent to a patient's being given medical treatment for mental disorder,
if, at the time when it is proposed to treat the patient, his treatment is regulated by Part 4 of the Mental Health Act 1983.
(2) "Medical treatment", "mental disorder" and "patient" have the same meaning as in that Act.

Restraint of P

Qualifications on lasting powers of attorney

A donee is only authorized to restrain P if the three conditions laid down under Section 11 are satisfied.

The three conditions under Section 11 required to ensure that the restraint is limited are:

1. P lacks, or the donee reasonably believes that P lacks, capacity in relation to the matter in question.
2. The donee reasonably believes that it is necessary to do the act to prevent harm to P.
3. The act is a proportionate response to the likelihood of P's suffering harm and the seriousness of that harm.

These conditions are similar to those discussed in Chapter 5 on the principle of acting in the best interests of P. The donee of the LPA can only exercise the powers under the LPA in relation to care and treatment if P lacks the requisite mental capacity.

The definition of restraint by a donee is if he or she uses, or threatens to use, force to secure the doing of an act which P resists, or restricts P's liberty of movement, whether or not P resists.

The original provision in Section 11(6) that the donee does more than merely restrain P if he or she deprives P

of his liberty within the meaning of Article 5(1) of the Human Rights Convention is repealed by the Mental Health Act 2007, which amends the MCA to fill the Bournewood gap by setting out Deprivation of Liberty Safeguards (see Chapters 3 and 14). Case law of the European Court of Human Rights (ECHR) distinguishes between a restriction of liberty and a deprivation of liberty. (This is further discussed in Chapter 3 and Case Study 3.1.)

An example of restriction of liberty would be a seat belt or restraining belt in a chair. A deprivation of liberty would be putting P in a locked room for which he did not have the key. A situation where a hoist is used which could be seen as a form of restraint is considered in Scenario 6.4.

As a consequence of the amendments to the MCA made by the Mental Health Act 2007 to remedy the Bournewood gap, it would now be possible for a donee to restrict the liberty of P but only if the conditions set down in Section 4A and 4B and Schedule A1 are met (Statute Boxes 14.2 and 14.3) (see Chapter 14).

Hypothetical dispute over LPA

An example, shown in Scenario 6.4, is given by Charles Hancock in an article[30] concerned with the problems which could arise for clinicians and managers over the introduction of LPAs under the MCA.

The author of the article accepts that the overwhelming majority of people who will act as holders of LPAs will do so in a sensible and cooperative manner with clinicians, managers, and staff, in order to provide the best possible care. However he states that the scenario provides a realistic depiction of a simple way in which the issue of managing the care of those who lack capacity could go seriously wrong. He suggests that there needs to be an urgent dialogue between senior healthcare managers and the Public Guardian to ensure that there are robust and simple systems in place for such eventualities. He also recommends that there needs to be a system whereby staff can contact the OPG in emergency situations, in order to request the suspension of the LPA prior to any formal investigation. Contact details for the OPG are given on its website[31] which suggests calling 999 if someone is in immediate danger or the local police if you think that someone has committed a criminal offence.

Scenario 6.4 LPAs and manual handling.

Patient A is a 67-year-old woman suffering from complex physical handicaps and who has also developed senile dementia. She is normally cared for at home by her daughter Mrs F who has a lasting power of attorney for personal welfare. The patient is admitted to hospital for elective surgery. She is seen by the daughter when being transferred by hoist from the bed to a trolley to be taken to theatre. The daughter, who has strong views against the use of mechanical devices for moving and handling her mother, objects to the use of the hoist. The nurses refuse, stating that it is unsafe for both the patient and themselves to move the patient in another way. Mrs F then states that unless they follow her instructions precisely, they will face a civil action for battery and may be reported to the police. The ward sister tries to persuade Mrs F that it is the patient's best interests to be lifted in this matter. The hypothetical scenario continues with Mrs F subsequently presenting the ward staff with a note setting out her powers as the holder of a lasting power of attorney, her view that mechanical lifting and handling of the patient is not in the patient's best interests and may contravene Article 8 of the European Convention on Human Rights and that anyone who attempts to use mechanical devices may face a civil action. In addition any failure to provide personal care to the patient will result in a complaint of a contravention of Section 44 of the MCA (ill-treatment or neglect). Mrs F also asks the nursing staff to sign that they will not use mechanical devices in the care of her mother. The staff nurse refuses to sign the document and eventually, after discussions with hospital management and social services, an application is made to the Office of Public Guardian, who is responsible for dealing with complaints against the holders of lasting powers of attorney and court-appointed deputies.

Scenario 6.4 raises the question of restraint. Could the use of a hoist be seen as a type of restraint in the care of the person lacking mental capacity?

Section 6(4) defines a person as using restraint if he:

a) uses, or threatens to use, force to secure the doing of an act which P resists, or

b) restricts P's liberty of movement, whether or not P resists.

Placing a person in a hoist would certainly appear to be a restriction of P's liberty of movement, whether or not P resists.

In what circumstances could the donee of the LPA covering personal welfare consent to restraint being used?

To use the hoist, which restricts P's liberty of movement and is therefore a restraint, could be justified under the MCA if:

- the patient/client lacks mental capacity,
- it is reasonably believed to be necessary to prevent harm to the patient/client, and
- the restraint is a proportionate response to the likelihood of P's suffering harm and the seriousness of that harm.

It would appear that these conditions are satisfied in Scenario 6.4, since harm could befall the patient if she were to be manually handled.

Manual handling and human rights

The question of whether the use of manual handling was contrary to the rights of the patient was discussed in a case involving East Sussex County Council.[32] In this case two severely disabled women claimed that they had a human right not to be manually handled. The judge accepted that both A and B and also their carers had rights, under Article 8 of the European Convention on Human Rights, to dignity. He stated it was highly questionable to state that manual handling is dignified whereas mechanical handling is undignified and said that:

> One must guard against jumping too readily to the conclusion that manual handling is necessarily more dignified than the use of equipment. … Hoisting is not inherently undignified, let alone inherently inhuman or degrading. I agree … that certain forms of manual lift, for example the drag lift, may in certain circumstances be less dignified than hoisting. Hoisting can facilitate dignity, comfort, safety and independence. It all depends on the context.

The judge went on to consider a framework for decision making, setting out the principles which should apply and considering the factors which should be taken into account in determining how to assess reasonable practicability.

Decisions on health and welfare

Under 11(7) (see Statute Box 6.1) in an LPA covering health and welfare decisions, the authority:

a) does not extend to making such decisions in circumstances other than those where P lacks, or the donee reasonably believes that P lacks, capacity;

b) is subject to Sections 24–26 (advance decisions to refuse treatment); and

c) extends to giving or refusing consent to the carrying out or continuation of a treatment by providing health care for P. (This does not authorise the giving or refusing of consent to the carrying out or continuation of life-sustaining treatment, unless the instrument contains express provision to that effect and is subject to any conditions or restrictions in the instrument (S.11(8)).)

The Code of Practice gives the following as examples of the types of decisions which the donee of an LPA granting general powers in relation to personal welfare could make[33]:

- Where the donor should live and who they should live with
- The donor's day-to-day care, including diet and dress
- Who the donor may have contact with
- Consenting to or refusing medical examination and treatment on the donor's behalf
- Arrangements needed for the donor to be given medical, dental, or optical treatment
- Assessments for and provision of community care services
- Whether the donor should take part in social activities, leisure activities, education, or training
- The donor's personal correspondence and papers
- Rights of access to personal information about the donor
- Complaints about the donor's care or treatment

What is the role of the LPA in advance decisions which relate to life and death issues?

There are strict provisions relating to the powers of a donee under an LPA where life and death decisions are involved. There was considerable concern in Parliament that a donee could be deciding in favor of a person being allowed to die, when there was no clear authorization to that effect. Section 4(5) on the definition of the best interests of the donor states that:

> Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.

Thus unless the donee of the LPA has explicit instructions from the donor about letting die or refusal of life-saving treatment, the donee must act in the best interests of the donor and this cannot be motivated by a desire to bring about his death. This is further strengthened by Section 11(8), which states that the LPA authority does not authorize the giving or refusing of consent to the carrying out or continuation of life-sustaining treatment, unless the instrument contains express provision to that effect, and is subject to any conditions or restrictions in the instrument. The authority is also subject to the provisions relating to advance decisions set out in Sections 24–26 (see Chapter 9).

LPA and advance decision

If P sets up an advance decision and then creates an LPA with instructions in the LPA which give powers to consent to or withhold consent to treatments specified in the advance decision, then the advance decision will cease to be effective. In other words, where there is a contradiction between the two instruments, that is, the LPA and the advance decision, then the later instrument will be the effective one. To ensure that the advance decision remains effective, the LPA should explicitly refer to it and not be incompatible with its provisions. This is discussed in Scenario 6.6. Scenario 6.5 considers the bringing into effect of two different LPAs.

Following the consultation on the forms required for setting up an LPA, it was decided by the Government that there would be two different LPA forms: one to create an LPA covering personal welfare decisions and the other covering property and finance. In Scenario 6.5 Ben and Gwen would have different documents appointing them as donees for their respective LPAs. Both could be general, that is, giving overall powers, or specific, that is, giving instructions over a defined issue. Ben, for example, could have been given a specific power as attorney to arrange for the sale of Cynthia's house and to have the power to sign for the receipt of the payment and the reimbursement of any outstanding mortgage. The significant difference between the two kinds of LPA (i.e., personal welfare and property and finance) is that Gwen could only take up the LPA when Cynthia has lost mental capacity to make her own personal welfare decisions.

On the facts of Scenario 6.5, Ben could act as Cynthia's attorney in relation to her property as soon as Cynthia makes that request. Ben would have to register the taking up of the power of attorney. Guidance from the OPG explains how this is done. The fact that Cynthia still has her mental capacity is irrelevant.

In contrast, Gwen can only exercise her powers as a donee under the LPA when Cynthia loses her mental

Scenario 6.5 Exercise of the LPA.

Cynthia learnt by chance when she was 45 that she was in the early stages of Huntington's chorea. An aunt had died from that condition and Cynthia was therefore familiar with the likely progress of the disease. She decided to give her daughter, Gwen, who was 23 years old, a lasting power of attorney over her personal welfare, since she felt that Gwen would know what Cynthia would want by way of care and treatment. She therefore drew up with the assistance of a solicitor, a lasting power of attorney to cover personal welfare. She notified Gwen of her intentions and Gwen agreed to become the holder of a lasting power of attorney. The solicitor asked her about decisions relating to property and finance and she asked her son Ben, who was 25, if he would take those kinds of decisions for her. He also agreed. Two separate documents were drawn up and appropriately signed by Cynthia, Gwen, and Ben. Cynthia went on holiday abroad and asked Ben to take responsibility for selling her house. While on holiday, she had a fall and Gwen was contacted about where Cynthia should be taken for treatment.

Scenario 6.6 An LPA and an advance decision.

On the facts of Scenario 6.5, Cynthia realized from her aunt's history that she was facing a future of suffering and pain, with possible indignities and loss of privacy. She therefore drew up an advance decision stating that in the event of her losing mental capacity as a result of Huntington's chorea, she would not wish to be given resuscitation, ventilation, artificial feeding, antibiotics, or other lifesaving treatments, but should be allowed to die. She also drew up and executed a lasting power of attorney covering personal welfare in which she appointed Gwen as her attorney. She then went on holiday abroad where she had a serious fall. She returned to England in an air ambulance and was admitted to a specialist hospital. Gwen visited and found her mother in a coma on a life support machine and being given artificial feeding. The consultant said that they had found the advance decision in Cynthia's handbag and asked Gwen if she thought that they should cease all lifesaving treatment.

capacity to make decisions on her personal welfare. Gwen has been contacted by persons abroad about Cynthia's fall and treatment. She should immediately establish if Cynthia has the capacity to make her own decisions. If however she is unconscious, then Gwen could, depending upon the terms of the LPA governing personal welfare, register the fact of Cynthia's mental capacity and make personal welfare decisions on her behalf.

Several questions arise for Gwen:

- Does Cynthia lack capacity?
- How do her powers under the LPA relate to the advance decision which Cynthia has drawn up?
- Do both the advance decision and the LPA apply to this situation or only one or neither?

The first issue over which Gwen must satisfy herself is Cynthia's lack of capacity. It is clear since she is in a coma that there is a temporary loss of capacity, but Gwen would need to discover from the consultant the likelihood of Cynthia recovering consciousness and making her own decisions.

Gwen's powers under the LPA are subject to the advance decision to refuse treatment (S.11(7)(b)). However where the LPA was created after the advance decision was made and gives authority to the donee to give or refuse consent to the treatment to which the advance decision relates, then the advance decision is not valid (S.25(2)(b)). This is because the inconsistency would suggest that the donor of the LPA no longer saw the advance decision as valid since the LPA, which was drawn up afterward, was incompatible with it.

If the advance decision was drawn up by Cynthia before the LPA was executed, is the latter in conflict with the instructions in the advance direction?

Superficially it would appear that there is no incompatibility. However if the LPA referred to and confirmed the compatibility of the advance decision with the powers given in the LPA, there would be no conflict.

Applicability of the advance decision to the present situation

However the question must be asked as to whether the advance decision is relevant and therefore applicable to the situation which has arisen. It refers to Cynthia becoming mentally incapacitated as a result of Huntington's chorea. On the facts she has (possibly temporarily) lost her mental capacity because of the fall.

It could be concluded therefore that the advance decision does not apply to the situation which exists, that is, the circumstances specified in the advance decision are absent (S.24(4)(b)).

Does the LPA apply?

It is assumed that Cynthia has drawn up an LPA appointing Gwen to make personal welfare decisions on her behalf on a general basis. Once it is established that Cynthia no longer has the requisite mental capacity, Gwen is bound by the MCA to follow the principles set out in Section 1 and also to act in Cynthia's best interests according to the criteria set out in Section 4 and discussed in Chapter 5 of this book and Scenarios in that chapter.

As the donee of the LPA, Gwen can make decisions about Cynthia's personal welfare, which includes the "giving or refusing consent to the carrying out or continuation of a treatment by a person providing health care for P" (S.11(7)(c)). Gwen could therefore, on Cynthia's behalf and acting in her best interests, give consent or refuse treatments suggested by the consultant for Cynthia. This power is however subject to a major qualification. Gwen would not be authorized to give or refuse consent to the carrying out or continuation of life-sustaining treatment unless the LPA contains express provision to that effect. In addition Gwen is subject to any conditions or restrictions laid down in the instrument of the LPA.

On the facts of Scenario 6.6, Cynthia is on a life support machine. Even if the consultant recommended that this should be switched off, Gwen would not have the power to give consent to that, unless the LPA drawn up by Cynthia specifically mentioned the power to refuse life-sustaining treatment.

As we have noted previously, the fact that the advance decision permitted the refusal of ventilation was irrelevant since the advance decision referred to Cynthia losing her mental capacity as a consequence of Huntington's chorea.

Power in LPA to refuse lifesaving treatment

If the facts in Scenario 6.6 were different and the LPA drawn up for personal welfare by Cynthia did specifically give Gwen the power to refuse life-sustaining

treatment, then she would be able to inform the consultant that she was refusing to give consent to Cynthia's continuation on a life support machine and the artificial feeding. The wording of the LPA must however be set out very clearly to cover this power, and there must be clear evidence that this actual situation would be covered by the powers granted in the LPA.

What is the significance if a patient in hospital has drawn up an LPA?

If the health professionals ascertain that a patient has drawn up an LPA in relation to personal welfare, it will not come into effect until and unless the patient lacks mental capacity. If mental incapacity is established, then the attorney or donee of the power, on being satisfied that the patient lacks capacity, can act according to the directions in the LPA. This may include giving consent or withholding consent to treatment (but if this is a life-saving issue, the provisions discussed previously apply). Health professionals should be entitled to have access to the LPA to ensure that the donee is acting within the powers granted by the donor. There could be a possible dispute between the donee of the LPA and the health or social services professionals. Such a situation is discussed in Scenario 6.4 in a dispute over manual handling. Scenario 6.7 considers a situation where a donee is considering whether the LPA enables her to refuse pain relief on the donor's behalf.

Refusing pain relief

The Law Commission in its draft Mental Incapacity Bill in 1995 suggested that it should be impossible for a patient by means of an advance decision to refuse basic care, which would include direct oral nutrition and hydration and also pain relief. It would also follow that an attorney acting under an LPA relating to personal welfare could not refuse such basic care on the patient's behalf. The situation is not so clear under the 2005 Act (see Chapter 9) and the doctors may well wish an application to be made, initially to the OPG and, if necessary, to the Court of Protection to determine whether pain relief could be validly withheld from Don in accordance with Jane's request. The topic is discussed in Chapter 9 (see Scenario 9.10 in relation to advance decisions).

Scenario 6.7 Refusal of pain relief.

Don, a Buddhist, had drawn up an LPA appointing his daughter Jane as the attorney. Subsequently he suffered from dementia and arthritis and was admitted to hospital. Jane had the power under the LPA to make decisions on treatment. The doctors stated that Don required a high level of pain killers to control the pain from the arthritis. Jane stated that as a Buddhist her father would not have agreed to any pain control and therefore he should not be given it. What is the law?

What is the significance for care homes if a resident has drawn up an LPA?

Similarly if a resident in a care home has drawn up an LPA which relates to his or her personal welfare, it will not come into effect until and unless the donor no longer has the requisite mental capacity, and the donee must be personally satisfied of that fact. Once the lack of mental capacity is established, then the donee can give consent to any care plans, or transfer of the resident to other accommodation, or take similar decisions, while being bound by the principles set out in Section 1 and while acting in the best interests of the donee according to the definition in Section 4. However where there are specific instructions in the instrument of the LPA which are seen as not being in the best interests of the donor, these must be followed by the donee (see provisions relating to life-sustaining treatment on page 89). In the event of a dispute over decisions by a donee under an LPA, an application could be made in the first instance to the OPG, which has the responsibility of overseeing the proper execution of LPAs. It may subsequently be necessary to refer the matter to the Court of Protection (see Chapter 7).

LPA and the best interests of the patient

There is a statutory duty for the holder of an LPA covering personal welfare to act in the best interests of the donor. However this would be subject to the actual instructions within the instrument, as we have seen

previously in relation to the instruction to refuse lifesaving treatment. The holder of the power could not however insist that specific treatment was given (as opposed to a refusal) contrary to the best interests of the patient. This issue was considered in the case of *Burke* v. *GMC*[34] which is considered in Chapter 9 (Case Study 9.7). In other words, the holder of the LPA could refuse to give consent to treatment if that power was given in the LPA, even though health professionals considered that the treatment was necessary in the best interests of the patient. However the holder of the LPA could not insist that health professionals provide treatment and care when such treatment was considered by the health professionals to be contrary to the best interests of the patient and against their professional discretion, even when the donor had stated in the LPA that he or she wished such treatment to be provided.

An example of a case where the CoP had to consider the actions of the donee and whether a revocation of the LPA was justified is shown in the case of *Re J* 2010 (See Cast Study 6.1).

> **Case Study 6.1** *Re J* 2010.[35]
>
> The Court of Protection had to determine the construction of Section 22(3)(b) which provides that a court has power to revoke an LPA where the donee:
>
> **i)** has behaved in a way that contravenes his authority or is not in P's best interests or
> **ii)** proposes to behave in a way which contravenes his authority or would not be in P's best interests.
>
> HHJ Marshall QC disagreed with a broad concept of *unsuitability* as grounds to revoke but also rejected the view that the court could only take into account for the purposes of 22(3)(b) that of a donee in his capacity as donee.
>
> HHJ Marshall QC said she needed to look at the matter in stages:
>
> 1. One must identify the allegedly offending behavior or prospective behavior.
> 2. One looks at all the circumstances and context and decides whether, taking everything into account, it really does amount to behavior which is not in P's best interests or can be fairly characterized as such.
> 3. Finally one must decide whether, taking everything into account including the fact that it is behavior in some other capacity, it also gives good reason to take the very serious step of revoking the LPA.

Gifts

When an LPA exists in relation to property and affairs, the donee is not authorized to dispose of the donor's property by making a gift unless the following conditions are satisfied (Section 12—see Statute Box 6.1):

- gifts can be made on customary occasions to persons (including himself) who are related to or connected with the donor, or
- to any charity to whom the donor made or might have been expected to make gifts (S.12(2)).

These conditions only apply if the value of each such gift is not unreasonable having regard to all the circumstances and, in particular, the size of the donor's estate. Any conditions or restrictions in the instrument of the power of attorney would also have to be followed (S.12(4)).

Customary occasion is defined as:

- the occasion or anniversary of a birth, marriage or the formation of a civil partnership, or
- any other occasion on which presents are customarily given within families or among friends or associates.

The court may also authorize the making of gifts, which do not come within Section 12(2), under the powers granted by Section 23(4). In the case of *GM* [2013][36] Senior Judge Lush set out the principles which applied in the making of gifts by a donee (see also Re Buckley—Case Study 6.4). Guidance has been issued by the Office of Public Guardian on Gifts: Deputies, EPA/LPA attorneys.[37]

Scenarios 6.8 and 6.9 consider situations where gifts are made under the powers of an LPA.

> **Scenario 6.8** Situation A—welcome gift.
>
> Mavis was the donee of an LPA drawn up by her father, Amos, who had recently been admitted to a nursing home. Amos had been examined by a doctor who declared him to be lacking mental capacity. Amos had considerable assets including a stash of cash which Mavis was aware of. She therefore decided that she would make a gift of the cash to herself, since she believed that the powers of the LPA extended to her making gifts on behalf of her father. What is the law?

Mavis would be entitled to give herself the cash, provided that the provisions of Section 12 are satisfied. The following questions would have to be answered:

- Is Mavis related to the donor?
- Is it a customary occasion?
- Is the size of the gift reasonable in relation to all the circumstances and in particular Amos's estate?

Mavis would be wise to ensure that the gift related to an occasion such as her birthday, her marriage, or some other particular occasion. Unless there was a specific requirement in the instrument to bestow a gift upon herself, she would also have to consider whether it was in her father's best interests for the gift to be made and have regard to the principles in Section 1.

Scenario 6.9 Not in the best interests.

Harold drew up an LPA appointing his daughter Jean to be a donee in property decisions. She knew that he had always favored giving money to an African charity and she intended to continue this tradition. However Harold had very little capital and only a small pension supplemented by social security for income. In spite of this, Jean decided that she would make a donation of £5000 from Harold's capital of £10 000 to the African charity. This gift was contested by Harold's son Michael as not being in Harold's best interests. Jean argued that that was not necessary since she was acting under an LPA.

Acting contrary to the best interests of the donor

If the donor had previously made regular or periodic donations to any charity, the attorney or donee would also be permitted to continue to make such donations from the donor's funds (S.12(2)(b)). However the gift to the charity is subject to the same conditions as a gift to relatives or to persons who are connected with the donor, that is, the gift must be reasonable having regard to all the circumstances and particularly the size of the donor's estate. To In Scenario 6.9 to donate half of Harold's estate to the charity would appear to be out of all proportion to the estate and therefore unreasonable. However if there were a specific requirement that Jean gave that amount to the charity in the LPA, then Jean would be acting in accordance with her instructions. Without such specific instructions Jean would have to comply with the provisions of Section 12, the principles set out in Section 1, and the definition of best interests as defined in Section 4.

An example of a case where the attorney made payments to himself is that of *Day and others* v. *Royal College of Music and Harris* [2013].[38] In this case Day was the carer of Malcolm Arnold and then became executor of his estate. The children of Malcolm Arnold argued that payments to himself made by an attorney (on the instructions of the donor) were outside the remit of the EPA and should be returned to the estate. The Court of Appeal held that the donor could give gifts outside the EPA if competent to do so.

How does the donee know when the LPA comes into effect?

LPA covering property and finance

This will come into effect at the time specified in the LPA. It can be while the donor still has the requisite mental capacity. It may be that it only comes into effect when the donor loses his mental capacity. If the LPA was made online, then either the donor or the donee of the LPA can register the LPA online on payment of the requisite fee. A notice of intention to register must be sent to all those people listed in the LPA by the donor. They have 3 weeks to raise any concerns with the OPG.

LPA covering personal welfare

This LPA will only come into effect when the donor loses mental capacity. Clearly the donee must maintain contact with the donor or his or her family to be sure at what point the LPA is now effective. The donee is advised to refer to guidance issued by the OPG.

Scenario 6.5 is concerned with the execution of the two different forms of LPA.

What principles must be followed by the donee in making decisions?

The donee is obliged to follow any requirements drawn up in the LPA. However if the instructions in the LPA are of a very general nature, for example, "to make all

decisions in relation to my care and treatment," then the donee must follow the principles set out in Section 1 and act in the best interests of the donor as defined in Section 4.

In what circumstances can a donee act contrary to the best interests of the donor?

There may be situations where a specific requirement in the LPA is not seen by some to be in the donor's best interests; however the donee is obliged to follow the requirements laid down in the LPA.

How would action to control a donee commence and be followed through?

If there were a dispute over the interpretation of an LPA, this could be referred to the OPG (see Chapter 7).

Similarly if there were fears that a donee was failing to act according to the LPA or was acting contrary to the statutory duties or duties at common law (see list of duties under the common law "Duties of donee or attorney" on page 96), any concerned person could apply to the OPG.

The Code of Practice has suggested certain warning signs that a donee might be abusing his or her position. The list is clearly not intended to be exhaustive.[39] It is as follows:

- Stopping relatives or friends contacting the donor—for example, the attorney may prevent contact or the donor may suddenly refuse visits or telephone calls from family and friends for no reason
- Sudden unexplained changes in living arrangements—for example, someone moves in to care for a donor they've had little contact with
- Not allowing healthcare or social care staff to see the donor
- Taking the donor out of hospital against medical advice, while the donor is having necessary medical treatment
- Unpaid bills—for example, residential care or nursing home fees
- An attorney opening a credit card account for the donor
- Spending money on things that are not obviously related to the donor's needs
- The attorney spending money in an unusual or extravagant way
- Transferring financial assets to another country

Under Regulation 46 power is given to the Public Guardian to require information from donees of LPAs in specified circumstances. These circumstances include where the donee may:

a) have behaved, or may be behaving, in a way that contravenes his authority or is not in the best interests of the donor of the power,
b) be proposing to behave in a way that would contravene that authority or would not be in the donor's best interests, or
c) have failed to comply with the requirements of an order made, or directions given, by the court.

In such circumstances the Public Guardian may require the donee to provide specified information, or information of a specified description, or to produce specified documents or documents of a specified description. The Public Guardian can specify a reasonable time within which they must be produced and specify the place. The Public Guardian may require any information provided to be verified or any document to be authenticated.

Following a report to the OPG, a Court of Protection visitor could be appointed to investigate any allegations against the donee of an LPA. In serious situations, the OPG could refer the matter to the Court of Protection and also notify the police (see Chapters 7 and 11). A conflict could arise where a donor has appointed two different donees for an LPA for property and affairs and an LPA for personal welfare. It might arise that the donee for personal welfare wishes P to be placed in a care home, but the donee for property and affairs disagrees and refuses to pay the care home fees from P's funds. In such a dispute, the OPG is likely to appoint a visitor and if agreement cannot be reached an application would be made to the CoP for a decision as to what was in the best interests of P.

Who would represent P in checking up on the actions of the donee?

Where an LPA for personal welfare has come into effect, this would be at a time when P had lost, or was alleged to have lost, the requisite mental capacity. Any person concerned that the donee was not acting in P's best

Scenario 6.10 The donee's power is challenged.

David drew up a power of attorney whereby his son James would make all decisions relating to his property and finance. James undertook several transactions on his father's behalf, including the selling of some antique furniture. It subsequently comes to light that the LPA was never registered according to the provisions of Schedule 1. Since prices for antiques have subsequently risen steeply, James's sister considers that the furniture could now be sold for four times the amount which James received. She claims that the transaction was void because of the fact that an LPA was not created and the furniture should still be seen as belonging to her father. What is the legal situation of David and the purchaser?

interests or according to the terms of the LPA, or the statutory duties of a donee, could contact the OPG, which has the overall supervisory responsibility for donees (see Chapter 7). Scenario 6.10 considers a situation where the exercise of the LPA is challenged.

In this situation, the fact that the LPA has not been registered means that no power of attorney has been created. What is the effect of this on the transactions which have taken place? The crucial question is the knowledge of David and the purchaser. If David is ignorant of the fact that the LPA had not been created, then he is protected by Section 14(2) and he does not incur any liability to his father (i.e., the donor), or to any other person. In addition any transaction between David and another person is as valid as if the power had been in existence, unless at the time of the transaction that person has knowledge that the LPA was not created. Therefore if the purchaser of the furniture was unaware of the failure to register the LPA and the fact that an LPA had not been created, the transaction for the sale of the furniture will stand (S.14(3)). The purchaser's position is safeguarded and it is conclusively presumed in favor of the purchaser that the transaction was valid, if within 3 months of the completion of the purchase he signs a statutory declaration stating that:

> He had no reason at the time of the transaction to doubt that the donee had authority to dispose of the property which was the subject of the transaction. (S.14(4)(b))

The purchaser's position is also protected if the transaction was completed within 12 months of the date on which the instrument was registered (S.14(4)(a)).

Duties of donee or attorney

Some duties are specified under the Act:

- To act in accordance with the Act's principles
- To act or make decisions in the donor's best interests
- To have regard to the guidance in the Code of Practice
- To act within the scope of their authority

Other duties would be specified under the common law:

- Duty of care
- To carry out instructions
- Not to delegate unless authorized to do so
- Not to benefit themselves but to benefit the donor
- To act in good faith
- Duty of confidentiality
- To comply with the directions of the Court of Protection
- Not to disclaim without complying with the relevant Regulations
- (In relation to LPA for property and finance) to keep the donor's money and property separate from their own

In addition the donee would be seen in law as the agent of P and the principles of agency law would apply to the situation.

What happens if the donor changes his mind about setting up an LPA?

As long as the donor has the requisite mental capacity, he or she can change his or her mind about the details in the LPA or even as to whether there should be an LPA. Thus the name of the donee(s) could be changed as well as the details in the LPA by revoking the original LPA and setting up a new one (if required). Regulation 21[40] provides for the revocation by the donor of an LPA. It requires the donor to notify the Public Guardian that he or she has revoked the LPA and to notify the donee(s) of the revocation. Where the Public Guardian receives a revocation notice from the donor, he or she must cancel the registration of the instrument creating the power, if he or she is satisfied that the donor has taken such steps as are necessary in law to revoke it. The Public Guardian may require the donor to provide such further information or produce such documents as the Public Guardian reasonably considers necessary to enable him to determine whether the steps necessary for revocation

have been taken. Where the Public Guardian cancels the registration of the instrument, he or she must notify the donor and the donee(s).

However once the donor loses capacity, the donor no longer has any power to revoke the LPA. The Court of Protection does however have the powers specified in Section 23, which include determining the meaning of the LPA and giving directions to the donee (see "Powers of the Court of Protection in relation to the validity of LPAs" on page 100).

How long does an LPA last?

Once the LPA has come into effect, it will last until the donor dies or, if there are specific instructions, until these instructions have been carried out. (The donor has the power to revoke the LPA while he or she still has the requisite mental capacity.)

Regulation 22 provides for the revocation of an LPA on the death of the donor. It requires the Public Guardian to cancel the registration of an instrument as an LPA if he or she is satisfied that the power has been revoked as a result of the donor's death. Where the Public Guardian cancels the registration, he or she must notify the donee(s).

How can an LPA be changed?

As long as the donor retains his or her mental capacity, then he or she can revoke an LPA. After it has been registered, the donor would have to follow the rules relating to the revocation of an LPA and guidance issued by the Office of Public Guardian (see Regulation 21).

Once however the donor has lost capacity, it is not possible for the donor to change its provisions. The Court of Protection does however have the power under Section 23 to determine any question as to the meaning or effect of an LPA or an instrument purporting to create one (see "Powers of the Court of Protection in relation to the validity of LPAs" on page 100).

Revocation of LPAs

The LPA can be revoked at any time when P has the capacity to do so (S.13(2) and Regulation 21). For the provisions relating to bankruptcy, see page 99.

The following events terminate the donee's appointment and revoke the power:

- The death of the donor (Regulation 22)
- The disclaimer of the appointment by the donee in accordance with such requirements as may be prescribed for the purposes of this section in regulations made by the Lord Chancellor
- The death or bankruptcy of the donee, or the winding-up or dissolution where the donee is a trust corporation (in a bankruptcy situation, only the power in relation to property and affairs is ended or, in an interim bankruptcy situation, suspended—S.13(6)(b) and (8) and (9))
- The dissolution or annulment of a marriage or civil partnership between the donor and the donee ((S.13(6)(c) unless the instrument provided to the contrary—S.13(11))
- The lack of capacity of the donee

The following events terminate the donee's appointment but do not revoke the power:

- The donee is replaced under the terms of the instrument.
- The donee is one of two or more persons appointed to act as donees jointly and severally in respect of any matter and, after the event, there is at least one remaining donee.

Case Study 6.2 *London Borough of Redbridge* v. *G and Others No 4.*[41]

One of the issues considered was the revocation of a health and welfare LPA purportedly granted by G in favor of C. Judge Russell decided that she did not have the evidence to revoke the LPA on grounds of lack of capacity of G at the relevant time (i.e., S9(2) However she was able to revoke it on grounds that the donee had acted contrary to the best interests of G. Such conduct did not have to be in relation to the LPA section 22 (3) (a)(i) and ii and/or b(i) to revoke under S. 22(4)(b) "it offends against logic to suggest that S 22(b)(i) can only refer to the behaviour of a donee when purporting to act under the authority of the instrument when the court has found that a donee has behaved in a way that is not in Ps best interests, particularly when the behaviour relates directly to the specific LPA in this case health and welfare)." She had previously held that she had powers under Section 17 to order C and F to vacate G's home (see also Chapter 7 and CoP power Case Study 7.4).

A further example of the revocation of an LPA by the Court of Protection is the following case.

Case Study 6.3 *The Public Guardian* v. *AW and DH*[42] [2014] EWCOP 28.

Senior Judge Lush revoked an LPA as the donee had used a substantial part of P's estate on improvements to the donee's house (where P lived) and payments for the donee's care of P without having sought the authority of the court, without obtaining the agreement of the co-donee, and without recording or protecting P's interests in the property. She had also severely restricted contact between P and the co-donee and her family. (The donees were sisters and P their mother.)

Senior Judge Lush held that the proper course for the donee would have been an application for authorization under Section 23(2)(b) of the MCA 2005—significant expenditure on improvements to a house where P was living should be protected by a declaration of trust and an entry on the Land Register.

Re DP (Revocation of a lasting power of attorney) (January 24, 2014)[43]

This was the first case to be reported under the Munby guidance issued on January 16, 2014. DP appointed her former gardener as her sole attorney for a property and affairs LPA and also as her residual heir. Evidence of misappropriation of funds was reported to the police, but CPS decided there was not sufficient evidence to prosecute. The OPG applied for the LPA to be revoked in April 2013 and it came for hearing in January 2014.

Senior Judge Lush held that it was in DP's best interests for the LPA to be revoked. The donee was in breach of his fiduciary duties as attorney by failing to keep proper accounts and financial records.

The judge explained the difference between a police investigation and an investigation conducted by the OPG and the former standard of beyond reasonable doubt and the latter on balance of probabilities. The fact that the first two beneficiaries were no longer able to benefit from DP's will because of sale of her house could be remedied by the deputy being authorized to execute a statutory will.

In *JL (Revocation of Lasting Power of Attorney)* [2014][44] Senior Judge Lush had to decide whether an attorney appointed by a digital LPA as attorney for property and affairs was valid. JL the donor received no independent advice when AS her daughter was appointed attorney and she admitted at the hearing that she failed to keep accounts and had not read the declaration relating to her responsibilities before she signed it. Lush SJ held that she had not acted in the best interests of JL who lacked the capacity to revoke the LPA.

Another example of a case on the importance of the duties of attorneys as regards the management of P's moneys and the revocation of the LPA is that of Re Buckley (January 22, 2013) Case Study 6.4.[45]

Case Study 6.4 *Re Buckley* 2013.

The Public Guardian applied to revoke an LPA and direct him to cancel its registration in the light of his concerns as to the conduct of the sole attorney, the niece of P. His investigation had revealed that (inter alia) a very substantial sum (nearly £90 000) of P's monies had been put by the niece into a reptile breeding venture and she had taken nearly £45 000 of P's capital for her own personal benefit.

The niece did not oppose the application. Nor did she attend the hearing. The application was granted and Senior Judge Lush set out the responsibilities of the attorney acting under an LPA when investing the donor's funds. Two misconceptions were both incorrect: (a) that attorneys acting under an LPA can do whatever they like with the donors funds and (b) the attorneys can do whatever the donors could—or would—have done personally, if they had the capacity to manage their property and financial affairs.

Attorneys must act under their fiduciary duty and act in the best interests of the donor.

Lush ruled that the niece had contravened her authority and acted in a way that was not in P's best interests. He therefore revoked the LPA and directed the cancellation of the registration.

Lush gave guidance on investments for the short term (donors with less than 5 years' life expectancy). His points of guidance (including some from the investing for patients—internal guidance of the OPG) were:

1. Make sure funds are protected under financial compensation scheme (up to £85 000).
2. In considering the suitability of investments, consider the donor's age and life expectancy and the need to diversify and take account of the level of risk.
3. Attorneys should keep donors' moneys separate from their own (see MCA code of practice Para 7.68).
4. An application can be made to court under S 23 re gifts; loans; investment in attorneys own business; sales and purchase at an under value and any other transaction where conflict between donor and attorney's interests.
5. Attorneys should be aware of the law regarding their role and responsibilities.

Another example of revocation of LPA is as follows.

Case Study 6.5 In *the Public Guardian* v. *AW and DH* [2014].[46]

The Public Guardian applied to revoke and cancel the LPA. The judge held that:

a) OB lacked the capacity to revoke the LPA herself and

b) AW had contravened her authority by taking advantage of her position and therefore he revoked AW's appointment as attorney.

The facts were that OB was a nurse and had two daughters, one AW had no children and the other DH had two children. OB lived with AW. OB set up an LPA for property affairs and the two daughters were jointly and severally to be her attorneys. LPA registered by OPG on March 4, 2011. In February 2013 DH stopped visiting the mother because of AW because of the abuse she received from AW. DH contacted the OPG to express concern that long-standing pocket money payments to OB's grandchildren had been stopped and that there had been excessive expenditure from OB's accounts. OB's house had been sold and a considerable part of the proceeds used to renovate AW's property. The Public Guardian opened an investigation and commissioned a CoP General Visitor to visit OB. The report of the Visitor said OB appeared to lack capacity to manage her affairs.

The Public Guardian applied to the court for orders, inter alia, requiring AW to account fully for all expenditure from the accounts held on behalf of OB, and if she failed to provide a satisfactory account and explanation of how it was in the best interests of OB, the court was asked to consider the revocation of the LPA and inviting a panel deputy to apply to be appointed to manage the financial affairs of OB.

Senior Judge Lush quoted from Code of Practice Para 7.60 on the fiduciary duty of the attorney. Here there was a conflict of interest between the interests of the donor and the interests of the attorney. AW should have sought a court application for paying her an appropriate allowance for the gratuitous care she provided for OB and for the improvements to her house. AW should not have been making these decisions unilaterally. AW also refused to consult or take into account the views of her sister and co-attorney as was required by Section 4(7)(b) and (c) of MCA. AW's words and actions have resulted in severely restricted contact between OB and DH and her family. "One of the surest sights of undue influence is controlling another person's environment and social interactions by isolating and excluding them from outside supervision and advisers."

The revocation of AW's appointment left DH as the sole attorney. DH was content for a panel deputy to be appointed and the judge suggested that she signed a disclaimer form LA 005 and sent it to the PG as soon as possible to facilitate that appointment.

Case Study 6.6 *Public Guardian* v. *Marvin* [2014][47]

In this case P appointed son as Attorney for finance and welfare. The son delegated his finance and affairs role to P's partner and P's home no longer registered in his name. The Public Guardian applied to revoke both powers of attorney. Marvin accepted that he had acted beyond his powers but asked if he could be appointed as joint deputy with a panel deputy. Senior Judge Lush agreed that this was possible because although he had acted outside his authority, he had not abused his power in any way. However such an appointment was unusual and dependent upon very specific facts and should not be a precedent. The attorneyship for welfare could continue.

Bankruptcy

Any reference to the bankruptcy of an individual includes a case where there is a bankruptcy restrictions order under the Insolvency Act 1986 in respect of that individual (S.64(3)).

If P becomes bankrupt, the power of attorney is revoked so far as it relates to P's property and affairs (S.13(3)). However if there are only interim bankruptcy restrictions, the power of attorney in relation to P's property and affairs is suspended so long as the order has effect (S.13(4)). Under Section 13(9), where the donee is bankrupt because of an interim bankruptcy restrictions order, then his power and appointment are suspended, so far as they relate to P's property and affairs, for so long as the order has effect.

The bankruptcy of a donee does not terminate his appointment, or revoke the power, in so far as his authority relates to P's personal welfare.

Bankruptcy restrictions orders include an interim bankruptcy restrictions order (MCA S.64(4)).

Fraudulent donee

Where the court is satisfied that fraud or undue pressure was used to induce P to execute an instrument for the purpose of creating an LPA, then the Court of Protection can declare that the instrument of the LPA is not to be registered (S.22(3) and (4)).

Where the fraud occurs after the LPA is registered and comes into effect, then the Court of Protection can, if P lacks capacity to do so, revoke the instrument or the LPA. Clearly if P still has the requisite capacity, he can revoke the LPA himself.

What happens if the donee does not carry out what the donor would have wished?

An application can be made to the OPG if there are fears that the donee of the power is not acting in accordance with the instructions therein or, if there are no specific powers, not acting in the best interests of the donor. If the Public Guardian is unable to resolve the situation, then application can be made to the Court of Protection.

Protection of donee and others if no power is created or the power is revoked

Section 14 (see Statute Box 6.1) makes provision for the situation where, although an instrument has been registered as an LPA, in fact a valid LPA was not created. In such a situation, if the donee acts in purported exercise of the power, he or she does not incur any liability to P or any other person, because of the nonexistence of the power. However to take advantage of these provisions, the donee must be unaware that an LPA was not created, or he or she must be unaware of circumstances which would have terminated his or her authority to act as a donee. In the circumstances where an LPA has not in fact been created, any transaction between the donee and another person is valid as if the power had been in existence unless that other person has knowledge of the nonexistence.

For a purchaser there is a presumption in favor of the purchaser of the validity of the transaction, if the transaction was completed within 12 months of the date on which the instrument was registered or the other person makes a statutory declaration, before or within 3 months after the completion of the purchase, that he or she had no reason at the time of the transaction to doubt that the donee had authority to dispose of the property which was the subject of the transaction (S.14(4)) (see Scenario 6.10).

Where two or more donees are appointed under an LPA, Section 14 applies as if references to the donee were to all or any of them (S.14(6)).

Powers of the Court of Protection in relation to the validity of LPAs (Sections 22 and 23)

Statute Box 6.3 sets out the provisions of Sections 22 and 23 of the MCA.

Where P has executed or purported to execute an instrument with a view to creating an LPA, or an instrument has been registered as an LPA, then the court may determine any question relating to whether the requirements for the creation of an LPA have been met, and any question relating to whether the power has been revoked or has otherwise come to an end.

The court has power to direct that an instrument purporting to create the LPA is not to be registered or, if P lacks the capacity to do so, revoke the instrument or the LPA in the following situations where the court is satisfied that:

- fraud or undue pressure was used to induce P to execute an instrument for the purpose of creating a lasting power of attorney or to create a lasting power of attorney, or
- the donee (or, if more than one, any of them) of a lasting power of attorney has behaved or is behaving in a way that contravenes his authority or is not in P's best interests or proposes to behave in a way that would contravene his authority or would not be in P's best interests.

If there is more than one donee, the court may under Section 22(4)(b) revoke the instrument or the LPA so far as it relates to any of them (S.22(5)).

The term donee includes an intended donee (S.22(6)).

These powers given to the Court of Protection are similar to those set out in Section 8 of the Enduring Powers of Attorney Act 1985, except that the administrative functions connected with registration are from October 2007 performed by the OPG.

Statute Box 6.3 Section 22 and 23 Powers of CoP and LPAs.

Section 22 Powers of court in relation to validity of lasting powers of attorney

1 This section and Section 23 apply if—
- **a)** a person ("P") has executed or purported to execute an instrument with a view to creating a lasting power of attorney, or
- **b)** an instrument has been registered as a lasting power of attorney conferred by P.

2 The court may determine any question relating to—
- **a)** whether one or more of the requirements for the creation of a lasting power of attorney have been met;
- **b)** whether the power has been revoked or has otherwise come to an end.

3 Subsection (4) applies if the court is satisfied—
- **a)** that fraud or undue pressure was used to induce P—
  - **i)** to execute an instrument for the purpose of creating a lasting power of attorney, or
  - **ii)** to create a lasting power of attorney, or
- **c)** that the donee (or, if more than one, any of them) of a lasting power of attorney—
  - **i)** has behaved, or is behaving, in a way that contravenes his authority or is not in P's best interests, or
  - **ii)** proposes to behave in a way that would contravene his authority or would not be in P's best interests.

4 The court may—
- **a)** direct that an instrument purporting to create the lasting power of attorney is not to be registered, or
- **b)** if P lacks capacity to do so, revoke the instrument or the lasting power of attorney.

5 If there is more than one donee, the court may under subsection (4)(b) revoke the instrument or the lasting power of attorney so far as it relates to any of them.

6 "Donee" includes an intended donee.

23 Powers of court in relation to operation of lasting powers of attorney

1 The court may determine any question as to the meaning or effect of a lasting power of attorney or an instrument purporting to create one.

2 The court may—
- **a)** give directions with respect to decisions—
  - **i)** which the donee of a lasting power of attorney has authority to make, and
  - **ii)** which P lacks capacity to make;
- **b)** give any consent or authorisation to act which the donee would have to obtain from P if P had capacity to give it.

3 The court may, if P lacks capacity to do so—
- **a)** give directions to the donee with respect to the rendering by him of reports or accounts and the production of records kept by him for that purpose;
- **b)** require the donee to supply information or produce documents or things in his possession as donee;
- **c)** give directions with respect to the remuneration or expenses of the donee;
- **d)** relieve the donee wholly or partly from any liability which he has or may have incurred on account of a breach of his duties as donee.

4 The court may authorise the making of gifts which are not within section 12(2) (permitted gifts).

5 Where two or more donees are appointed under a lasting power of attorney, this section applies as if references to the donee were to all or any of them.

Powers of the Court of Protection in relation to the operation of LPAs

Section 23 gives the court the power to determine any questions as to the meaning or effect of an LPA or an instrument purporting to create one. The powers are set out in Statute Box 6.3.

The court may also authorize the making of gifts, which are not within Section 12(2). (The Explanatory Memorandum on the MCA suggests that this authorization of such gifts could be used for tax planning purposes.)

Where two or more donees are appointed under an LPA Section 23 applies as if references to the donee were to all or any of them (S.23(5)).

The powers of the Court of Protection in relation to an LPA are illustrated in the following case.

Case Study 6.7 *Re Harcourt* (July 31, 2012)[48] (best interests and revocation).

Two months after her husband died, Mrs Harcourt appointed her younger daughter to manage her property and affairs under an LPA. Care home arrears, questionable borrowing, unaccountable financial transfers, and frequent cash withdrawals resulted in an investigation being conducted by the OPG. Since the OPG has no powers of enforcement: to freeze the accounts or suspend the LPA or revoke the LPA it had to apply to the Court of Protection.

The CoP concluded that Mrs Harcourt lacked the mental capacity to give instructions to an LPA. The daughter (who was an auditor) had not managed the finances well and her refusal to cooperate with the court and the OPG meant she was not acting in the best interests of her mother. The court would not take a decision to revoke an LPA lightly because of article 8. However Senior Judge Lush said:

> In this case, I believe that the revocation of the LPA in order to facilitate the appointment of a deputy is a necessary and proportionate response for the protection of Mrs Harcourt's right to have her financial affairs managed competently, honestly and for her benefit, and for the possible prevention of crime.

The LPA was revoked and a deputy appointed.

Application to the Court of Protection

The donor or donee or other interested person could apply to the Court of Protection for the use of its powers under Section 22 and Section 23 (see Statute Box 6.3). The Rules require that the applicant must ensure that those involved have a copy of the application form, so the donor must serve a copy on the donee(s), the donee(s) on the donor, and, if the applicant is not a donor or donee, on those parties, respectively. The persons served with a copy of the application form in this way are known as a respondent to the proceedings (Rule 30).

All parties to the proceedings would of course be bound by the pre-action protocol and the Rules of the Court of Protection, which require the court to encourage cooperation between the parties and the settlement of the dispute without the need for court proceedings (see Chapter 7 and Scenario 7.2 on an application to the Court of Protection).

Where the Court of Protection makes an order without a hearing, anyone affected by the order can apply under Rule 89 of the CoP rules 2007 to the CoP within 21 days for the order to be reconsidered. An example of this process is shown in the following case.

Case Study 6.8 *Re MRJ (Reconsideration of an order)*[49] [2014].

MRJ created an LPA for health and welfare and one for property and finance. Her deputies were JT (her daughter) and KT (her grandson). The Senior Judge Lush held that the hearing was not an appeal but an opportunity to allow a party who has not been given a chance to be heard. Evidence was given by a social worker for Surrey County Council the KT had been cynically and systematically misappropriating his grandmother's money. Lush cited the judgment of HH Judge Hazel Marshall QC in *Re S and S* [2008].[50] He was satisfied that MRJ lacked capacity to revoke the LPA.

Senior Judge Lush

i) confirmed the order revoking the LPA for health and welfare and

ii) confirmed the order suspending the authority of JT and KT to act under the LPA for property and financial affairs and

iii) formally revoked the LPA for property and affairs and appointed Suffolk County Council as substantive deputy.

Future changes

A consultation paper was published in July 2012 "Transforming the Services of the Office of the Public Guardian." Subsequently the Government announced that by April 2013 it would reduce the statutory waiting period for registering an LPA form from 6 to 4 weeks and it would amend the regulations to allow court-appointed deputies to change bond provider without the need to apply to the Court of Protection. Further changes which were to take place by 2014 include the digitalizing of the process of LPAs so that customers can complete most of the LPA process online.[51] Creating and registering LPAs is now completely possible online.[52]

In 2014 the House of Lords Select Committee reported on the Mental Capacity Act[53] and recommended that:

(Rec. 25)

We recommend that the Government working with independent oversight body recommended in chapter 4 and the OPG:

- Address the poor levels of understanding of LPAs among professional groups, especially in the health and social care sector, paying specific attention to the status of the LPA in decision making
- Consider how best to ensure that information concerning registered LPA can be shared between public bodies and where appropriate with private sector bodies such as banks and utilities

- Issue guidance to LAs that their new responsibilities for provision of information in relation to care contained in the Care Bill (now Act) should include information on LPAs
- Consider how attorneys and deputies faced with noncompliance by public bodies or private companies can be supported in the absence of specific sanctions, review the apparent anomalies in the current arrangements with regard to successive replacement attorneys, and the status in England of Scottish Powers of Attorney

The Government responded in June 2014[54] and Chapter 8 of the response dealt with the recommendations from the Select Committee on LPAs.

It agreed on the need to raise awareness of the value of LPAs and was planning a *life planning day* in 2015 to raise awareness about LPAs and other such life planning devices; in addition the Office of Public Guardian was working to raise awareness;

Information sharing: work of OPG plus they are looking at an intermediate tier of access for accredited parties providing more info than would be provided on a basic search by public.

Supporting LPAs and Deputies: Financial Conduct authority and Care Quality Commission have important role to play in encouraging and ensuring compliance in their relevant areas.

Replacement attorneys: Under S 10(8) a replacement attorney can only replace an original attorney and cannot replace a replacement attorney. Court of Protection has suggested that the problem can be resolved by setting up two LPAs the one only to come into effect when the first is inoperable for any reason.

In response to public criticisms the OPG announced in August 2014 that it intended to simplify the process of setting up an LPA with new simplified forms. It still intended to keep the two separate forms for property and affairs and for personal welfare and they would keep the requirements for a signature and witness for the life-sustaining treatment section. They would also keep the need for an independent witness to sections of the LPA and the requirement for a person known to the donor to certify that in his or her judgment the donor had capacity. The new simplified forms which are to come into existence early in 2015 will allow people to state when they wish their LPA to come into effect. The new forms will complement the existing online service which makes it simpler, clearer, and faster to apply for LPAs. The number of applications for LPAs is increasing with 200 000 in 2011/2012 and 295 000 in 2013/2014.

Conclusions

The extension of the powers of an attorney to cover health and welfare is welcomed, and it is likely that their use will become more popular and health and social services professionals will become familiar with their existence and operation. Extended powers of attorney will continue to be used, but no new EPAs can be created after October 2007. In time they will of necessity end as their creators die. Case law has developed over some of the issues raised in this chapter. The ignorance of many bank and financial company employees over the implications of LPAs[55] shows the need for the recommendations of the House of Lords Select Committee to be promptly implemented.

Quick fire quiz, QFQ6

1. When does a lasting power of attorney in relation to health and welfare decisions come into force?
2. How can a valid lasting power of attorney be created?
3. In what circumstances would the donee of an LPA be acting *ultra vires*?
4. Is it possible for a person to be named as the donee of an LPA without his or her knowledge?
5. What is meant by *jointly*, *severally*, and *jointly and severally*?
6. In what circumstances could the donee of an LPA relating to health and welfare agree to the ending of lifesaving treatment of the donor?

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5 *Ibid*.
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to registration), 2009/1884 (new forms introduced), 2010/1063 (amendment reregistration when original instrument lost plus other changes), 2013/506 (changes to time limits for various activities), and 2015/899 (updates the language and changes the forms).

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CHAPTER 7

Court of Protection, court-appointed deputies, the Office of the Public Guardian, and visitors

THIS CHAPTER CONSIDERS THE FOLLOWING TOPICS

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Introduction

The Court of Protection (CoP), while retaining the old title, is a new court with a much wider jurisdiction than its predecessor. It has the power to make decisions about both personal welfare and property and affairs for a person who lacks the requisite mental capacity and can make declarations about advance decisions. It also has ultimate control over those appointed under a lasting power of attorney (LPA). Court-appointed deputies replace the previous system of receiverships and have extended powers to include welfare and healthcare matters, as well as financial and property affairs.

The significant new feature is that there is now a single integrated framework for making personal welfare decisions, healthcare decisions, and financial decisions on behalf of those lacking the requisite mental capacity, as recommended by the Law Commission in 1995. The court can make both one-off orders and also appoint a deputy with continuing powers.

Court of Protection

Constitution of the CoP

Part 2 of the Mental Capacity Act (MCA) 2005 Sections 45–56 makes provision for a new CoP. The provisions under Part 7 of the Mental Health Act 1983 are repealed.

The jurisdiction of the court covers England and Wales and it can sit at any place, on any day, and at any time. It has a central office and registry located by the Lord Chancellor, who has the power to designate any district registry of the High Court and any county court office as an additional registry of the CoP.

Judges are appointed by the Lord Chancellor or a person acting on his behalf. There are specified conditions of eligibility for the appointment of a judge to the CoP, that is,

a) The President of the Family Division
b) The Vice-Chancellor
c) A puisne judge of the High Court
d) A circuit judge
e) A district judge

Legal Aspects of Mental Capacity: A Practical Guide for Health and Social Care Professionals, Second Edition. Bridgit Dimond.

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The Lord Chancellor must appoint the President and Vice-President of the court from one of categories a, b, or c. From among the other categories the Lord Chancellor must appoint a Senior Judge of the CoP, with administrative functions set by the Lord Chancellor.

General powers and effect of orders

The court has the same powers, rights, privileges, and authority as the High Court (S.47(1)). This means that all the High Court powers in relation to witnesses, contempt of court, and enforcement of its decisions apply to the CoP. It cannot however develop its own inherent jurisdiction to go beyond its statutory powers, but the High Court is able to draw on its inherent jurisdiction which survives the MCA.[1] This is considered in Chapter 2. In making decisions in the best interests of P, the CoP has no greater powers than the patient would have if he or she were of full capacity.[2]

The powers given by Section 204 of the Law of Property Act 1925, which lay down that the High Court orders are conclusive in favor of purchasers, apply to the CoP. Office copies of the official documents of the court which are sealed with its official seal are admissible in all legal proceedings as evidence of the originals without any further proof.

Interim orders and directions

The CoP has the power, pending the determination of an application to it, to make an order or give directions on any matter which is within its jurisdiction, if there is reason to believe that P lacks the capacity in relation to that matter and it is in the person's best interests to make the order or give the directions without delay.

General powers of the CoP

The CoP is given powers under Section 15 of the MCA 2005 to make declarations and under Section 16 to make decisions and appoint deputies. The powers under Sections 15 and 16 are shown in Statute Box 7.1, page 107. Section 17 details the powers in relation to personal welfare (Statute Box 7.2, page 107). Section 18 (which is shown in Statute Box 7.4, page 121) details the powers in relation to property and finance. Section 16A which was added by the Mental Health Act 2007 and limits the powers of the CoP in relation to orders for deprivation of liberty is considered in Chapter 14 and shown in Statute Box 14.4.

As can be seen from Statute Box 7.1, Section 15 (Power to make declarations) covers the determination of the mental capacity of P and also the lawfulness or otherwise of any act (which includes an omission and course of conduct) done, or yet to be done, in relation to that person. Examples of this latter power might include deciding whether the withholding or withdrawing of medical treatment is in the best interests of P. In determining whether or not P has the requisite mental capacity, the court is not bound to follow the views of medical experts but must consider all aspects of the situation. In the case of *CC* v. *KK*[3] Judge Baker rejected the unanimous view of the medical experts that KK lacked the capacity to make decisions about her residence and care.

Scenario 7.1 on page 108 illustrates how Section 15 works.

The first question which will have to be resolved is whether Henry has the requisite mental capacity to decide on the question of his future accommodation.

Evidence will be provided by social services and by Monica about Henry's capacity, and Henry should have the opportunity of trying to establish his capacity to make the decision (possibly with the assistance of the independent mental capacity advocate (IMCA) (see Chapter 8), but this appointment will depend upon it being shown that there were no appropriate persons who could speak on behalf of Henry). If there is no agreement on Henry having the requisite capacity, then an application could be made to the CoP for a court declaration on this point (see Chapter 4 and the scenarios in that chapter on the determination of capacity).

If the CoP determines that Henry lacks the requisite capacity, it then has the option of the following measures:

- Appointing a deputy with the power to decide on which accommodation is appropriate for Henry's needs
- Making the decision on the basis of papers submitted
- Holding a hearing to determine the issue

In selecting which option is appropriate, the CoP would be mindful of the statutory provisions that a decision of the court is to be preferred to the appointment of a deputy to make a decision (S.16(4)). Since

Statute Box 7.1 Powers of Court of Protection under Sections 15 and 16.

15 Power to make declarations

1 The court may make declarations as to—
  a) whether a person has or lacks capacity to make a decision specified in the declaration;
  b) whether a person has or lacks capacity to make decisions on such matters as are described in the declaration;
  c) the lawfulness or otherwise of any act done, or yet to be done, in relation to that person.
2 "Act" includes an omission and a course of conduct.

16 Powers to make decisions and appoint deputies: general

1 This section applies if a person ("P") lacks capacity in relation to a matter or matters concerning—
  a) P's personal welfare, or
  b) P's property and affairs.
2 The court may—
  a) by making an order, make the decision or decisions on P's behalf in relation to the matter or matters, or
  b) appoint a person (a "deputy") to make decisions on P's behalf in relation to the matter or matters.
3 The powers of the court under this section are subject to the provisions of this Act and, in particular, to sections 1 (the principles) and 4 (best interests).
4 When deciding whether it is in P's best interests to appoint a deputy, the court must have regard (in addition to the matters mentioned in section 4) to the principles that—
  a) a decision by the court is to be preferred to the appointment of a deputy to make a decision, and
  b) the powers conferred on a deputy should be as limited in scope and duration as is reasonably practicable in the circumstances.
5 The court may make such further orders or give such directions, and confer on a deputy such powers or impose on him such duties, as it thinks necessary or expedient for giving effect to, or otherwise in connection with, an order or appointment made by it under subsection (2).
6 Without prejudice to section 4, the court may make the order, give the directions or make the appointment on such terms as it considers are in P's best interests, even though no application is before the court for an order, directions or an appointment on those terms.
7 An order of the court may be varied or discharged by a subsequent order.
8 The court may, in particular, revoke the appointment of a deputy or vary the powers conferred on him if it is satisfied that the deputy—
  a) has behaved, or is behaving, in a way that contravenes the authority conferred on him by the court or is not in P's best interests, or
  b) proposes to behave in a way that would contravene that authority or would not be in P's best interests.

16A added by Mental Health Act 2007 and considered in Chapter 14 on Deprivation of Liberty Safeguards (see Statute Box 14.4).

Statute Box 7.2 Section 17: Section 16 powers: personal welfare.

1 The powers under section 16 as respects P's personal welfare extend in particular to—
  a) deciding where P is to live;
  b) deciding what contact, if any, P is to have with any specified persons;
  c) making an order prohibiting a named person from having contact with P;
  d) giving or refusing consent to the carrying out or continuation of a treatment by a person providing health care for P;
  e) giving a direction that a person responsible for P's health care allow a different person to take over that responsibility.

there is a single issue to be determined in this case and therefore continuing supervision is not required, it is highly probable that the accommodation decision will be made either on the basis of the papers submitted to the court or after a short hearing of the court. In making its decision, the CoP is bound to apply the principles set out in Section 1 of the Act (see Chapter 3) and also to use the criteria set down in Section 4 for deciding what is in the best interests of Henry (see Chapter 5 and the scenarios in that chapter). It would take into account the fact that Henry's condition, both mentally and physically, appears to be deteriorating and even if Monica could care for him initially, this would appear to be only for the short term.

Scenario 7.1 Whose decision?

Henry, aged 84, was in hospital following a hip operation. A predischarge assessment was carried out by an occupational therapist who advised his wife, Monica, that it was highly likely that she would be unable to care for him at home and that it was preferable if they considered discharge to a care home. He would require a substantial input of nursing care which was not easily provided at home. Monica had not worked during her married life and was dependent upon Henry's occupational pension and state benefits. She feared that if he were to be admitted to a care home and had to pay fees, she would have an inadequate income to live upon. She therefore opposed his admission to a care home and favored his return back home. Henry was in the early stages of dementia. When lucid, he appeared to favor going to a care home, but his periods of lucidity were declining both in frequency and length. The hospital was concerned that Henry was blocking a bed, and with the pressures of winter increasing, they wanted him discharged since he no longer needed hospital care. The social worker was anxious to find accommodation for Henry since under the delayed discharges legislation social services faced the possibility of a fine. Henry and Monica's two children were drawn into the dispute, and while they sympathized with their mother's plight, they agreed that Henry would be too much for her to cope with and they raised the question of why Henry's accommodation should not be funded through the National Health Service (NHS), since his continuing care needs appear to meet the justification for top-level fees being paid for his care. An independent mental capacity advocate was not appointed to represent Henry in the decision making, since it was considered that there were appropriate persons who could be consulted. In order to speed up the decision making, the social services department made an application to the Court of Protection for the issue of Henry's mental capacity and accommodation to be determined.

Who should provide the accommodation?

The relatives have raised the question of why Henry's accommodation should not be funded through the NHS. Whoever becomes responsible for making decisions on behalf of Henry will have to ensure that Henry is represented in any application to the NHS trust that it is the appropriate body to be providing his accommodation.

A case which considered the eligibility for NHS continuing care is discussed in Case Study 7.1.

Case Study 7.1 Continuing care [Grogan 2006].[4]

G. applied for judicial review of a decision by an NHS trust that she did not qualify for continuing NHS healthcare. If the NHS provided care, it would be free; if it were the social services, she would be means tested. The High Court held that an NHS trust should apply a primary health need test to determine whether accommodation should be provided by the NHS or social services. The criteria of the NHS trust for determining whether the patient had continuing care needs were fatally flawed, and it failed to give reasons why it considered that the patient's continuing care needs were neither complex nor intense. The court ordered the trust's decision to be set aside and remitted for fresh consideration.

Subsequently to Case Study 7.1 the National Framework on NHS Continuing Healthcare and NHS-funded Nursing Care was published in October 2007[5] which was revised in 2009 and 2012 and updated in 2013. It sets out the national framework, the legal framework, the primary health need, core values and principles, eligibility considerations, links to other policies, care planning and provision, review, dispute resolution, and governance. The Care Act 2014 defines LA duties in relation to the assessment of clients and carers. A white paper on social care[6] was published in 2010. This recommended a national care service which would be free at the point of delivery to be set up within 5 years (see Chapter 11).

Decisions of the CoP

Where a person lacks capacity in relation to a matter or matters concerning his or her personal welfare or property and affairs, then the court may make an order which makes the decisions on P's behalf or may appoint a deputy to make the decision on P's behalf. The powers must be exercised in accordance with the principles set out in Section 1 of the Act (see Chapter 3 of this book) and in accordance with the best interests of P as defined in Section 4 (see Chapter 5 of this book).

The powers of the court are extensive in that the court may make the order, give the directions, or make the appointment on such terms as it considers are in P's best interests, even though no application is before the court for an order, directions, or an appointment on those terms (S.16(6)) (see Statute Box 7.1).

In the *case* of M (Adult) [2015] EWCA Civ 411, the Court of Appeal had to determine the precise scope of the CoP's powers in a situation where the care provider was not prepared to provide or fund the care sought. Sir James Munby P stated the function of the CoP is to take, on behalf of adults who lack capacity, the decisions which, if they had the capacity, they would take themselves. The CoP has no more power, just because it is acting on behalf of an adult who lacks capacity, to obtain resources or facilities from a third party, whether a private individual or a public authority, than the adult if he had capacity would be able to obtain himself… in the final analysis the CoP cannot compel a public authority to agree to a care plan which the authority is unwilling to implement. Sir James Munby also gave guidance on the use of declarations by the CoP and its conduct of welfare proceedings. The judgment is likely to lead to the ad hoc rules committee of the CoP making more decisions.

See also the case of *Bedford Borough Council* v. *(1) Mrs LC and (2) Mr LC* [2015][7] which is considered in Chapter 5 on best interests (Case Study 5.24).

Reports for the CoP

Where proceedings are brought in respect of a person under Part 1 of the MCA and the court is considering a question in relation to P, then the powers of the CoP include the calling for reports from the Public Guardian (see page 127) or by a CoP visitor (see page 129). The CoP can also require a local authority or an NHS body to arrange for a report to be made by one of its officers or employees or such other person as it thinks appropriate to make a report. The CoP can specify matters which must be included in any such report and can also direct whether the report should be made in writing or by word of mouth.

Making an application to the CoP

Application by a social worker

Unless social services come under one of the persons or organizations listed in Section 50(1) and under the CoP Rules 2007[8] (i.e., the person lacking capacity, if under 18 years, anyone with parental responsibility for him, a deputy, or donor or donee of an LPA and a person named in the order) who can make an application to the CoP without seeking permission, it would have to seek the permission of the court to bring the application. As applicant the social services department would begin the proceedings by filing an application notice on the approved form (unless there is an exception to this requirement) and comply with all the preaction protocols.

Box 7.1 Application form to commence Court of Protection proceedings.

- the matter which the applicant wants the court to decide
- the order which the applicant is seeking
- Name
  - **i)** the applicant
  - **ii)** P
  - **iii)** as a respondent, any person (other than P) whom the applicant reasonably believes to have an interest which means that he ought to be heard in relation to the application (as opposed to being notified of it in accordance with rule 70); and
  - **iv)** any person whom the applicant intends to notify in accordance with rule 70 and
- whether the applicant is acting in a representative capacity and if so, what that capacity is

The court would issue an application form. This must set out the information shown in Box 7.1[9] in accordance with Rule 63. The CoP rules have been supplemented with practice directions which are available on the Ministry of Justice website.[10]

The application form will be accompanied by any written evidence on which the applicant intends to rely and any other documents referred to in the application form. This may include written evidence that P is a person who lacks capacity to make the decision(s) in relation to the matter to which the application relates.

On receipt of the application the court will consider:

- Whether to grant permission (if that is required)
- Whether it could be linked with another application relating to P

The Social Care Institute for Excellence has published guidance on accessing the CoP which is available on its website.[11] It covers the issues of when to apply, who should apply, how to apply, the court's response to applications, and preparing for and attending a hearing.

Informing P

Once the application form has been issued the applicant, the social services department must provide Henry with the information shown in Box 7.2 in a way that is appropriate to his circumstances (using simple language, visual aids, or other means).[12]

Box 7.2 Informing P about an application to the Court of Protection.

- that an application relating to P has been issued
- who the applicant is
- that the application raised the question of whether P lacks capacity in relation to the matter or matters
- what will happen if the court makes any order or direction that has been applied for
- that P may seek advice and assistance, and
- where the application contains a proposal for an appointment of a person to make decisions on P's behalf in relation to the matter or matters to which the application relates, who that person is (if different from the applicant).

Box 7.3 Notice of the application form.

In addition to P, and any person named as a respondent in the application, the notice must be given to:

- if P is under 18 years, his parent or guardian or a person with parental responsibility
- any person who has authority to act as an attorney or deputy in relation to a matter to which the application relates
- relatives of P (but where the applicant is a relative of P this need only be sent to those relatives who have the same or nearer degree of relationship to P than the applicant)
- any other person that the applicant reasonably considers has an interest in matters relating to P's best interest.

In Scenario 7.1 Henry must be provided with this information personally (Rule 46(2)) and it must be accompanied by a form for acknowledging service (Rule 47). (There is easy access to the CoP Rules by website.[13])

The social services department is also required under Rule 70 to serve a copy of the form on any person who is named as a respondent in the application, unless they have already been served with the form under another rule. Other persons specified in the practice direction must be notified of the application. These are listed in Box 7.3.

Any person served with the notice of the application must file an acknowledgement of service within 21 days,

Box 7.4 Dispensing with a hearing (Rule 84(3)). Factors to be considered.

- the nature of the proceedings and the order sought
- whether the order sought is, or is likely to be, opposed by a person who appears to the court to have an interest in matters relating to P's best interests
- whether the case is likely to involve a substantial dispute of fact
- the complexity of facts and laws
- any wider public interest in the proceedings
- the circumstances of P and of any party with an interest
- any other matter specified in the relevant practice direction.
- whether the parties agree that the court should dispose of the application without a hearing

beginning with the date on which the document is served (Rule 72(2)). If that person opposes the application or seeks a different order, then his acknowledgement of service must be accompanied by written evidence on which the person intends to rely. Where P is notified under Rule 42 or one of the persons listed in Box 7.3 opposes the application or seeks a different order, the acknowledgement of service would be accompanied by an application for joinder as a party (Rule 75).

Failure by any of the persons, who have been served notice, to file an acknowledgement of service within the time limit means that they are bound by any order made or directions given as if he or she was a party to the proceedings.

Consideration of applications

Once the time allowed for the filing of an acknowledgment of service has passed, a court officer will give notice of the date on which the application is to be considered by the court. The notice will be given to P, each person who has filed an acknowledgment of service, and any other person the court may direct.

Dispensing with a hearing

The court may deal with an application without a hearing if the parties agree that the court should dispose of the application without a hearing or if the

court does not consider that a hearing would be appropriate. The court would have regard to the factors listed in Box 7.4 in deciding whether a hearing was necessary.

Would a hearing be likely in Henry's situation in Scenarios 7.1 and 7.2?

Let us assume that the social services department has requested an order declaring that Henry lacks the mental capacity to make his own decision on accommodation and that it requires him to be discharged from hospital and transferred to a named care home.

It could be assumed that the IMCA (if one has been appointed) will have assisted Henry in returning an acknowledgement of service together with a joinder notice. Henry's wife and possibly the two children should have received notice under Rule 70 as relatives of Henry, and they could have responded with an acknowledgment of service together with a joinder notice.

The court will be faced with disputed evidence over whether Henry lacks capacity and to which accommodation Henry is discharged. While the issues appear simple, the court may propose to hold a hearing because of the substantial dispute over the facts and the fact that an order is required as to whether Henry has the requisite mental capacity.

Private or public hearing

Once the court decides that a hearing is necessary and the decision cannot be made on the basis of the written information submitted, then the general rule is that the hearing should be in private (Rule 90(1)).

Rule 90(2) states that a private hearing is a hearing which only the following persons are entitled to attend:

- The parties
- P (whether or not a party)
- Any person acting as a litigation friend
- Any legal representative of a person specified above
- Any court officer

Rule 91 gives the court general powers to authorize publication of information about proceedings and impose restrictions in identifying parties, and under Rule 92 the court has the power to make an order that a hearing be held in public. Rule 93 requires that an order under Rules 90, 91, and 92 may be made only where it appears to the court that there is a good reason for making the order. A good reason includes the public interest in holding public authorities accountable for the actions of their employees.[14]

Practice Direction 13A covers hearings in the court and reporting restriction orders.

In the case of *SCC* v. *JM and others*,[15] the CoP judge HHJ Cardinal sentenced to 5 months' imprisonment (to be served concurrently with a previous 5 months' sentence) a person who was held in contempt of court by breaching orders made by the court including Rule 90/91 in identifying P publicly.

P and attendance at court

Henry should be able to attend at court and be heard on the question of whether an order should be made (whether or not he is a party to the proceedings). However the court can proceed with a hearing in his absence unless it considers that it would be inappropriate to do so. The CoP judge may also visit P as took place in the case of *Re M* [2013].[16] The European Court of Human Rights has stated that decisions which were made without seeing or hearing the applicant were unreasonable and in breach of the adversarial principles enshrined in Article 6.[17]

The CoP rules govern the extent to which publication of the CoP proceedings are restricted.

In the case of a *Healthcare NHS Trust* v. *P and Q* [2015] EWCOP 15, the issue was what information could be provided to the press in a public medical treatment case where an application for a reporting restriction order is sought but has not yet been granted (see Rule 91). In the case of *JX MX* v. *Dartford and Gravesham NHS Trust* [2015] EWCA 96, the Court of Appeal set out the procedures to be followed in relation to determining the publication of the proceedings. The trial court had in approving a settlement for a child in a clinical negligence case directed that the child's address should not be disclosed but refused to make an order preventing publication of the child's name. The claimant appealed through the litigation friend. The Court of Appeal held that in determining the competing article 8 and article 10 rights, the trial judge had set the bar too high in requiring the child's family to provide evidence of specific risks of tangible harm to the child. The principle that proceedings would be held in public (or with press access) with anonymization of the orders may become the norm in CoP cases (according to 39 Essex Chambers).

Permission to apply

Procedure for applications to the CoP (S.50)

No permission is required for an application to the court for the exercise of any of its powers under the MCA by:

- a person who lacks, or is alleged to lack, capacity
- if such a person has not reached 18, by anyone with parental responsibility for him (parental responsibility has the same meaning as in the Children Act 1989; see Chapter 12)
- by the donor or a donee of a lasting power of attorney to which the application relates
- by a deputy appointed by the court for a person to whom the application relates, or
- by a person named in an existing order of the court, if the application relates to the order.

The Mental Health Act 2007 has added a new Subsection 1A to Section 50 so that no permission is required for an application to the court under Section 21A by the relevant person's representative. Section 21A is considered in Chapter 14.

Others not listed above will need to obtain permission to apply to the CoP (see Scenario 7.2) subject to the CoP Rules (see following text) and declarations relating to private international law (see "Permission to apply to the CoP" and Chapter 3).

Rule 51 sets out the circumstances where, in addition to those listed above under Section 50(1), permission is not required. They include a situation where the application relates to property and affairs of a person who lacks capacity. The reasoning behind this exception is that most cases dealt with by the present CoP are undisputed finance cases, where a quick decision is needed to ensure the financial security and well-being of a person who is losing capacity. Such cases include a situation where a third party such as a bank, building society, or pension fund cannot accept a receipt or signature from anyone other than the person who lacks capacity. The commentary on the draft rules suggested that to require a permission stage to access the CoP would add unnecessary delay and complexity.[18]

On the facts of Scenario 7.1, how would the action be commenced? The situation is illustrated in Scenario 7.2.

Scenario 7.2 Making an application.

Social services under pressure to arrange for Henry's discharge to alternative accommodation were prepared to apply to the Court of Protection but sought advice on how the application was to be made and what action was required of it.

Social services must comply with the preaction protocol and make every effort to resolve the issue before it comes to court. Before it made its application to the court, social services would have to ensure that all reasonable practicable steps had been taken to secure the agreement of the parties in the dispute. Only if these steps had been taken and failed would social services be justified in seeking for permission to apply to the court. This is explained on page 115.

Private international law

An interested person may apply to the court for a declaration as to whether a protective measure taken under the law of a country other than England and Wales is to be recognised in England and Wales, and no permission is required for an application to the court under this paragraph (Schedule 3, Para 20(2)).

Permission to apply to the CoP

In considering whether permission for a person to apply is to be granted, the CoP must have regard to:

- the applicant's connection with the person to whom the application relates
- the reasons for the application
- the benefit to the person to whom the application relates of a proposed order or direction, and
- whether the benefit can be achieved in any other way.

The Explanatory Memorandum suggests that the factors to which the court must have regard are designed to ensure that any proposed application will promote the interests of the person concerned, rather than causing unnecessary distress or difficulty for him.

CoP Rules (S.51)

These can be made by the Lord Chancellor in relation to the practice and procedure of the court and can cover the areas listed in Section 51(2). These include the areas shown in Statute Box 7.3.

Rules were finalized and approved for implementation on October 1, 2007.[19] Amendments were made which came into force on December 12, 2011,[20] which enable a court officer to be authorized to exercise the jurisdiction of the court in specified circumstances but not to hold a hearing.

Statute Box 7.3 Practice and procedure issues covered by the Court of Protection Rules.

- The manner and form in which proceedings are to be commenced
- The persons entitled to be notified of, and to be made parties to, the proceedings
- The allocation of any proceedings to a specified judge
- The exercise of the jurisdiction of the court by its officers or other staff
- To enable the court to appoint a suitable person to act in the name of or represent the person to whom the proceedings relate
- To enable an application to the court to be disposed of without a hearing
- To enable the court to proceed with a hearing in the absence of the person to whom they relate
- To enable proceedings or any part of them to be conducted in private, who should be admitted and who excluded
- What may be received as evidence and the manner in which it is to be presented
- The enforcement of orders made and direction given in the proceedings

In July 2015 amendment rules[21] relating to the CoP came into force. A new rule (3A) requires the CoP to consider, either on its own initiative or on the application of any person, whether it should make one or more of several directions relating to P's participations. These include P being a party, P's participation being secured by the appointment of a representative as to P's wishes and feelings, and specific provision for P to address (directly or indirectly) the judge determining the application.

The rules may make different provisions for different geographical areas (S.51(4)).

The rules can be accessed at the Ministry of Justice, Public Guardianship, Legislation, or The Stationery Office websites.

CoP practice directions (S.52)

The President of the CoP with the agreement of the Lord Chancellor may give directions as to the practice and procedure of the court.

The Explanatory Memorandum makes it clear that these are directions about a court's practices and procedures issued for the assistance and guidance of litigants. They often support and add detail to the Rules of Court. Practice directions for the CoP will have to be made by the President with the approval of the Lord Chancellor or by another person (e.g., the Vice-President) with the approval of the President and the Lord Chancellor.

Section 52(3) enables the President of the CoP to give directions which contain guidance as to the law or making judicial decisions without the concurrence of the Lord Chancellor. Section 51(3) of the MCA states that "the rules may, instead of providing for any matter, refer to provision made or to be made about that matter by the directions" made under Section 52. The intention was to make rules accompanied by practice directions on the model of the Civil Procedure Rules 1998.[22]

New practice directions supplementing the CoP Rules came into force on April 6, 2015, covering 3A (Authorized court officers), 3B (Levels of judiciary), 11A (Human rights), 12A (Court's jurisdiction to be exercised by certain judges), 20A (Appeals), and 30B (Allocation of appeals).

Rights of appeal (S.53)

An appeal from any decision of the CoP lies to the Court of Appeal, but the CoP Rules Part 20 enable appeals against decisions made by specified judges to be made to a higher judge of the CoP. An appeal from a decision of a District Judge is heard by a Circuit Judge, and an appeal from the decision of a Circuit Judge is heard by a High Court Judge. An appeal from the decision of a High Court Judge would be heard by the Court of Appeal. The CoP Rules provide that an appeal against the decision of the CoP should not be made without permission and set out in Rule 172 which is able to grant permission to appeal. Rule 173 sets out the matters that the court will take into account when considering an application for permission to appeal. Rules 174–182 govern the process by which and time limits within which applications in respect of an appeal against a decision of the court must be made.

Under Section 53(4) no appeal may be made to the Court of Appeal from the decision of a judge hearing an appeal, unless the Court of Appeal considers that:

- the appeal would raise an important point of principle or practice, or
- there is some other compelling reason for the Court of Appeal to hear it.

This matches the *2nd appeal* test in the Civil Procedure Rules 1998, Rule 52.13.

Award of damages

The CoP has the power to award damages for deprivation of liberty. Section 47(1) of the MCA gives the CoP the same powers, rights, privileges, and authority as the High Court. In the case of *London Borough of Hillingdon* v. *Neary* [2011],[23] £35 000 was awarded in respect of 12 months' detention, and in a *Local Authority* v. *Mr and Mrs D* [2013],[24] £15 000 plus costs was awarded in respect of 4 months' unlawful detention of Mrs D and £12 500 and costs to the husband. In the case of *Essex County Council* v. *RF and Others* [2015],[25] (Case Study 7.5 on page 116) P—a man of 91 years—was unlawfully removed from his home and placed in a locked dementia unit. The LA agreed that he had been unlawfully deprived of his liberty for 13 months and agreed a settlement of £60 000 damages. In that case District Judge Mort gave guidance on how damages should be assessed in loss of liberty cases.

Fees and costs

The CoP Fees Order[26] sets the fees to be charged. The fee for an application to the CoP is £400; a hearing fee, £500; an appeal fee, £400; and a copy of a document fee, £5. There are exemptions from payment of those in receipt of specified benefits such as income support. A practice direction issued on May 15, 2014, sets out the fixed costs in the CoP and can be downloaded.[27] Fees for the Public Guardian were set by a Statutory Instrument.[28] These include applying for registering an LPA and are considered in Chapter 6.

Who pays the fees?

The general rule set out in Rule 156 of CoP Rules[29] is that in proceedings relating to P's property and affairs, the fees shall be paid by P or charged to his estate. In contrast in matters relating to personal welfare, Rule 157 sets out the general rule that there will be no order as to the costs of the proceedings relating to personal welfare. Where proceedings relate to both property and affairs and personal welfare, there will be an apportionment of costs insofar as practicable (Rule 158). However under Rule 159 the court may depart from these principles if the circumstances so justify, taking into account the conduct of the parties, whether a party has succeeded on part of his case and the role of any public body involved. Conduct of the parties is defined in Rule 159 (2). Rule 9 of the CoP Fees Order enables the Lord Chancellor to reduce or remit the fees payable where exceptional circumstances would involve undue hardship. In the case of the *Public Guardian* v. *CT and EY* [2014][30] refused a claim that the OPG should pay the costs of EY the daughter and attorney of CT (who was found to have intermittent mental capacity) and ordered that she should bear her own costs and not recover them from CT's estate.

The underlying principle accepted by the Department for Constitutional Affairs (DCA), which was not subject to the consultation, was that, for the first year of operation, the CoP and the OPG fees will be set at a level to recover approximately 80% of the costs of the two organizations. Fee exemptions and fee remissions will ensure that access to justice is protected for those unable to pay.

Rules laid down in Sections 54, 55, and 56 relate to the prescribing of fees and the awarding of costs by the CoP. The DCA (now the Ministry of Justice) published a second public consultation, this time on fees for the CoP and the OPG on September 6, 2006. The consultation closed on November 29, 2006. The fees were set out in SI. 2007 No 1745 and updated in 2009 and 2013.[31]

The Joint Committee was concerned about the issue of costs in relation to accessibility and recommended that costs should not act as a disincentive. It stated that:

> We seek assurances that public funds will be made available to ensure that the Court of Protection is sufficiently accessible for those with limited assets. Furthermore, we seek clarification as to the types of cases for which legal aid will be provided to mentally incapacitated applicants and alternative remedies for those cases which will not qualify.

An example of the application of Rule 157 that there is no order for costs in welfare proceedings is that of an unreported case, *Re KS* 2010.[32] In this case welfare proceedings were issued by a private carer who made allegations of abuse against P's family. The carer applied to be made a welfare deputy. The Official Solicitor (OS) instructed for P and the local authority became involved and the carer subsequently withdrew from the case. Subsequently the carer sought payment of his costs since he had blown the whistle about the abuse of P. The court held it had made no findings of fact, and it was therefore impossible for the carer to claim. He had withdrawn from the case before any such decision had been made. The case illustrates the general rule that no order or costs will be made in welfare applications. 39 Essex Chambers commented that the lesson from case is that third parties must be sure of their grounds and see the

case through to its conclusion if they have any realistic chance of recovering costs. A better course would have been to inform the OS about any abuse and request the OS to issue proceedings.

In the case of *JS* v. *KB and MP* (Property and Affairs Deputy) [2014],[33] the daughter and son-in-law had misappropriated funds of DB which led to a dispute over the payment of costs. It was held that the daughter should pay for 4/5 of the costs of litigation. MP—a solicitor appointed as panel deputy—was given permission to seek to obtain the costs from JS by an equity release scheme.

Application to the CoP

The Rules of the CoP govern the way in which applications can be made to the CoP and the procedure which must be followed. The Rules of the CoP require the applicant to bring proceedings by filing an application of notice and to comply with the preaction protocols. The preaction protocols specify:

a) The action which must be taken prior to an application being made to the court
b) Any procedures that must be followed
c) Time periods within which any actions must be taken or any procedures must be followed
d) The need to encourage cooperation between the parties
e) The promotion of an early exchange of information
f) The need to encourage the parties to settle any dispute, otherwise than by proceedings in a court
g) The need to support the efficient management of the court's proceedings

(Scenario 7.2 illustrates a potential situation. See page 112.)

Preaction protocol

Parties must comply with the preaction protocol and ensure that every reasonable action is taken to resolve the dispute prior to the application to the court being made. Failure to comply with this requirement could lead to costs being awarded against the party. The preaction protocol covers the action which must be taken prior to making an application to the court, the procedures which must be followed, encouragement to the parties to cooperate, promotion of the early exchange of information, and encouragement for the parties to settle any dispute without proceedings in court (Rule 9 applies the Civil Procedure Rules).

Overriding objective of the CoP

The CoP Rule 3 states that the overriding objective of the Rules of Court is to enable the court to deal with cases justly, having regard to principles contained in the Act. The CoP is required to give effect to the overriding objective in its exercise of any power under the MCA or the rules and its interpretation of any rule or provision of the MCA. Dealing with any case justly includes ensuring that it is dealt with expeditiously and fairly, dealing with the case in ways which are proportionate to the nature, importance, and complexity of the issues. It must also ensure that the parties are on an equal footing (see Rule 3(3)(d)). Rule 5 requires the court to actively manage the cases, and Rule 5(2) lists the many ways in which the court should be involved in active management.

Attempting a reconciliation

The preaction protocol and the Rules of Court require the parties to attempt to resolve the dispute prior to a court hearing. The CoP as part of its duty of actively managing cases must encourage the parties to use an alternative dispute resolution procedure if the court considers that to be appropriate, and it must facilitate the use of such procedure. It must also help the parties settle the whole or part of the case.

Decisions which can only be made by the CoP

There are certain kinds of serious decisions relating to medical treatment which have under common law been referred to the courts for a declaration as to their validity, and these cases are now referred to the CoP. They include the following:

- decisions about the proposed withholding or withdrawal of artificial nutrition and hydration (ANH) from patients in a permanent vegetative state (PVS)
- cases involving organ or bone marrow donation by a person who lacks capacity to consent
- cases involving the proposed non-therapeutic sterilisation of a person who lacks capacity to consent to this (e.g. for contraceptive purposes)
- all other cases where there is a doubt or dispute about whether a particular treatment will be in a person's best interests.
- termination of pregnancy in certain cases[34]
- any other cases where there are disputes and concerns over whether proposed treatment is in the best interests of the person lacking the requisite capacity.[35]

Case Study 7.2 *LG* v. *DK* [2011].

In *LG* v. *DK* [2011][36] the court had to decide what action the court could or should take if a person lacked capacity to decide to consent to a test to determine whether they are another's parent. The facts of the case were that it appeared that an 84-year-old man with dementia who had a professional deputy to manage his affairs may have had a daughter BJ. There was evidence that he had earlier refused to give a DNA sample. The court held that the powers of the CoP to order a test derived not from S 15–16 of MCA but from S 20–21 of Family Law Act 1986, but the court would approach the question from what was in P's best interests. The decision on whether to authorize taking of a DNA sample was reserved for a future occasion when a statutory will was to be considered.

In Case Study 7.2 the CoP had to determine whether a DNA test could be ordered under the powers given by Section 16 or under the Family Law Act 1986.

Powers of CoP and the Deprivation of Liberty Safeguards

As a consequence of the amendments to the MCA introduced to remedy the defects identified by the European Court of Human Rights in the Bournewood case, that is, the Deprivation of Liberty Safeguards (DOLs), a new 16A and S21A were contained in the Mental Health Act 2007, defining the powers of the CoP in relation to the new Schedule A1 and powers to restrict the liberty of persons in specified circumstances. They are considered in Chapter 14 on the deprivation of liberty safeguards and shown in Statute Box 14.4.

Enforcement of decisions

The following case studies illustrate the power of the CoP to ensure its orders are implemented by backing an order relating to contact by a penal notice and injunctions.

Court-appointed deputy

The CoP can make a single order or appoint a deputy in relation to a matter within its jurisdiction. Section 16 makes provisions for the CoP to make decisions and for the appointment of deputies (see Statute Box 7.1).

Case Study 7.6 on page 117 is an example of appointment of a deputy.

Case Study 7.3 *A County Council* v. *E & others* [2012] [37]

E and K suffered from fragile X syndrome with associated learning disabilities. They were moved to a care home, and contact with their mother SB was limited to prearranged supervised contact in a public place. JB was the stepfather. JB was imprisoned for dangerous driving (his vehicle had collided with the contact supervisor who was carried on the bonnet for some distance). Both SB and JB were found to be in breach of contract of earlier orders and injunctions, and a penal notice and injunctions were ordered.

Case Study 7.4 *London Borough of Redbridge* v. *G and others No 4* [2014].[38]

In this case Judge Russell considered the powers of the court in relation to a lasting power of attorney and an order requiring people to leave a house. She considered that the CoP could order a carer and her husband to leave the house (see Chapter 6, Case Study 6.2 and the powers of an attorney).

Case Study 7.5 *Essex County Council* v. *RF and others* [2015].

This case illustrates the powers of enforcement of the Court of Protection.[39] The CoP criticized Essex County Council which admitted breaches of P's article 5 rights to liberty and security and Article 8 rights to respect for private and family life. They had moved P from his home to a locked dementia unit of a residential care home against his wishes. The Council had failed to ensure that he was represented and that his detention was regularly reviewed. Assessments showed that he had the capacity to make decisions about his residence and that it was in his best interests to return home, yet the Council failed to act. Judge Paul Mort awarded P compensation of £60 000 and waived the 17-month care home fees of £25 000.

Another case where consideration was given to the factors to be taken into account when appointing a deputy was that of Case Study 7.7.

Crucial test for appointment of deputy is S 16 (see Statute Box 7.1).

Case Study 7.6 *Re EU* [2014][40] EWCOP 21.

In this case Senior Judge Lush set out the principles to apply in deciding who to appoint as a deputy. Usually a family member would be appointed because of respect for the relationship and article 8 rights, and a family member was more likely to be familiar with P's affairs and aware of his wishes and feelings. A family member is more likely to be in a better position to meet the obligations of a deputy to consult with P and to permit and encourage P to participate as fully as possible in any act or decision affecting P. Also because professionals charge for services, appointment of a relative or friend is preferred for reasons of economy. However there were circumstances where the court would never contemplate appointing a family member as deputy. Examples were given by the same judge in *Re GW London Borough of Haringey* v. *CM* [2014].[41] Senior Judge Lush listed the advantages of appointing an LA to act as deputy:

a) considerable hands-on experience in dealing with property and financial affairs of adults who lack capacity to manage their own affairs;
b) more rigorous checks and balances against financial misconduct and other forms of abuse than are possible in cases where a lay deputy is appointed
c) membership of a professional association the Association of Public Authority Deputies (APAD), which provides guidance on professional ethics and best practice
d) a greater awareness of: the MCA; principles of section 1; requirement to assess capacity to make a particular decision at a particular time; criteria and procedure for making best interests decision; contents of MCA code of practice, especially those relevant to a deputy and the on-going case law.

Case Study 7.7 *Re BM, JB* v. *AG* [2014].[42]

Senior Judge Lush laid down the principles relating to who should be appointed deputy and identified situations when the courts would not appoint a family member. In this case the judge had to choose between a person from 2 different support groups: church on one hand and family, friends, and neighbors on the other hand. He chose from latter. The decision was also influenced by the fact that when P was competent, he chose AG to be his executor.

Contested applications for appointment of deputy

In Case Study 7.10 case there was a dispute between P's wife and his colleagues over whom should be appointed deputy.

Case Study 7.8 *Re RGS No 2* [2013].[43]

In this case the court appointed the council to act as deputy to manage RGS's affairs because the son RBS had been found to use his father's assets to his own advantage. In an earlier hearing it was held that RGS did not have the capacity to conduct proceedings and the court appointed a litigation friend to act on his behalf. In this second hearing it was held that if it was in RGS's best interest to reside in a care home, then it was in his best interests for a painting to be sold to meet costs. RBS had opposed the sale.

Case Study 7.9 *SBC* v. *PBA* [2011].[44]

In this case the judge stated that the unvarnished words of S 16 (see Statute Box 7.1) set down the test for the appointment of a deputy and the Code of Practice did not compel the CoP to be satisfied that the circumstances were difficult or unusual before a deputy could be appointed.

Case Study 7.10 *Re M, N* v. *O and P* [January 28, 2013].[45]

There was an application by M's work colleagues to be appointed deputy for property and financial affairs in circumstances where it was anticipated that M's health would improve and he would regain capacity. His wife opposed the application and put herself forward as deputy. SJ Lush looked at earlier authorities and felt that they set out an order of preference in which P's relatives were preferred over strangers such as professional advisers or statutory bodies.

He applied the balance sheet approach to the competing potential deputies and concluded that M's colleagues should be appointed. Factors the court considered were ability to act; willingness to act; qualifications; place of residence; security; conduct before and during the proceedings; nature of relationship with M; M's wishes and feelings; views of others; effect of hostility conflicts of interest; remuneration; and terms of M's will. Factors of magnetic importance were his past wishes and feelings and the unanimous views of others who are particularly close to him as to what would be in his best interests.

See also the case of *Re P* [2010][46] where Hedley J gave guidance on the appointment of deputies. The court should be sympathetic to the family requests for appointment of deputies provided they are not embroiled in disputes.

Case Study 7.11 *Suffolk County Council* v. *JU and another* [2014] EWCOP 21.

The son of EU who had little contact with his father claimed that he would be a more appropriate deputy than Suffolk County Council. Senior Judge Lush held that there were distinct advantages in having a local authority as a deputy and that it was in EU's best interests for him to remain in Suffolk with Suffolk County Council appointed as deputy for his property and affairs.

Guidance for deputies appointed by the court

A code provided for the guidance of deputies appointed by the court (S.42(1(d))) may contain separate guidance for deputies appointed by virtue of Para 1(2) of Schedule 5 (Functions of deputy conferred on receiver appointed under the Mental Health Act (S.42(6))), and guidance is included in Chapter 8 of the Code of Practice for the MCA. The OPG publishes an annual report and fees forms and guidance for anyone appointed as a deputy together with eight guidance leaflets which are available from the government website.[47]

Single order or appointment of deputy?

The Joint Committees of the Houses of Parliament[48] were concerned to ensure that further guidance should be provided to assist the CoP in deciding when a single order is more appropriate than the appointment of a deputy.

Section 16(4) (see Statute Box 7.1) therefore provides that when deciding whether it is in P's best interests to appoint a deputy, the court must have regard (in addition to following the principles in Section 1 and the best interests of P as defined in Section 4) to the principles that:

- a decision by the court is to be preferred to the appointment of a deputy to make a decision, and
- the powers conferred on a deputy should be as limited in scope and duration as is reasonably practicable in the circumstances.

The court has the power to make further orders or give directions and confer on a deputy such powers as it thinks necessary or expedient for giving effect to an order or appointment made by it. This power may prevent repeated applications to the CoP itself, enabling the deputy to deal with questions as they arise. Scenario 7.3 illustrates the appointment of a deputy.

Scenario 7.3 The appointment of a deputy.

Ralph was severely injured in a road accident. After many months in hospital he was discharged home but required 24-h nursing care. Under a compensation settlement agreed with the court, he received £2 million which was in trust to be administered on his behalf. A dispute arose between the trustees, which included Ralph's father and one brother, as to whether some of these funds should be used to build a new property or whether an extension on his parents' existing home should be built for him. He has two older brothers who are opposed to the idea of an extension, since they consider that their share in the parental home would be forfeited were Ralph to have an extension there, and they consider that Ralph should have his own accommodation. Ralph himself had serious head injuries and appears unable to understand information given to him or to communicate. In addition ongoing decisions relating to Ralph's contact with an uncle whom the father and brothers consider has an upsetting effect upon Ralph and decisions relating to the treatment which Ralph should be receiving in the future need to be made.

The CoP determined that Ralph lacked capacity and decided to appoint a family friend (Bob) as deputy for Ralph. Bob, since he did not seem to be involved in the family dispute, could be trusted to act in Ralph's best interests, and such an appointment was acceptable to him.

Bob must consent to the appointment and be at least 18 years.

Bob could make the following decisions:

- He could decide where Ralph is to live.
- He could specify how much contact Ralph's uncle is to have with Ralph, but he would not be able to prohibit the uncle having any contact at all.
- He could agree the treatment regime which Ralph is to have with the general practitioner and visiting nurses, but he could not refuse consent to the carrying out or continuation of life-sustaining treatment.
- He must make all these decisions in the best interests of Ralph and follow the principles set down in Section 1 of the MCA.
- He cannot carry out an act which is intended to restrain Ralph unless:
  - **a)** He is acting within the scope of an authority expressly given him by the Court of Protection.
  - **b)** He believes Ralph to lack mental capacity to make these decisions.

c) He believes it necessary to do the act in order to prevent harm to Ralph.

d) The act is a proportionate response to the likelihood of Ralph's suffering harm and the seriousness of that harm and (or[49]).

- He will be treated as Ralph's agent in relation to anything done or decided by him within the scope of his appointment.
- He will be entitled to be reimbursed out of Ralph's property for his reasonable expenses in discharging these functions.
- He will be entitled to remuneration out of Ralph's property for his work if the CoP had made the appropriate direction when he was appointed.
- He may be required to give a security to the Public Guardian, as directed by the court, for the due discharge of his functions.
- He may be required by the CoP to submit such reports to the Public Guardian at such times or at such intervals as directed by the court.

Control of a deputy by the CoP

The court may vary or discharge an order made previously. Section 16(8) states:

> The court may revoke the appointment of a deputy or vary the powers conferred upon him if it is satisfied that the deputy
> **a)** has behaved, or is behaving, in such a way that contravenes the authority conferred on him by the court or is not in P's best interests, or
> **b)** proposes to behave in a way that would contravene that authority or would not be in P's best interests.

The removal of deputy was considered in Case Study 7.12.

Case Study 7.12 *Re Rodman* [2012].[50]

There was an application for the removal of the property and affairs deputy appointed on behalf of Mrs R, a lady suffering from Alzheimer's disease. Mrs R was then living in Nevada. The court looked at jurisdictional issues and also at reasons for removing a deputy, who was a solicitor, under S.16(7). It dismissed the application holding that the decision to replace the deputy must be taken in the best interests of the wife and that was not the case here. The solicitor was more qualified than the guardian; the appointment of a new deputy would be costly in terms of time and money, and while the solicitor's fees were high, they were not manifestly excessive.

Supervision of a deputy

Scenario 7.4 illustrates the supervision of a deputy by the CoP.

Scenario 7.4 Supervision of a deputy.

Jack was appointed by the Court of Protection as a deputy with responsibilities for the property and affairs of his brother, Amos, who had been injured at birth as the result of negligence by the midwife. He had received compensation from the NHS trust, and Jack had specific powers to take financial decisions in the best interests of Amos.

Mandy, the sister of Jack and Amos, suspected that Jack was not acting in Amos's best interests, but was funding his own family from Amos's money. She wished to challenge his actions.

The first step Mandy should take would probably be to see if her concerns could be resolved by direct contact with Jack. Jack should have prepared accounts showing how Amos's property had been used. If these inquiries fail to meet her concerns, then she could ask the OPG to investigate whether Jack was acting appropriately. As the supervising authority for court-appointed deputies, the OPG has a responsibility to hear complaints. The Public Guardian can direct a CoP visitor to visit a deputy to investigate any matter of concern (see Scenario 7.7). If Mandy's fears prove to be based on sound evidence, then Jack could be removed as deputy. In addition a report could be made to the police that Jack is guilty of a criminal offence of theft or fraud.

In a more recent case, *Re HC* [2015] EWCOP 29, the Public Guardian failed in his application for the revocation of a deputyship which had been made in favor of P's son as a result of his failure to account properly for expenditure on P's house and payments he had made to himself and his sister for caring for P. Senior Judge Lush gave retrospective approval for the expenditure on the house and the payments to the deputy and his sister and agreed £1500 per month payment to the deputy and £100 to the sister with annual increases, noting that this was significantly less than any alternative care package for P.

Illustrative cases

An example of the principle that the deputy must act in accordance with best interests is the case of *JS* v. *KB and MP (Property and Affairs Deputy)* [2014].[51]

The deputy must not have a conflict of interest. This is illustrated in Case Study 7.13.

Case Study 7.13 *EG* v. *RS, JS and BEN PCT* [2010].[52]

This case concerned an application for costs to be paid for a solicitor EG who had unsuccessfully applied to be a health and welfare deputy of RS who was severely injured in an RTA and brain damaged. EG was the solicitor for CH, the brother-in-law of RS. There was a clear conflict of interest and she lost her application.

The principles governing the management of P's property and affairs by a deputy were considered in three separate hearings (see Case Study 7.14).

Case Study 7.14 *Re Clarke* [2012].[53]

Mr Clarke sought to discharge the property and affairs deputy appointed on behalf of his mother who had received some time previously a substantial sum of damages in compensation for injuries sustained in a road traffic accident (including brain injuries). Because of Clarke's invasions of his mother's entitlement to privacy, the court delivered its judgments in public. Clarke had used the Internet to wage a campaign against the deputy, the Office of Public Guardian, and the Court of Protection (CoP). The deputy had obtained an injunction against him to restrain him from further harassment of the deputy and the firm. Other siblings contested Clarke's application because they felt that if deputy were discharged, their mother's property would be spent by him. The only asset left to Mrs Clarke was her house in Blackpool. Peter Jackson directed that this not be sold. It was noted in the case that the CoP has no jurisdiction to make decision about who should be the appointee to receive benefits on P's behalf. This lies solely with the Department for Work and Pensions (DWP). Guidance by the DWP upon the question of appointeeship can be found on the website.[54]

Case Study 7.15 *Re JDS* [2012].[55]

The application to court concerned a gift to be made for the purpose of reducing inheritance tax to his parents by a young man who lacked capacity and had been awarded compensation for clinical negligence. The Official Solicitor opposed the application. SJ Lush used the balance sheet approach which resulted in nine factors for the gift and 14 against. He also considered if there was any factor of magnetic importance. It was important that the moneys which came from compensation were calculated on the basis that he would have funds to last his life so that "the last pound would be spent on the last day of his life." It was held that the application was not in JD's best interests.

In Case Study 7.15 there was a dispute on the use of funds from a compensation payment.

Deputy and personal welfare decisions

While Section 5 enables the carers and professionals concerned with P's welfare to make decisions on P's care and treatment and take appropriate action on behalf of P (see Chapter 5), in cases of dispute the CoP may appoint a deputy to resolve any issues on welfare and health.

Under Section 16 (see Statute Box 7.1) decisions can be made by the CoP, and the deputies can be given powers (with specified limitations) over matters of personal welfare which extend in particular to:

- deciding where P is to live (where a deputy makes a decision on this, it is subject to the restrictions on deputies—see "Restrictions upon the powers of deputies" on pages 123–5)
- deciding what contact, if any, P is to have with any specified persons (the deputy has no power to make an order prohibiting a named person from having contact with P—see "Restrictions upon the powers of deputies")
- giving or refusing consent to the carrying out or continuation of a treatment by a person providing health care for P.

A deputy cannot give a direction that a person responsible for P's healthcare should allow a different person to take over that responsibility: only the CoP has that power (see "Restrictions upon the powers of deputies").

The words *extend in particular to* indicate that this list is not exhaustive and other powers could be added to those listed. In addition the list does not mean that these kinds of decisions have to be made by the CoP or by deputies. They could, and generally will, be made by carers or professionals involved in the welfare of P.

Case Study 7.16 *London Borough of Havering* v. *LD* [2010].[56]

In this case the court gave guidance on the appointment of a welfare deputy. The court accepted the submissions of the Official Solicitor that a welfare deputy would be appointed only in extreme circumstances and mere convenience to a LA was not relevant. On the facts of the case the matters which it was proposed a welfare deputy could be dealt with either under S5 or were serious and would require the court's involvement.

In general the CoP prefers to allow carers to make day-to-day decisions on welfare rather than appoint a deputy as can be seen in Case Study 7.16.

Deputies and property and affairs

In connection with property and affairs, Section 18 makes provision for the decisions which can be made by the court, and the powers which can be given to deputies extend in particular to the matters shown in Statute Box 7.4.

As in the list of powers in relation to personal welfare decisions (see Statute Box 7.2), the list shown in Statute Box 7.4 is not intended to be exhaustive, and other powers could be added as necessary. In addition the list does not mean that such decisions always have to go to the CoP or be made by a deputy. They can be taken by carers and professionals. However, frequently in matters concerning property and affairs, it may be necessary to have the formal authorization of the CoP or of a deputy.

> **Case Study 7.17** *Re AB.*[57]
>
> The Court of Protection (CoP) had to decide whether in providing a statutory will for a young adult who suffered a brain injury as a teenager the CoP could dispense with service upon her father. Solicitors who managed her property applied for execution of a statutory will to be authorized by the CoP on her behalf under S 18(1)(i) of MCA. Her father's whereabouts were unknown. The judge refused to dispense with the service, because of the Article 6 and 8 rights of the father and the decision over the service came under Rule 3 and the overriding objective of the CoP rules. It did not come under Principle 1(5) of the MCA, that is, best interests.

> **Statute Box 7.4** Section 18.
>
> **1** The powers of deputy under 16 as respects P's property and affairs extend in particular to:
> - **a)** the control and management of P's property
> - **b)** the sale, exchange, charging, gift or other disposition of P's property
> - **c)** the acquisition of property in P's name or on P's behalf
> - **d)** the carrying on, on P's behalf, of any profession, trade or business
> - **e)** the taking of a decision which will have the effect of dissolving a partnership of which P is a member
> - **f)** the carrying out of any contract entered into by P
> - **g)** the discharge of P's debts and of any of P's obligations, whether legally enforceable or not
> - **h)** the settlement of any of P's property, whether for P's benefit or for the benefit of others;
> - **i)** the execution for P of a will;
> - **j)** the exercise of any power (including a power to consent) vested in P whether beneficially or as trustee or otherwise;
> - **k)** the conduct of legal proceedings in P's name or on P's behalf.
>
> **2** No will may be made under subsection (1)(i) at a time when P has not reached 18.
>
> **3** The powers under section 16 as respects any other matter relating to P's property and affairs may be exercised even though P has not reached 16, if the court considers it likely that P will still lack capacity to make decisions in respect of that matter when he reaches 18.
>
> **4** Schedule 2 supplements the provisions of this section.
>
> **5** Section 16(7) (variation and discharge of court orders) is subject to paragraph 6 of Schedule 2.
>
> **6** Subsection (1) is subject to section 20 (restrictions on deputies).

Where deputies make such decisions on property and affairs, they are subject to the restrictions laid down under Section 20 (see "Restrictions upon the powers of deputies").

With the exception of the execution of a will (which cannot be made unless P is 18 years), the powers under Section 16 can be exercised, even though P has not reached 16, if the court considers that it is likely that P will still lack capacity to make decisions in respect of that matter when he or she reaches 18. Thus in the case of a young person with severe learning disabilities, a decision about his or her property and affairs can be made even though he or she is under 16 years, if it seems unlikely that he or she will have the necessary mental capacity at 18 years (see Chapter 12 on children).

However a will cannot be made for a person who has not reached 18 years (S.18 (2) and Chapter 12).

The following cases are examples where the CoP has to deal with issues relating to statutory wills.

Case Study 7.18 contrasts with the following cases.

Schedule 2

Schedule 2 provides supplementary provisions relating to property and affairs. These cover the making of a will and the effect of the execution of a will, the settlement of any property, variation of settlements, and the effects of disposing of any property.

Case Study 7.18 *NT* v. *FS and others*.[58]

A deputy applied to court for authority to execute a statutory will on behalf of F who was 74 with Alzheimer's dementia. The estimated value of his estate was £3.1 million. There was no dispute that he lacked capacity. S 18(1)(i) gave a power to execute a will, but this could not be performed by deputy S 20(3)(b). The judge listed the principles from the earlier cases which applied:

1. Overarching principle is that any decision must be made in his best interests which is an objective, not substituted judgment, test.
2. Follow structured decision making process of MCA under S 4. especially (6)–(7).
3. There was no hierarchy between best interests factors, but in specific circumstances one factor may have magnetic importance.
4. Authorities disagreed on whether there was a presumption in favour of implementing P's wishes.
5. Authorities disagreed on the extent to which P's doing the right thing was important.

Case Study 7.19 *ITW* v. *Z and M and others* [2009].[59]

Munby LJ held that the principle of P being seen to do the right thing was important since the concept of best interests survived after death including how people think of the deceased. This ruling contrasts with that in the cases of *Re G* [2011][60] and *Re J (C)* [2012][61] where it was felt that since it was a statutory will, it would be realized that it was not the deceased who has done the right thing.

Case Study 7.20 *Re D (Statutory will); VAC* v. *JAD and others* [2010].[62]

The court had to decide if the CoP should authorize a statutory will for an incapacitated person where an earlier will's validity was disputed. Judge held that the CoP should not refrain as a matter of principle, from directing the execution of a statutory will, rather than leaving her estate to be eroded by the costs of litigation after her death. It was in her best interests for the CoP to authorize the statutory will.

Appointment of deputy

Section 19 covers the provisions relating to the appointment of deputies. To be appointed as a deputy, an individual must be 18 years or over. An individual of at least 18 years or a trust corporation can be appointed as a deputy in respect of powers relating to property and affairs. The deputy must give consent to the appointment. The holder of a specified office or position may be appointed as deputy. Two or more deputies could be appointed to act jointly or jointly and severally. (*Jointly* means that they act together in making decisions and exercising the powers; *severally* means that they act as individuals separately.) Some powers could be specified to be taken by the deputies acting together, that is, jointly, and others to be taken by the deputy acting separately. The court has the power to appoint a succession of deputies in certain circumstances and for a specified period. Scenario 7.5 illustrates the choice of a deputy.

Scenario 7.5 Who should be the deputy?

Beryl has motor neuron disease and has been moved to a residential home. She is unable to speak, but carers are able to communicate with her through signs and pictures. There are many decisions relating to her care and treatment and accommodation which require determination. Social services recommend that an application should be made to the Court of Protection for a deputy to be appointed. Who is likely to be the chosen person?

The CoP would, if it decided that a deputy was the most suitable means of acting in Beryl's best interests, consider all possible persons. If Beryl has no close friend or relative who was able to act on her behalf, it is likely that it would appoint someone who is an officeholder or in a specified position, such as a director of social services or other person to be the deputy.

The deputy must be over 18 years and consent to being appointed as deputy. The Code of Practice recommends that:

> Paid care workers (for example, care home managers) should not agree to act as a deputy because of the possible conflict of interest – unless there are exceptional circumstances (for example, if the care worker is the only close relative of the person who lacks capacity). But the court can appoint someone who is an office-holder or in a specified position (for example, the Director of Adult Services of the relevant local authority). In this situation, the court will need to be satisfied that there is no conflict of interest before making such an appointment[63] (see also paragraphs 8.58–8.60 on the fiduciary duty of deputies and possible conflict of interests).

It would be possible in Scenario 7.5 for the CoP to appoint two deputies: one with the power to make care and treatment decisions and the other with responsibilities in relation to property and affairs.

The deputy as agent of P

The deputy is treated as P's agent in relation to anything done or decided by him within the scope of his appointment and in accordance with Part 1 of the MCA. This imports into the law of mental capacity the principles of agency law and the rules which apply to the agency/principal relationship in law.

Payment of deputies

Expenses and fees

The deputy is entitled to be reimbursed out of P's property for his reasonable expenses in discharging his functions, which would include costs of visiting P, phone calls, and postage. The deputy can also claim repayment of the fees which he or she has to pay to the CoP. These comprise a £400 application fee and £500 if the court decides to have a hearing. An annual supervision fee depending upon what level of supervision the deputyship needs is from £35 to £320. A new deputy pays a £100 assessment fee.

Remuneration

In addition, if the court so directs when appointing the deputy, the deputy can receive remuneration out of P's property for discharging his functions. This will usually only apply to a professional deputy.

The court can give the deputy powers to take possession or control of all or any specified part of P's property and to exercise all or any specified powers in respect of it, including such powers of investment as the court decides.

Security

A court may require a deputy "to give to the Public Guardian such security as the court thinks fit for the due discharge of his functions." This security bond is to protect the finances of P before the person can start acting as property and affairs deputy.

Reports

A court may require a deputy "to submit to the Public Guardian such reports at such times or at such intervals as the court may direct" (S.19(9)). The Regulations make further provisions in relation to security and reports.[64] Under Regulation 38 a deputy can apply to the Public Guardian (see "Right of deputy to require review of decisions made by the Public Guardian") for an extension of the time within which the report must be submitted. The report must include any information required by the court and also contain or be accompanied by information and documents reasonably required by the Public Guardian. The Public Guardian may require the deputy (or where the deputy has died, his personal representative) to submit a final report on the discharge of his functions. If the Public Guardian is dissatisfied with any aspect of the final report, he or she may apply to the court for an appropriate remedy (including the enforcement of security given by the deputy).[65]

Where the Public Guardian has concerns about the way in which the deputy is exercising his powers or any failure to exercise them or there are concerns about the conduct of the deputy, the Public Guardian may require the deputy to provide specified information or documents.[66]

Right of deputy to require review of decisions made by the Public Guardian

The deputy may require the Public Guardian to reconsider any decision he or she has made in relation to the deputy under Regulation 42 of the Regulations. He or she has 14 days beginning with the date on which the notice of the decision is given to request the reconsideration.

Restrictions upon the powers of deputies

Section 20 which places restrictions on the powers of deputies is shown in Statute Box 7.5

P must lack capacity

Under Section 20, a deputy does not have the power to make decisions on behalf of P in relation to a matter if he knows or has reasonable grounds for believing that P has capacity in relation to the matter.

The explanatory notes use the example of a person suffering from fluctuating mental capacity and state that if P recovered his capacity, then the deputy could not carry on making decisions on his behalf.

No power to prohibit a person having contact with P

Nor does the deputy have power to prohibit a named person from having contact with P. This is a power which can only be exercised by the CoP.

Statute Box 7.5 Section 20: Restrictions on deputies

1 A deputy does not have power to make a decision on behalf of P in relation to a matter if he knows or has reasonable grounds for believing that P has capacity in relation to the matter.
2 Nothing in section 16(5) or 17 permits a deputy to be given power—
  a) to prohibit a named person from having contact with P;
  b) to direct a person responsible for P's health care to allow a different person to take over that responsibility.
3 A deputy may not be given powers with respect to—
  a) the settlement of any of P's property, whether for P's benefit or for the benefit of others,
  b) the execution for P of a will, or
  c) the exercise of any power (including a power to consent) vested in P whether beneficially or as trustee or otherwise.
4 A deputy may not be given power to make a decision on behalf of P which is inconsistent with a decision made, within the scope of his authority and in accordance with this Act, by the donee of a lasting power of attorney granted by P (or, if there is more than one donee, by any of them).
5 A deputy may not refuse consent to the carrying out or continuation of life-sustaining treatment in relation to P.
6 The authority conferred on a deputy is subject to the provisions of this Act and, in particular, sections 1 (the principles) and 4 (best interests).
7 A deputy may not do an act that is intended to restrain P unless four conditions are satisfied.
8 The first condition is that, in doing the act, the deputy is acting within the scope of an authority expressly conferred on him by the court.
9 The second is that P lacks, or the deputy reasonably believes that P lacks, capacity in relation to the matter in question.
10 The third is that the deputy reasonably believes that it is necessary to do the act in order to prevent harm to P.
11 The fourth is that the act is a proportionate response to—
  a) the likelihood of P's suffering harm, or
  b) the seriousness of that harm.
12 For the purposes of this section, a deputy restrains P if he—
  a) uses, or threatens to use, force to secure the doing of an act which P resists, or
  b) restricts P's liberty of movement, whether or not P resists, or if he authorises another person to do any of those things.
13 *But a deputy does more than merely restrain P if he deprives P of his liberty* within the meaning of Article 5(1) of the Human Rights Convention (whether *or not the deputy is a public authority).* (Repealed by Mental Health Act 2007 S 50(4)(c))

No power to replace a person responsible for P's healthcare

The deputy cannot direct a person responsible for P's healthcare to allow a different person to take over that responsibility. Again this is a power which can only be exercised by the court.

Restrictions on powers in relation to property

In relation to property, the deputy cannot be given powers in respect of the settlement of any of P's property (whether for P's benefit or of others), the execution for P of a will, or the exercise of any power (including a power to consent) vested in P whether beneficially or as trustee or otherwise. These powers would be exercised by the court.

Cannot overrule a donee under an LPA

"A deputy may not be given power to make a decision on behalf of P which is inconsistent with a decision made, within the scope of his authority and in accordance with the MCA, by the donee of a lasting power of attorney granted by P (or, if there is more than one donee, by any of them)" (S.20(4)).

Thus the deputy cannot go against what has been or is being decided by the donee(s) of an lasting LPA if the donee(s) is (are) acting lawfully. If there is a dispute over the actions of a donee, then the CoP should use its powers under Sections 22 and 23 in relation to the validity and operation of LPAs rather than appoint a deputy (see Chapter 6).

No power to refuse to consent to life-sustaining treatment

"A deputy may not refuse consent to the carrying out or continuation of life-sustaining treatment in relation to P" (S.20(5)). (The words "unless the court has conferred on the deputy express authority to that effect" and "The court can only give express authority in exceptional circumstances" were contained in the Bill but omitted from the Act, so that the court cannot authorize the deputy to that effect. See discussion in Chapter 9 on advance decisions.)

The Joint Committees were strongly against giving powers to deputies to refuse life-sustaining treatment.[67]

The Joint Committees strongly urged that the provisions allowing deputies to consent to treatment be restricted to exclude the withdrawal or refusal of life-sustaining treatment. The Joint Committees considered that unless there is a valid lasting LPA or advance decision expressing the individual's wishes in relation to the subject, decisions relating to the carrying out or continuation of life-sustaining treatment should be referred to the CoP for determination.[68]

The deputy must follow Section 1, "The principles," and Section 4, "Best interests."

The deputy's authority is subject to the provisions of the MCA, in particular the principles set out in Section 1 (see Chapter 3, Section 4 and the duty to act in the best interests of P, and Chapter 5). The Joint Committee was concerned that further guidance was required for deputies as to the standard of conduct they must maintain in the operation of their duties.[69]

Restriction on deputy in exercise of restraint of P

A deputy may not do any act intended to restrain P unless the four following conditions are satisfied:

1 that in doing the act the deputy is acting within the scope of an authority expressly conferred on him by the court

2 that P lacks, or the deputy reasonably believes that P lacks, capacity in relation to the matter in question

3 that the deputy reasonably believes that it is necessary to do the act in order to prevent harm to P

4 that the act is a proportionate response to—

(a) the likelihood of P's suffering harm, and (or[70])

(b) the seriousness of that harm

The definition of restraint for the purposes of this section is if the deputy "uses, or threatens to use, force to secure the doing of an act which P resists, or restricts P's liberty of movement, whether or not P resists," or if the deputy authorizes another person to take such action.

Section 20(13) had stated that the "deputy does more than merely restrain P if he deprives P of his liberty within the meaning of Article 5(1) of the Human Rights Convention." However like comparable provisions in the MCA (e.g., Section 6(5) (treatment) and Section 11(6) (donees)), this was repealed, as a consequence of the amendments to the MCA by the Mental Health Act 2007 required by the provisions to fill the Bournewood gap, that is, the Deprivation of Liberty Safeguards (see Chapters 3, 13, and 14). An additional section to clarify the CoP's powers in relation to welfare orders has been enacted (see Section 16A Statute Box 14.4 on the Deprivation of Liberty Safeguards).

These restrictions on a deputy using restraint are the same as those imposed upon the donee of an LPA (Section 11) and upon a carer or professional acting on behalf of P (Section 5).

Duties of deputies

The Code of Practice identifies the following list as duties to be followed by the court-appointed deputy.[71] It notes that when agreeing to act as deputy, whether in relation to welfare or financial affairs, the deputy is taking on a role which carries power that he or she must use carefully and responsibly. The standard of conduct expected of deputies involves compliance with the following duties as an agent and with the statutory requirements:

- To comply with the principles of the Act
- To act in the best interests of the client
- To follow the Code of Practice
- To act within the scope of their authority given by the CoP
- To act with due care and skill (duty of care)
- Not to take advantage of their situation (fiduciary duty)
- To indemnify the person against liability to third parties caused by the deputy's negligence
- Not to delegate duties unless authorized to do so
- To act in good faith
- To respect the person's confidentiality
- To comply with the directions of the CoP

Property and affairs deputies also have a duty to:

- Keep accounts
- Keep the person's money and property separate from own finances

Guidance has been issued by the OPG on the standards to be followed by professional deputies available on the OPG website.[72] The standards cover:

1. Secure the client's finances and assets. 2. Gain insight into the client to make decisions in their best interests. 3. Maintain effective internal office processes and organization. 4. Have the skills and knowledge to carry out the duties of a deputy. 5. Health and welfare standards.

Scenario 7.6 on page 127 illustrates the appointment of a deputy for a person in a care home.

Making gifts

A case which is first discussed when a proposed gift by a deputy was reasonable is shown in Case Study 7.21.

In the case of *Newcastle City Council* v. *PV and Criminal Injuries Compensation Authority* [2015],[77] Senior Judge Lush ruled that an application to the CICA by an adult who lacks mental capacity should be made by the holder of a property and affairs EPA or LPA or a deputy or other person authorized to do so by the CoP. Where the CICA required a trust to be set up, then the CoP should set up the trust and an application be made to the CoP under S 18(1)(h) of the MCA. SJ Lush also ruled that a Peters undertaking was appropriate, or if the deputyship order is discharged, there should be a suitable restriction of the trustees' powers to ensure that double recovery does not take place.

A case on whether a deputy could be required to make payments to P's adult daughter as being in P's best interests is considered in Chapter 5 (Case Study 5.15).[78]

> **Case Study 7.21** *Re GM* [2013].[73]
>
> Two financial deputies sought approval for gifts they had made to charities and themselves, spending 44% of GM's assets. GM was 92 and had £200 000 remaining. The court held that the so-called expenses were unauthorized gifts and they were not in GM's best interests. (The purchases included cars, laptops, designer handbags, etc.) Senior Judge Lush set out when gifts were appropriate and how much should be permitted. The deputyship order permitted gifts to be made on customary occasions which is defined in Section 12(3) of the MCA as an anniversary of a birth, a marriage or civil partnership or any other occasions on which presents are customarily given. It was ruled that the reasonableness of a gift was £4500 p.a (covering the £3000 inheritance exemption and £250 for 6 other people). Moneys paid out in excess of this had to be repaid by the deputies. The principles set out by SJ Lush also apply to those acting under a lasting power of attorney. (See also *Re Buckley* [2013][74] COPLR 39 (Case Study 6.4).)

> **Case Study 7.22** Re Mark Reeves [January 5, 2010].[75]
>
> The deputy has a duty to ensure all public funding available for P is obtained. This case reinforces the OPG guidance already in place to the effect that Peter's undertakings (where deputy undertakes that she would notify the court of any application to obtain public funding) are not retrospective (decision of CA in *Peters* v. *East Midland SHA and Others* [2009][76]) to prevent double funding of P. (i.e., P compensated in damages following PI to cover care costs but then seeks public funding of care). This case reinforces duties upon deputies to ensure the maximization of P's assets by drawing upon the resources of the state where appropriate.

> **Case Study 7.23** *Re AK (Gift Application)* [2014].[79]
>
> AK who as a result of negligence at birth suffered from cerebral palsy received a settlement of over £1 million plus a series of index linked periodical payments. The deputy appointed for property and affairs applied to the court for an order gifting £150 000 to AK's parents to build a property in Pakistan suitably adapted to AK's complex needs. Senior Judge Lush agreed to an interest-free loan of £150 000 repayable at £15 000 a year, but he authorized the deputy to make annual gifts from the estate of AK of £15 000 to the parents. This arrangement was more likely to ensure that the moneys were used for the building, and it also took into account uncertainties about AK's life expectancy since the annual gifts were only payable if there were surplus funds.

P and his representation

At any stage, the court may give a direction as it sees fit for the appointment of a litigation friend to conduct proceedings on behalf of P or any other person with sufficient interest, if P or the other person lacks capacity to conduct the proceedings himself/herself. A person may act as a litigation friend if he or she can fairly and competently conduct proceedings on behalf of P and he or she has no interest adverse to that of P. The person who wishes to act as a litigation friend must file a certificate of suitability stating that he or she satisfies the above conditions and serve the certificate of suitability on any person who is P's attorney or deputy and every person who is party to the proceedings. If the person wishing to be a litigation friend is a court-appointed deputy for P, then he or she must serve a copy of the court order which appointed him (Rule 142(4)). This rule does not apply to the OS.

The court can under Rule 143 appoint the OS or some other person to act as P's litigation friend. The court has considerable powers under Rule 144 to direct that a person cannot act as a litigation friend or to terminate

Scenario 7.6 Deputy appointed for resident.

Joyce is the manager of a care home. She is a registered nurse and has considerable experience in the residential care sector. Freda is admitted to the home from her family home. Freda has suffered a severe stroke which has left her unable to speak and with limited mobility. She is unable to communicate her decisions, and the Court of Protection has appointed a deputy to take decisions on her behalf. Following her admission Freda suffers a cardiac arrest, and Joyce is uncertain what action should be taken.

the appointment or appoint a new litigation friend in substitution for an existing one.

If P regains capacity, then if a litigation friend has been appointed for him this person will continue with his appointment until it is brought to an end by order of the court (Rule 148).

Scenario 7.6 considers the situation where the manager of a home is informed that a deputy has been appointed for one of the residents.

As soon as Joyce becomes aware that a deputy has been appointed on behalf of a resident, she needs to investigate to establish the following facts:

- What powers have been given to the deputy?
- How long do these powers last?
- How can contact be made with the deputy?
- What information must be given to the deputy?
- In what circumstances must the deputy be contacted?

In Scenario 7.6 it is possible that the CoP has only given the deputy powers in relation to Freda's financial affairs and the deputy has no duties in relation to Freda's care and treatment. Nevertheless it is in the best interests of Freda that Joyce should have regular contact with the deputy, since it may be that further funding of outings and extras to the basic care Freda receives could improve her quality of life. In the circumstances of the heart attack, Joyce has a duty of care to ensure that Freda receives immediate medical attention, and an ambulance should be called. In the case of *Public Guardian* v. *Marvin* [2014][80] which is considered in Chapter 6 (Case Study 6.6), the son who had been appointed LPA for finance and welfare wrongly delegated his financial responsibilities but applied to be a deputy when the Public Guardian applied to cancel both LPAs. It was decided that the LPA for welfare could continue.

A successor deputy

It is possible for the CoP to appoint a successor to the deputy whom it appoints if the circumstances require. The Code of Practice uses the example of an elderly couple with a son with Down's syndrome who are appointed as joint deputies but are concerned what would happen when they die. In such a situation the CoP could appoint other relatives to succeed them as deputies.[81]

Office of Public Guardian

The OPG was established in October 2007 (S 57) as an executive agency of the Ministry of Justice with a remit to support and enable people to plan ahead for both their health and their finances to be looked after should they lose capacity in the future and to safeguard the interests of people who may lack the mental capacity to make certain decisions for themselves. Sections 57–60 of the MCA set out the provisions relating to the Public Guardian. The Public Guardian, paid out of moneys provided by Parliament, is appointed by the Lord Chancellor with functions specified under Section 58 of the MCA. The Lord Chancellor may provide him with (or contract for the provision of) officers and staff. The functions may be performed by any of his officers. The functions are shown in Statute Box 7.6

The Lord Chancellor may by regulations confer other functions on the Public Guardian and specify how he carries out his functions. These regulations can cover the security given by deputies appointed by the court, the fees which may be charged by the Public Guardian, how the fees are to be paid, and the making of reports.

Regulations which came into force on October 1, 2007,[82] cover the functions of the Public Guardian in establishing and maintaining the registers, applications for searches of the registers, and the disclosure of additional information held by the Public Guardian. The Regulations also cover rules relating to security for the discharge of their functions (paragraphs 33–37).

Statutory powers given to the Public Guardian include, at all reasonable times, the examination and taking of copies of:

- Any health record
- Any record held by a local authority and compiled in connection with a social services function

Statute Box 7.6 Section 58: Functions of the Public Guardian.

1 The Public Guardian has the following functions—
- **a)** establishing and maintaining a register of lasting powers of attorney,
- **b)** establishing and maintaining a register of orders appointing deputies,
- **c)** supervising deputies appointed by the court,
- **d)** directing a Court of Protection Visitor to visit—
  - **i)** a donee of a lasting power of attorney,
  - **ii)** a deputy appointed by the court, or
  - **iii)** the person granting the power of attorney or for whom the deputy is appointed ("P"), and to make a report to the Public Guardian on such matters as he may direct,
- **e)** receiving security which the court requires a person to give for the discharge of his functions,
- **f)** receiving reports from donees of lasting powers of attorney and deputies appointed by the court,
- **g)** reporting to the court on such matters relating to proceedings under this Act as the court requires,
- **h)** dealing with representations (including complaints) about the way in which a donee of a lasting power of attorney or a deputy appointed by the court is exercising his powers,
- **i)** publishing, in any manner the Public Guardian thinks appropriate, any information he thinks appropriate about the discharge of his functions.

2 The functions conferred by subsection (1)(c) and (h) may be discharged in cooperation with any other person who has functions in relation to the care or treatment of P.

3 The Lord Chancellor may by regulations make provision—
- **a)** conferring on the Public Guardian other functions in connection with this Act;
- **b)** in connection with the discharge by the Public Guardian of his functions.

4 Regulations made under subsection (3)(b) may in particular make provision as to—
- **a)** the giving of security by deputies appointed by the court and the enforcement and discharge of security so given;
- **b)** the fees which may be charged by the Public Guardian;
- **c)** the way in which, and funds from which, such fees are to be paid;
- **d)** exemptions from and reductions in such fees;
- **e)** remission of such fees in whole or in part;
- **f)** the making of reports to the Public Guardian by deputies appointed by the court and others who are directed by the court to carry out any transaction for a person who lacks capacity.

5 For the purpose of enabling him to carry out his functions, the Public Guardian may, at all reasonable times, examine and take copies of—
- **a)** any health record,
- **b)** any record of, or held by, a local authority and compiled in connection with a social services function, and
- **c)** any record held by a person registered under Part 2 of the Care Standards Act 2000 (c. 14), so far as the record relates to P.

6 The Public Guardian may also for that purpose interview P in private.

- Any record held by a person registered under Part 2 of the Care Standards Act 2000 which relates to P

The Public Guardian may interview P in private.

The Public Guardian is required under Section 60 to make an annual report to the Lord Chancellor about the discharge of his functions, and within 1 month of its receipt the Lord Chancellor must lay a copy of it before the Parliament.

The OPG has an important role to play in overseeing the registration of LPAs. This was spelt out explicitly by Mr Burstow (a Liberal MP) in the House of Commons Select Committees[83]:

> That brings me to the role of the **Office of the Public Guardian**. In future, it will become aware of the vast majority of LPAs as they are registered, but the problem with that is that registration is no indication of the power being used, because one registers ahead of loss of capacity. How can we be certain that an LPA has been triggered and is being used appropriately? Under a later group of amendments, we will deal with safeguards relating to the individual who becomes the donee, checks on donees, and so on.

The new Public Guardian (Designate) was named as Richard Brook, who joined the DCA in February 2006 as Chief Executive of the OPG. He was responsible for the new OPG when it was launched in October 2007. As the Public Guardian, he was responsible for regulating people appointed to make finance, health, and welfare decisions for those who lack capacity. He defined his role as follows:

> Working in effective partnership with the judiciary, it will be our role to ensure that appropriate supervision regimes are in place which balance the autonomy of the individual with the most appropriate protection against abuse. We are currently considering how this regime can be effective yet as unobtrusive as possible. We will also have a role in providing the public with information about mental capacity issues and sign-posting people to the most appropriate form of help and assistance.[84]

Further information about the work of the OPG and the forms used can be obtained from its website.[85] The annual report of the OPG is available on the government website.[86] The report for 2013–2014 stated that the year saw the OPG progressing toward delivering simpler, clearer, faster services for its customers and partners. The fees for registering an LPA were reduced in October 2013 from £130 to £110. It was undertaking a fundamental review of its supervision regime for court-appointed deputies. Its priorities for 2014–2015 were to understand its customers better and plan ways in measuring how well it was meeting their needs; provide more digital services and work with partner organizations to improve its service; and ensure that it can be accessed by all its users. In October 2014 it published a list of court-approved professionals who could act as panel deputies.

Public Guardian Board

The Board, established under Section 59 of the MCA, has the duty of scrutinizing and reviewing the way in which the Public Guardian discharges his functions and making such recommendations to the Lord Chancellor about that matter as it thinks appropriate. The Lord Chancellor has a statutory duty to give due consideration to recommendations made by the Board in discharging its functions in relation to the appointment and function of the Public Guardian. The Lord Chancellor appoints the members of the Board, which must consist of at least one member who is a judge of the court and at least four members who are persons appearing to the Lord Chancellor to have appropriate knowledge or experience of the work of the Public Guardian. The Lord Chancellor has the power to make regulations covering the appointment and reappointment of the members, the selection of chairman, the term of office of chairman and members, their resignation, suspension or removal, the procedure, and validation of proceedings. The Lord Chancellor also has the power to determine payments of expenses, allowances, and remuneration to the members.

"The Board must make an annual report to the Lord Chancellor about the discharge of its functions" (S.59(9)).

CoP visitors (S.61)

The Lord Chancellor can appoint a CoP visitor to a panel of Special Visitors or a panel of General Visitors. (These CoP visitors replace the current "Lord Chancellor's Visitors") (see Section 102 of the Mental Health Act 1983).

Special Visitor

To be eligible for appointment as a Special Visitor, a person must be a registered medical practitioner (or appear to the Lord Chancellor to have other suitable qualifications or training) and also appear to the Lord Chancellor to have special knowledge of and experience in cases of impairment of or disturbance in the functioning of the mind or brain.

General visitor

In contrast a General Visitor need not have a medical qualification.

In the Code of Practice guidance is given on the role of the OPG, and the following situation set out in Scenario 7.7 is provided to give an example of the role of a visitor.[87]

The following is an example of the role of a visitor.

Duties of visitors

Visitors have the duty to carry out visits and produce reports, as directed by the court (Section 49(2)) or the Public Guardian (Section 58(1)(d)) in relation to those who lack capacity. Their functions and powers are similar to those of Lord Chancellor's Visitors appointed under Part 7 of the Mental Health Act 1983.

The CoP visitor may be appointed for such term and subject to such conditions and may be paid such remuneration and allowances as the Lord Chancellor may determine.

Regulations set requirements for the notification of visits by the Public Guardian or the CoP visitors.[89]

Scenario 7.7 illustrates the appointment of a visitor.

Scenario 7.7 The appointment of a General Visitor.

Mrs Quinn made a lasting power of attorney (LPA) appointing her nephew, Ian, as her financial attorney. She recently lost capacity to make her own financial decisions, and Ian has registered the LPA. He has taken control of Mrs Quinn's financial affairs. But Mrs Quinn's niece suspects that Ian is using Mrs Quinn's money to pay off his own debts. She contacts the OPG, which sends a General Visitor to visit Mrs Quinn and Ian. The visitor's report will assess the facts. It might suggest the case go to court to consider whether Ian has behaved in a way which:

- Goes against his authority under the LPA
- Is not in Mrs Quinn's best interests

The Public Guardian will decide whether the court should be involved in the matter. The court will then decide if it requires further evidence. If it thinks that Ian is abusing his position, the court may cancel the LPA.

Case Study 7.24 *D vR (Deputy of S) and S* [2010].[88]

R, the deputy, sought declarations that gifts of money made by Mr S to a Mrs D (a legal secretary employed by his solicitors) totaling over £500 000 were procured by undue influence and should be set aside.

Henderson J had previously appointed a Special Visitor to consider whether Mr S had the capacity to decide whether the proceedings should continue or be compromised. The visitor reported that he lacked the requisite capacity. The judge Looked at Section 1(4) and he stated that the fact that decision was an unwise one did not justify a conclusion of incapacity.

Powers of visitors

The Public Guardian (see page 129) or a CoP visitor, in carrying out his functions, has the power at all reasonable times to examine and take copies of the following:

a) any health record
b) any record of, or held by, a local authority and compiled in connection with a social services function, and
c) any record held by a person registered under Part 2 of the Care Standards Act 2000,

so far as the record relates to P.

The Public Guardian or the CoP visitor may also interview P in private for the purpose of carrying out his functions.

If the CoP visitor is a Special Visitor (i.e., a registered medical practitioner or someone with other suitable qualifications or training) and is making a visit in the course of complying with a requirement to make a report, he may if the court so directs carry out in private a medical, psychiatric or psychological examination of P's capacity and condition (S.49(9)).

When would a visitor be appointed?

The Code of Practice notes that:

> Court of Protection Visitors have an important part to play in investigating possible abuse. But their role is much wider than this. They can also check on the general wellbeing of the person who lacks capacity, and they can give support to attorneys and deputies who need help to carry out their duties.[90]

The Code of Practice describes a situation where a visitor is appointed, which is discussed in Scenario 7.7.

Advocacy and the CoP

The Joint Committee was concerned that people lacking capacity might have considerable difficulties in accessing the CoP and recommended that consideration is given to the provision of independent advocacy services and other means of enabling people lacking capacity to participate as fully as possible in any hearing affecting their rights and entitlements.[91] (This is discussed in Chapter 8.)

People under 18 years

There is provision under Section 21 for the Lord Chancellor to make provision, in specified circumstances, for the transfer of proceedings relating to a person under 18, from the CoP to a court with jurisdiction under the Children Act 1989 and vice versa (S.21), and Regulations were accordingly passed.[92] See Chapter 12 for further consideration on children and the MCA.

Code of Practice

The Joint Committee considered that further guidance is required for deputies as to the standard of conduct they must maintain in the operation of their duties. They also considered that guidance should also be issued to the CoP to assist in the appointment of the most appropriate individual to act as a deputy. Paragraphs 8.31–8.71 of the Code of Practice provide guidance on the appointment of deputies by the CoP and their duties and responsibilities. The Code of Practice sets out the following analysis of the role of the Public Guardian in supervising deputies[93]:

> [Para 8.70] The OPG is responsible for supervising and supporting deputies. But it must also protect people lacking capacity from possible abuse or exploitation. Anybody who suspects that a deputy is abusing their position should contact the OPG immediately. The OPG may instruct a Court of Protection Visitor to visit a deputy to investigate any matter of concern. It can also apply to the court to cancel a deputy's appointment.
>
> The OPG will consider carefully any concerns or complaints against deputies [Para 8.71]. But if somebody suspects physical or sexual abuse or serious fraud, they should contact the police and/or social services immediately, as well as informing the OPG. Chapter 14 (of the Code of Practice) gives more information about the role of the OPG. It also discusses the protection of vulnerable people from abuse, ill treatment or wilful neglect and the responsibilities of various relevant agencies.

CoP and LPAs

The powers of the CoP in relation to the validity and operation of LPAs are set out in Sections 22 and 23 and are considered in Chapter 6.

Official Solicitor

The Official Solicitor and Public Trustee works within the Ministry of Justice. The OS acts as a last resort litigation friend and in some cases solicitor for children (other than those who are the subject of child welfare proceedings) and for adults who lack mental capacity. Further information can be found on the government website.[94] In Annex 1 to the annual report for 2013–2014, the OS describes his role in preventing injustice to the vulnerable by the following business activities:

- Acting as last resort litigation friend and in some cases solicitor for adults who lack mental capacity and for children (other than those who are the subject of child welfare proceedings) in court proceedings because they lack decision-making capacity in relation to the proceedings. As litigation friend the OS *steps into the shoes* of the client who lacks mental or legal capacity to conduct the proceedings. He or she does so in relation to the conduct of the proceedings and also provides the party with the service of conducting the litigation in certain classes of cases under his power to do so conferred by the Senior Courts Act 1981. His role is to conduct the litigation on behalf of the client and in his best interests. For this purpose the litigation friend must make all the decisions that the client would have made, had he or she been able. The litigation friend is responsible to the court for the propriety and the progress of the proceedings.
- Acting as last resort administrator of estates, trustee, and property and affairs deputy in relation to CoP clients.
- Being appointed, in place of a parent, to act as the registered contact in the administration of the government Child Trust Fund scheme for looked after children in England and Wales when there is no other suitable person to do so.

Case Study 7.25 *Bradbury and others* v. *Paterson and others* [2014].[95]

This case raised the issue of what should happen when the OPG concludes that he or she can no longer continue to act as litigation friend for a protected party in civil litigation because the anticipated source of funding for the Official Solicitor's costs ceases to be available. The Medical Defence Union had withdrawn its support for the defendant (a surgeon, who was being sued for alleged negligence in a breast operation but who now lacked capacity), and the Official Solicitor then withdrew as litigation friend. At an earlier hearing McGowan agreed that the Official Solicitor could be discharged and the solicitors acting for the surgeon could be released from their duties. As a consequence the proceedings were stayed because the litigation could not proceed where P was without a litigation friend. Foskett J held that the court under its case management provisions or its inherent jurisdiction had the power to direct that one or more of the parties to the litigation should fund the Official Solicitors costs of instructing lawyers to act for P, the initial outlay to be recoverable as part of the costs of the litigation in due course.

This case shows that a litigation friend is entitled to withdraw if no funding available.

The court will attempt to ensure proceedings can continue where the litigation friend has withdrawn.

The OS cannot be compelled to act in the absence of proper funding for the costs of instructing legal representatives.

House of Lords Post-Legislative Scrutiny of the MCA 2005[96]

In 2014 the House of Lords published a review of the operation of the MCA setting out many recommendations to improve its implementation.

In relation to the CoP, the House of Lords made the following recommendations:

Recommendation 27

We recommend the Government consider increasing the staff complement of authorised officers, following consultation with the Court of Protection, to achieve a significant reduction in the time taken to deal with non-contentious property and financial affairs cases.

Recommendation 28

We also recommend that the Government consider as a matter of urgency the updating of the Rules of the Court, as recommended by the ad hoc Rules Committee and, as necessary, in light of subsequent changes.

Recommendation 29

We recommend that the Government consider enabling the Court to address the needs of its audiences either by giving it greater control of the information provided on

www.gov.uk or by enabling the Court to have a dedicated website.

Recommendation 30

We are persuaded that mediation would be beneficial in many more cases prior to initiating proceedings in the Court of Protection. We recommend that consideration be given to making mediation a prerequisite for launching proceedings, especially in cases concerning property and financial affairs where the costs fall to "P."

Recommendation 31

We recommend that the Government, and in future the independent oversight body, provide clearer guidance to public authorities regarding which disputes under the Act must be proactively referred to the Court by local authorities. This should include situations in which it is the person who is alleged to lack capacity who disagrees with the proposed course of action. Efforts must be made to disseminate this guidance to families and carers as well as to local authorities.

Recommendations relating to legal aid are considered in Chapter 17.

The government responded positively in June 2014 to these recommendations.[97]

It agreed that there would be an increase in staff for the CoP and more staff would be in post by the end of 2014. Following a review of the CoP rules, amendment rules were enacted[98] and are considered earlier.

The government's digital strategy aimed at a single government web domain, and it would work with the GDS to develop the content on the CoP. It would work to increase the use of mediation in appropriate cases. It would develop more guidance on which cases should go to the CoP as part of its general awareness raising activity.

Conclusions

The CoP and its appointed deputies, the OPG and its visitors, and the Public Guardian Board have a key role to play in ensuring that the fundamental provisions of the mental capacity legislation are implemented and that the rights of those lacking mental capacity are reasonably protected. An annual report is provided by the Public Guardian Board, and the CoP regularly updates its rules and practice directions. The House of Lords has carried out a rigorous post-legislative scrutiny of the MCA to identify weaknesses in the newly established institutions, systems, and procedures, and at the time of writing the implementation of the government's response is ongoing.

Quick fire quiz, QFQ7

1. Does the Court of Protection have power to make orders relating to young persons under 16 years?
2. Section 16(4) states that a decision of the Court of Protection is to be preferred to the appointment of a deputy. In what circumstances would this apply?
3. In what circumstances can the Court of Protection dispense with the need for a hearing?
4. Would you be permitted to attend a Court of Protection hearing even if you had no personal nor professional involvement in the case?
5. What is the overriding objective of the Rules of Court?
6. What is the role of the Office of Public Guardian in relation to a deputy?

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CHAPTER 8
Independent mental capacity advocates

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Legal Aspects of Mental Capacity: A Practical Guide for Health and Social Care Professionals, Second Edition. Bridgit Dimond.
© 2016 John Wiley & Sons, Ltd. Published 2016 by John Wiley & Sons, Ltd.

Background to the provision on independent advocates

There was considerable concern during the parliamentary debates on the bill and the discussions of the Joint Committee that adults who lacked mental capacity did not in the earlier drafts have a right of access to an independent mental capacity advocate (IMCA) or advocacy service. As a consequence of these concerns, significant provisions were made in Sections 35–41 for an Independent Mental Capacity Advocacy service. These provisions are set out in Statute Boxes 8.1, 8.2, 8.3, 8.4, 8.5, 8.6, and 8.7. The new sections (39A–39E) relating to deprivation of liberty safeguards are set out and discussed in Chapter 14 (Statute Box 14.6).

Statute Box 8.1 Section 35: Appointment of independent mental capacity advocates (as amended).

1 The appropriate authority must make such arrangements as it considers reasonable to enable persons ("independent mental capacity advocates") to be available to represent and support persons to whom acts or decisions proposed under sections 37, 38 and 39 relate.

2 The appropriate authority may make regulations as to the appointment of independent mental capacity advocates.

3 The regulations may, in particular, provide—

- **a)** that a person may act as an independent mental capacity advocate only in such circumstances, or only subject to such conditions, as may be prescribed;
- **b)** for the appointment of a person as an independent mental capacity advocate to be subject to approval in accordance with the regulations.

4 In making arrangements under subsection (1), the responsible authority must have regard to the principle that a person to whom a proposed act or decision relates should, so far as practicable, be represented and supported by a person who is independent of any person who will be responsible for the act or decision.

5 The arrangements may include provision for payments to be made to, or in relation to, persons carrying out functions in accordance with the arrangements.

6 For the purpose of enabling him to carry out his functions, an independent mental capacity advocate—

- **a)** may interview in private the person whom he has been instructed to represent, and
- **b)** may, at all reasonable times, examine and take copies of—
  - **i)** any health record,
  - **ii)** any record of, or held by, a local authority and compiled in connection with a social services function, and
  - **iii)** any record held by a person registered under Part 2 of the Care Standards Act 2000 (c. 14), or Chapter 2 of Part 1 of the Health and Social Care Act 2008 which the person holding the record considers may be relevant to the independent mental capacity advocate's investigation. In subsections (1) and (4) the responsible authority means
- **a)** in relation to the provision of the services of independent mental capacity advocates in England, that local authority and
- **b)** in relation to the provision of the services of independent mental capacity advocates in Wales, the Welsh Ministers.

6B In subsection S (6A)(a) "local authority" has the meaning given in Section 64(1) except that it does not include the council of a county or county borough in Wales.

7 In this section, section 36 and section 37, "the appropriate authority" means—

- **a)** in relation to the provision of the services of independent mental capacity advocates in England, the Secretary of State and
- **b)** in relation to the provision of the services of independent mental capacity advocates in Wales, the National Assembly of Wales.

Statute Box 8.2 Section 36: Functions of independent mental capacity advocates.

1 The appropriate authority may make regulations as to the functions of independent mental capacity advocates.

2 The regulations may, in particular, make provision requiring an advocate to take such steps as may be prescribed for the purpose of—

- **a)** providing support to the person whom he has been instructed to represent ("P") so that P may participate as fully as possible in any relevant decision;
- **b)** obtaining and evaluating relevant information;
- **c)** ascertaining what P's wishes and feelings would be likely to be, and the beliefs and values that would be likely to influence P, if he had capacity;
- **d)** ascertaining what alternative courses of action are available in relation to P;
- **e)** obtaining a further medical opinion where treatment is proposed and the advocate thinks that one should be obtained.

3 The regulations may also make provision as to circumstances in which the advocate may challenge, or provide assistance for the purpose of challenging, any relevant decision.

Statute Box 8.3 Section 37: Provision of serious medical treatment by NHS body (as amended).

1 This section applies if an NHS body—

a) is proposing to provide, or secure the provision of, serious medical treatment for a person ("P") who lacks capacity to consent to the treatment, and

b) is satisfied that there is no person, other than one engaged in providing care or treatment for P in a professional capacity or for remuneration, whom it would be appropriate to consult in determining what would be in P's best interests.

2 But this section does not apply if P's treatment is regulated by Part 4 or 4A of the Mental Health Act.

3 Before the treatment is provided, the NHS body must instruct an independent mental capacity advocate to represent P.

4 If the treatment needs to be provided as a matter of urgency, it may be provided even though the NHS body has not been able to comply with subsection (3).

5 The NHS body must, in providing or securing the provision of treatment for P, take into account any information given, or submissions made, by the independent mental capacity advocate.

6 "Serious medical treatment" means treatment which involves providing, withholding or withdrawing treatment of a kind prescribed by regulations made by the appropriate authority.

7 "NHS body" has such meaning as may be prescribed by regulations made for the purposes of this section by—

a) the Secretary of State, in relation to bodies in England, or

b) the National Assembly for Wales, in relation to bodies in Wales.

Statute Box 8.4 Section 38: Provision of accommodation by NHS body.

1 This section applies if an NHS body proposes to make arrangements—

a) for the provision of accommodation in a hospital or care home for a person ("P") who lacks capacity to agree to the arrangements, or

b) for a change in P's accommodation to another hospital or care home, and is satisfied that there is no person, other than one engaged in providing care or treatment for P in a professional capacity or for remuneration, whom it would be appropriate for it to consult in determining what would be in P's best interests.

2 But this section does not apply if P is accommodated as a result of an obligation imposed on him under the Mental Health Act.

2A This section [i.e. Section 38] does not apply if:

a) an independent mental capacity advocate must be appointed under Section 39A or 39C (whether or not by the NHS body) to represent P and

b) the hospital or care home in which P is to be accommodated under the arrangements referred to in this section is the relevant hospital or care home under the authorisation referred to in that section. (2A added by Mental Health Act 2007)

3 Before making the arrangements, the NHS body must instruct an independent mental capacity advocate to represent P unless it is satisfied that—

a) the accommodation is likely to be provided for a continuous period which is less than the applicable period, or

b) the arrangements need to be made as a matter of urgency

4 If the NHS body—

a) did not instruct an independent mental capacity advocate to represent P before making the arrangements because it was satisfied that subsection (3)(a) or (b) applied, but

b) subsequently has reason to believe that the accommodation is likely to be provided for a continuous period—

i) beginning with the day on which accommodation was first provided in accordance with the arrangements, and

ii) ending on or after the expiry of the applicable period,

it must instruct an independent mental capacity advocate to represent P.

5 The NHS body must, in deciding what arrangements to make for P, take into account any information given, or submissions made, by the independent mental capacity advocate.

6 "Care home" has the meaning given in section 3 of the Care Standards Act 2000 (c. 14).

7 "Hospital" means—

a) a health service hospital as defined by section 128 of the National Health Service Act 1977 (c. 49), or

b) an independent hospital as defined by section 2 of the Care Standards Act 2000.

8 "NHS body" has such meaning as may be prescribed by regulations made for the purposes of this section by—

a) the Secretary of State, in relation to bodies in England, or

b) the National Assembly for Wales, in relation to bodies in Wales.

9 "Applicable period" means—

a) in relation to accommodation in a hospital, 28 days, and

b) in relation to accommodation in a care home, 8 weeks.

Statute Box 8.5 Section 39: Provision of accommodation by local authority.

1 This section applies if a local authority propose to make arrangements—
- **a)** for the provision of residential accommodation for a person ("P") who lacks capacity to agree to the arrangements, or
- **b)** for a change in P's residential accommodation, and are satisfied that there is no person, other than one engaged in providing care or treatment for P in a professional capacity or for remuneration, whom it would be appropriate for them to consult in determining what would be in P's best interests.

2 But this section applies only if the accommodation is to be provided in accordance with—
- **a)** section 21 or 29 of the National Assistance Act 1948 (c. 29), or
- **b)** section 117 of the Mental Health Act, as the result of a decision taken by the local authority under section 47 of the National Health Service and Community Care Act 1990 (c. 19).

3 This section does not apply if P is accommodated as a result of an obligation imposed on him under the Mental Health Act.

3A Section 39 does not apply if:
- **a)** an independent mental capacity advocate must be appointed under section 39A or 39C (whether or not by the local authority) to represent P, and
- **b)** the place in which P is to be accommodated under the arrangements referred to in this section is the relevant hospital or care home under the authorisation referred to in that section.

4 Before making the arrangements, the local authority must instruct an independent mental capacity advocate to represent P unless they are satisfied that—
- **a)** the accommodation is likely to be provided for a continuous period of less than 8 weeks, or
- **b)** the arrangements need to be made as a matter of urgency.

5 If the local authority—
- **a)** did not instruct an independent mental capacity advocate to represent P before making the arrangements because they were satisfied that subsection (4)(a) or (b) applied, but
- **b)** subsequently have reason to believe that the accommodation is likely to be provided for a continuous period that will end 8 weeks or more after the day on which accommodation was first provided in accordance with the arrangements,

they must instruct an independent mental capacity advocate to represent P.

6 The local authority must, in deciding what arrangements to make for P, take into account any information given, or submissions made, by the independent mental capacity advocate

Sections 39A–E which relate to the appointment of IMCAs in connection with the Deprivation of Liberty Safeguards (DOLs) are shown and discussed in Chapter 14 (Statute Box 14.6).

Statute Box 8.6 Section 40: Exceptions (as substituted by Section 49 Mental Health Act 2007).

S.40(1) The duty imposed by section 37(3), 38(3) or (4) or 39(4) or (5), 39A(3), 39C(3) or 39D(2) does not apply where there is—
- **a)** a person nominated by P (in whatever manner) as a person to be consulted on matters to which that duty relates,
- **b)** a donee of a lasting power of attorney created by P who is authorised to make decisions in relation to those matters, or
- **c)** a deputy appointed by the court for P with power to make decisions in relation to those matters.

(2) A person appointed under Part 10 of Schedule A1 to be P's representative is not, by virtue of that appointment, a person nominated by P as a person to be consulted in matters to which a duty mentioned in subsection (1) relates."

Statute Box 8.7 Section 41: Power to adjust role of independent mental capacity advocate.

1 The appropriate authority may make regulations—
- **a)** expanding the role of independent mental capacity advocates in relation to persons who lack capacity, and
- **b)** adjusting the obligation to make arrangements imposed by section 35.

2 The regulations may, in particular—
- **a)** prescribe circumstances (different to those set out in sections 37, 38 and 39) in which an independent mental capacity advocate must, or circumstances in which one may, be instructed by a person of a prescribed description to represent a person who lacks capacity, and
- **b)** include provision similar to any made by section 37, 38, 39 or 40.

3 "Appropriate authority" has the same meaning as in section 35.

In July 2005 the Department of Health (DH) issued a consultation paper on the new IMCA service.[1] The consultation period ended on September 30, 2005. Consultation covered the following main areas:

- The operation of the IMCA service
- The main functions the IMCA will carry out
- The definition of *serious medical treatment*—one of the triggers for involving an IMCA
- Whether to extend the service to cover other groups of people or different circumstances

The DH published the results of its consultation on the IMCA service on April 19, 2006. The report included the government's response on the implementation and operation of the service.[2] (Separate consultation took place in Wales (see Chapter 18).)

The appropriate authority may make regulations as to the appointment of independent mental capacity advocates (S.35(2)). These regulations may, in particular, provide:

a) that a person may act as an independent mental capacity advocate only in such circumstances, or only subject to such conditions as may be prescribed;

b) for the appointment of a person as an independent mental capacity advocate to be subject to approval in accordance with the regulations.

In making arrangements for IMCAs to be available, the appropriate authority must have regard to the principle that a person to whom a proposed act or decision relates should, so far as practicable, be represented and supported by a person who is independent of any person who will be responsible for the act or decision (S.35(4)).

This is a significant statutory provision. It prevents health or local authorities saving funds by using their own staff as IMCAs. The IMCA must be independent of any person who will be responsible for the act or decision which is to be made.

The arrangements may include provision for payments to be made to or in relation to, persons carrying out functions in accordance with the arrangements (S.35(5)).

The principle of advocacy

The philosophy behind the appointment of an advocate, which is given statutory force, is that a person to whom a proposed act or decision relates should, so far as practicable, be represented and supported by a person who is independent of any person who will be responsible for the act or decision (S.35(4)).

When should an advocate be appointed?

There are three provisions for the involvement of IMCAs contained in the Mental Capacity Act (MCA). They are in relation to the provision of:

1. Serious medical treatment by National Health Service (NHS) body (S.37)
2. Accommodation by NHS body (S.38)
3. Accommodation by a local authority (LA) (S.39)

In addition, using the powers given in the MCA, the Secretary of State and the Welsh Assembly may make regulations as to the functions of IMCAs. Regulations made under these provisions[3] for England (for Wales, see Chapter 18) extend the appointment of an IMCA to the following circumstances:

- Where there is a review of the accommodation arrangements (Regulation 3)
- Where an NHS body or LA proposes to take protective measures in relation to a person who lacks the requisite mental capacity (Regulation 4)

There are conditions specified for each of these situations which are considered in detail later.

The LA was criticized by the Court of Protection (CoP) in the Stephen Neary case[4] for its delay in ensuring an IMCA was appointed. Failure to appoint an IMCA, failure to carry out an effective review, and failure to ensure timely proceedings meant that Hillingdon was in breach of Stephen Neary's Article 5(4) rights. The case is considered in Chapter 14 (Case Study 14.8). See also the case of *Re P and Essex County Council*[5] which is considered in Chapter 7 (Case Study 7.5) where the LA, among other breaches, failed to ensure that P was represented.

Who can be an advocate?

Following the consultation on the IMCA services, the government published regulations relating to minimum standards for individual advocates including the Criminal Records Bureau (CRB) checks on employment and that they receive appropriate training. In addition, the organizations who provide the IMCA service have to meet appropriate standards as part of the commissioning/contract arrangements.

The General Regulations[6] stipulate that:

No person may be appointed to act as an IMCA for the purposes of Sections 37–39 or under the regulations made under Section 41, unless:

a) he is for the time being approved by a local authority on the grounds that he satisfies the appointment requirements, or

b) he belongs to a class of persons which is for the time being approved by a local authority on the grounds that all persons in that class satisfy the appointment requirements.

The appointment requirements are defined as:

a) he has appropriate experience or training or an appropriate combination of experience and training,

b) he is a person of integrity and good character, and

c) he is able to act independently of any person who instructs him.[7]

Before deciding if a person is of integrity and good character, an enhanced criminal record certificate issued under Sections 113A or B of the Police Act 1997 as amended by Section 163 of the Serious Organised Crime and Police Act 2005 is required.

IMCAs were named as a group that is subject to mandatory checking under the vetting and barring system in the Safeguarding Vulnerable Groups Act 2006. The Mental Capacity Implementation Programme published guidance on IMCAs in 2007.[8] It covers advocacy, the IMCA service, how the service works, how an IMCA works, and complaints. See also guidance on the website of the Social Care Institute for Excellence (SCIE).[9]

Powers of the IMCA (S.35(6))

In order to enable him to carry out his functions, an IMCA may:

a) interview in private the person whom he has been instructed to represent, and

b) at all reasonable times, examine and take copies of:

- any health record
- any record of, or held by a local authority and compiled in connection with a social services function, and
- any record held by a person registered under Part 2 of the Care Standards Act 2000,

which the person holding the record considers may be relevant to the independent mental capacity advocate's investigation.

These statutory provisions (see Statute Box 8.1) followed significant criticisms by the Joint Committee,[10] which noted the absence of provision in the Bill to clarify rights of access to information about the mentally incapacitated persons by advocates.

What are the duties and functions of the independent mental capacity advocate?

The MCA gives powers to the appropriate authorities to draw up regulations[11] which may require the advocate to take specified steps toward the purposes shown in Box 8.1.

The regulations have also made provision as to circumstances in which the advocate may challenge, or provide assistance for the purpose of challenging, any relevant decision (see following text).

The regulations which came into force on April 1, 2007, specify the following functions for the IMCA in England (for Wales, see Chapter 18):

The general duty of the IMCA, when instructed by an authorized person to represent a person *P*, is that he "must determine in all the circumstances how best to represent and support P."

In particular, the IMCA must:

a) verify that the instructions were issued by an authorised person;

b) to the extent that it is practicable and appropriate to do so

- interview P, and
- examine the records relevant to P to which the IMCA has access under Section 35(6) of the Act;

Box 8.1 Purposes of the IMCA (S.36(2) MCA).

a) providing support to the person whom he has been instructed to represent ("P") so that P may participate as fully as possible in any relevant decision;

b) obtaining and evaluating relevant information;

c) ascertaining what P's wishes and feelings would be likely to be, and the beliefs and values that would be likely to influence P, if he had capacity;

d) ascertaining what alternative courses of action are available in relation to P;

e) obtaining a further medical opinion where treatment is proposed and the advocate thinks that one should be obtained.

c) to the extent that it is practicable and appropriate to do so, consult
- persons engaged in providing care or treatment for P in a professional capacity or for remuneration, and
- other persons who may be in a position to comment on P's wishes, feelings, beliefs or values; and

d) take all practicable steps to obtain such other information about P, or the act or decision that is proposed in relation to P, as the IMCA considers necessary.[12]

The IMCA must evaluate all the information he has obtained for the purpose of:

a) ascertaining the extent of the support provided to P to enable him to participate in making any decision about the matter in relation to which the IMCA has been instructed;

b) ascertaining what P's wishes and feelings would be likely to be, and the beliefs and values that would be likely to influence P, if he had capacity in relation to the proposed act or decision;

c) ascertaining what alternative courses of action are available in relation to P;

d) where medical treatment is proposed for P, ascertaining whether he would be likely to benefit from a further medical opinion.[13]

The IMCA is required to prepare a report for the authorized person who instructed him (Regulation 6(6)) and may include in the report such submissions as he considers appropriate in relation to P and the act or decision which is proposed in relation to him (Regulation 6(7)). Action for Advocacy (A4a) produced a guide for IMCAs on report writing (2010).[14] (A4a closed in 2013 but a former employee Martin Coyle has set up the True Voice Trust to promote advocacy in health and social care.[15])

It should be noted that the IMCA does not actually make the decision and his own view of P's best interests is irrelevant. His or her role is to support P by ascertaining what P's wishes and feelings, beliefs, and values would likely have been had P had the requisite capacity. The IMCA collates all the relevant information and passes it on to the authority responsible for making the decision. The IMCA can also obtain a second medical opinion where he or she considers it necessary. The regulations also enable the IMCA to challenge any decision which has been made, according to the power granted in Section 36(3) (see "Disputes between IMCA and others.")

How is an advocate held to account, if he or she has failed to fulfill these duties?

The IMCA service would be responsible for ensuring that the individual advocate performs his or her duties in accordance with the statutory provisions and ensures that P's wishes and feelings, beliefs, and values are made known to the appropriate authorities.

Who monitors what the advocate is doing?

The IMCA service would carry out a monitoring role and would report to its commissioners on the overall effectiveness and functioning of the service.

What about payment to the advocate?

The individual advocate would be paid by the IMCA service, which in turn would look to the appropriate NHS body or LA to fund the service. Government funds are allocated to the statutory bodies for this purpose.

Who can challenge the appointment of an advocate, for example, if there is a split in the family?

In the event of a dispute over the appointment of an IMCA, the complainant would be encouraged to discuss his or her concerns with the appropriate body. It may be that a family member considers that an advocate should not have been appointed or that the wrong person, who is not independent, has been appointed. Eventually such concerns which relate to whether the decision making will be in the best interests of the person lacking the requisite mental capacity would be resolved by the CoP.

Can an advocate access the patient's records?

As noted earlier the advocate has a statutory power, at all reasonable times, to examine and take copies of any health record, any record of, or held by a local authority

and compiled in connection with a social services function, and any record held by a person registered under Part 2 of the Care Standards Act 2000. However the person holding the record must consider that the record may be relevant to the IMCA's investigation. If the holder of the record is of the view that the record in question is not relevant, access can be refused. To disclose irrelevant personal information to the IMCA could be a breach of P's Article 8 rights.

Is an advocate under a duty of confidentiality?

The advocate has a duty to ensure that information he or she obtains about P is only made known to a person or authority, which, because of the decision which has to be made, has a legal right to that information. To pass on that information to a person who is not so eligible would be a breach of confidentiality and also an offence under data protection legislation.

What training will an advocate have?

The IMCA service arranges for training to be made available for the advocates.

The DH worked with the SCIE[16] and commissioned A4A to develop induction training materials for people who are appointed to act as IMCAs in England and Wales. The training pack was ready before the implementation of the IMCA service in April 2007.[17] SCIE provides the UK's largest database of social care information which can be accessed on its website.[18] It has published several guides relating to mental capacity including Guide 39 on IMCA involvement in accommodation decisions and care reviews, Guide 33 on the commissioning and monitoring of IMCA services, Guide 32 on the involvement of IMCA in safeguarding adults, and Guides 41 and 43 on the DOLs (see Chapter 14 of this book) and the IMCAs. Guide 42 covers access to the CoP.

The Department for Constitutional Affairs (DCA) (the predecessor of the Ministry of Justice) commissioned the Making Decisions Alliance (MDA) and the National Care Association (NCA)[19] to write two information booklets on the MCA. One is for people who may lack capacity and the other for family and unpaid carers. They are available from the Ministry of Justice website (www.justice.gov.uk).

When could an advocate be appointed in spite of family and friends being available?

When decisions are being made about serious medical treatment, the NHS body has a duty to arrange for the appointment of an IMCA, only if it is satisfied that there is no person, other than one engaged in providing care or treatment for P in a professional capacity or for remuneration, whom it would be appropriate to consult in determining what would be in P's best interests (S.37(1)(b)). Thus if a family member or close friend of P is able to speak on behalf of P, then the duty to appoint an IMCA does not arise.

The wording here is important: "whom it would be appropriate to consult" would hopefully rule out those family members or friends who have decided views on the outcome and would not ascertain P's own wishes, feelings, beliefs, and values. It should also rule out family members who are suspected of abusive treatment of P (see Scenario 8.7). Hopefully resource constraints will not affect the decision on when it would be *appropriate* to have an IMCA in such circumstances. Similar requirements exist in relation to the appointment of an advocate when accommodation decisions are being made by an NHS body or an LA. Section 38(1)(b) states that "… if it is satisfied that there is no person, other than one engaged in providing care or treatment for P in a professional capacity or for remuneration, whom it would be appropriate for it to consult in determining what would be in P's best interests." There is similar wording for Section 39(1)(b) and the arrangements by an LA for accommodation. Where protective measures are being taken in relation to P, then an IMCA should be appointed irrespective of the existence of a person whom it would be appropriate to consult.

Who else could be consulted before an IMCA is appointed?

There is a statutory duty on the decision maker under Section 4(7), when determining what is in P's best interests, to take into account, if it is practicable and appropriate to consult them, the views of:

a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,

b) anyone engaged in caring for the person or interested in his welfare, as to what would be in the person's best interests and, in particular:
- the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity)
- the beliefs and values that would be likely to influence his decision if he had capacity, and
- the other factors that he would be likely to consider if he were able to do so.

Exceptions to the appointment of an IMCA

The authorities are not required to arrange for the appointment of an IMCA where there is:

a) a person nominated by P (in whatever manner) as a person to be consulted in matters affecting his interests,

b) a donee of a lasting power of attorney created by P,

c) a deputy appointed by the court for P, or

d) a donee of an enduring power of attorney (within the meaning of Schedule 4) created by P.

IMCA and court-appointed deputy

It is clear from the statutory provisions that if a deputy has been appointed for P, then an IMCA cannot be appointed. The deputy makes decisions on behalf of P within the powers granted by the CoP. However it is clear that where decisions relating to serious treatment and NHS and LA accommodation are to be made, then the deputy will be consulted by the decision maker and an IMCA will not be appointed. Similar provisions would apply where a lasting power of attorney has been appointed by P.

How can an advocate challenge decisions made in the light of information he or she has provided which seems to have been ignored?

There is a statutory duty for the NHS body or the LA to take into account the report of the IMCA. If the question of serious medical treatment arises, then the NHS body must, in providing or securing the provision of treatment for P, take into account any information given, or submissions made, by the independent mental capacity advocate (S.37(5)). Where the NHS is involved in providing accommodation, then under Section 38(5), the NHS body must, in deciding what arrangements to make for P, take into account any information given, or submissions made, by the independent mental capacity advocate. Likewise the local authority must, under Section 39(6), in deciding what arrangements to make for P take into account any information given, or submissions made, by the independent mental capacity advocate.

The authorities only have to *take into account* the information or submissions of the IMCA. It may be difficult for the IMCA to provide evidence that they failed in this duty, even when the decision made is completely contrary to his or her report. However the Regulations provide that where an IMCA has been instructed to represent a person and a decision affecting P is made (including a decision as to his capacity), then the IMCA has the same rights to challenge the decision as he would have if he were a person (other than an IMCA) engaged in caring for P or interested in his welfare.[20] This is illustrated in Scenario 8.1.

Right of IMCA to challenge the decisions

Section 36(3) states that the regulations may make provision as to circumstances in which the advocate may challenge, or provide assistance for the purpose of challenging, any relevant decision. This is provided for in Regulation 7 of the General Regulations for England[21] which is shown in Statute Box 8.8.

Statute Box 8.8 Regulation 7 of IMCA regulations.

Challenges to decisions affecting persons who lack capacity

7.—(1) This regulation applies where—

a) an IMCA has been instructed to represent a person ("P") in relation to any matter, and

b) a decision affecting P (including a decision as to his capacity) is made in that matter.

(2) The IMCA has the same rights to challenge the decision as he would have if he were a person (other than an IMCA) engaged in caring for P or interested in his welfare.

In its response to the consultation on IMCA services, the government stated that:

> The Government intends to use regulations made under S.36(3) to set out the circumstances in which the advocate may challenge or assist in challenging the decision maker. Whilst the IMCA should aim to reach consensus and exhaust every avenue in reaching decisions before challenging decisions, there will be situations where disputes arise about the decision reached or the process followed. In such cases, the intention is that the IMCA should use existing complaints mechanisms to resolve cases locally as far as possible. However, in particularly serious cases or where there is no other way of resolving the matter, the IMCA may as a last resort seek to refer the matter to the Court of Protection—following the process as set out in paragraph 21 below.

Chapter 10 of the Code of Practice[22] suggests possible informal ways of resolving disputes at an early stage which could include:

- In relation to disagreements about health care or treatment:
  - involving the Patient Advice and Liaison Service (PALS) (in England) or the Community Health Council (in Wales)
  - using the NHS Complaints Procedure
  - referring the matter to the local continuing care review panel
- In relation to disagreements about social care:
  - if the person is in a care home, using the care home's own complaints procedure
  - using the local authority complaints procedure.

In particularly in serious cases where there is no other way of resolving the matter, an IMCA may seek permission to refer the matter to the CoP.

Formal dispute resolution

The Code of Practice[23] gives the following advice for pursuing disputes formally:

> The first step in making a formal challenge is to approach the Official Solicitor (OS) with the facts of the case. The OS can decide to apply to the court as a litigation friend (acting on behalf of the person the IMCA is representing). If the OS decides not to apply himself, the IMCA can ask for permission to apply to the Court of Protection. The OS can still be asked to act as a litigation friend for the person who lacks capacity.
>
> In extremely serious cases, the IMCA might want to consider an application for judicial review in the High Court. This might happen if the IMCA thinks there are very serious consequences to a decision that has been made by a public authority. There are time limits for making an application, and the IMCA would have to instruct solicitors – and may be liable for the costs of the case going to court. So IMCAs should get legal advice before choosing this approach. The IMCA can also ask the OS to consider making the claim.

The right of an IMCA to challenge a decision is illustrated by Scenario 8.1.

Regulation 7 enables Paul, the IMCA, to challenge the decision. The following conditions are required:

- Paul must have been instructed to represent Sheila.
- A decision affecting Sheila has been made.

Paul then has the same rights to challenge the decision as he would have if he were a person (other than an IMCA) engaged in caring for P or interested in his welfare.[24]

The means of challenge would be first to take up the question of the decision through the LA's complaints and representations procedures. Then, if that fails, and Paul still considers that the wrong decision has been made for Sheila, he could go to the Official Solicitor (OS). The OS would then decide if a case should be brought, and if so, he would consider acting as litigation friend. The CoP would then make a decision on what was in Sheila's best interests.

Scenario 8.1 Challenging the decision.

Paul is nominated to act as the IMCA for Sheila, who is 22 years old and has Down's syndrome. She has lived with her family all her life and attends a day center where she met Jimmy, who also has Down's syndrome. They became friendly and wanted to move into the same community home together. Her parents have opposed the move, but the manager of the day center disagreed with their refusal. He suggested that an IMCA should be appointed for Sheila and Paul was appointed. After interviewing Sheila and talking to her parents and others who had been involved in her care, Paul wrote a report which put firmly his conclusion that Sheila wished to move out of the family home and that it appeared to be in her best interests to do so. He noted however that her parents were opposed to the move. He was surprised to learn subsequently that the local authority had decided that it was in Sheila's best interests to remain with her parents. He suspected that the driving force behind the decision was not Sheila's best interests but the resource issues. The local authority was not subsidizing Sheila's care at present since she was being cared for by the parents (apart from the day center). However were she to be moved to a community home, there would be significant cost implications. Paul wished to challenge the decision. How should this proceed?

It might be questioned whether in practice such a situation would arise, since in all likelihood the LA might decide that there was no requirement for an IMCA, since Sheila lived with her parents who could be consulted on her behalf and therefore Paul would not have been appointed.

Can an advocate delegate responsibility?

The appointment of the IMCA would be a personal one, and any change of IMCA would be subject to the decision of the IMCA service. It is highly unlikely that they would permit any delegation of the IMCA's duties.

What problems might an advocate face?

Perhaps the biggest problem that an advocate might face will be the time constraints within which the information has to be obtained and the report prepared. Resource issues means that only a limited time is available for this work to be done. The IMCA may be fortunate if paid carers have a long-standing knowledge of and relationship with P. They would then be able to pass on to the IMCA much information about P's wishes, feelings, etc. However where there is a swift turnover of staff and they do not know P so well, then more time would have to be taken by the IMCA to obtain this information. Because of communication difficulties and the fact that a considerable time is taken for systems of communication to develop, the IMCA might not find it possible to obtain the information and write the report within the expected time. Some conditions, for example, strokes, might leave a person with profound communication problems and for an IMCA to determine whether or not they have capacity, and also if they are deemed to lack capacity, what would their wishes and feelings be, could take a considerable time. It must be remembered that Principle 2 in Section 1 states that:

> A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

This principle must be followed by the IMCA and so all practicable steps must be taken by the IMCA to enable P to make his or her own decisions. Research into the advocacy role of the learning disability nurse has shown the complexity of the advocacy role.[25] It showed that clients with learning disabilities considered that the relationship between themselves and any possible advocate was of the utmost importance and that these relationships should preferably be long term, enabling the development of mutual trust and understanding which they considered vital to the successful advocacy partnership.[26] This will clearly not be a feature of the one-off statutory provision of IMCAs.

The problem of obtaining sufficient information in the time available is illustrated in Scenario 8.2.

Scenario 8.2 Time constraints.

Andy was asked to act as the IMCA on behalf of Sophie, who lived in a community home for those with challenging behavior. Discussions were taking place over the transfer of Sophie to another home, where the social worker felt that Sophie would have closer ties with other residents. The home manager opposed such a transfer on the grounds that Sophie had been in his home for over ten years and any move would be contrary to her best interests. Sophie, who had severe learning disabilities, had no one who could be consulted on her behalf. She was unable to speak but was however able to communicate by signs and facial expressions. Unfortunately a care assistant who had worked for many years with Sophie and had developed a close rapport with her had recently left the home. The high turnover of staff meant that there was no one who could give any considered views on what was in Sophie's best interests. Andy realized that if he was to be able to get a full picture of Sophie's best interests in terms of accommodation and prepare a considered report, he would require much longer than the half day allowed for the interview, the record research, and the preparation of the report. What is the situation?

A question of time

The conditions and terms of service of the appointment of IMCAs should take into account the fact that there will be occasions where an IMCA will need longer than the average assumed time to prepare his or her submissions. Andy may be able to trace and talk to the care assistant to find more about Sophie's best interests. Hopefully the monitoring of the IMCA following its first year of full implementation will consider the existence

and implications of any such time constraints. SCIE Guide 31 covers the commissioning and monitoring of IMCA services.

What happens if an advocate wishes to have an input into decisions on which the responsible authority decides that there is no need to seek IMCA advice?

This is considered in Scenario 8.3.

An issue of discrimination

Scenario 8.3 paints a situation where someone should be standing up for the rights of the residents and challenging the discrimination to which they are subjected on their trips outside the home. A case could be made for representation to the Equality and Human Rights Commission for action to be taken on their behalf. Perhaps too, those responsible for the change of policy at the day center could be persuaded to permit the residents to attend. If the paid staff or other interested persons fail to take up any of these issues, there are at present no statutory provisions for an IMCA to be appointed, and the scenario illustrates the fact that there may be many situations and many persons who, because of the present narrow definition of the situations identified by statute requiring the appointment of an IMCA, are not receiving the representation and support which they need. Since December 2006 public bodies have a new disability equality duty to fulfill (see Chapter 3). It remains to be seen how far this improves the circumstances of those lacking the requisite mental capacity.

Scenario 8.3 Treated differently.

Rodney lives in a community home for those with challenging behavior with three other residents. The local day center has recently changed its policy and no longer accepts Rodney and his coresidents, but expects the home to provide its own activities. The home has a van which it can use for excursions, but the van is rarely used since visits to local cafes, sports centers, and pubs have resulted in the service users being abused and ridiculed. It is not always possible for the staff to arrange individual outings since the staffing is such that two people could not be spared to take one person on a trip. As a consequence the residents find that they rarely leave the home and their quality of life is diminished.

However since 2014 and the implementation of the Care Act 2014 and Regulations under that Act,[27] LAs have a duty to arrange for independent advocates to be available to represent and support certain persons to facilitate those persons' involvement in the exercise of functions by the LA. Thus persons who may fall outside the remit of an IMCA under the MCA may be included under the Care Act.

There are of course in addition many advocacy arrangements in place run by voluntary groups, charities, statutory, and other organizations, and it may be possible for a person to receive such help, even though it is outside of the provisions of the MCA or the Care Act 2014. (See list of websites for some of these organizations.)

Scenarios 8.5 and 8.3 illustrate situations which could arise when the IMCA who has been commissioned to represent a person incapable of making the requisite decision in a specific area considers that he or she should be represented in other types of decisions, where the authority is not yet obliged to appoint an IMCA under the MCA, but may be able to under the Care Act 2014.

What if P disagrees with the IMCA?

It is difficult to see this arising, since the main role of the IMCA is to report to the appropriate authority what P's wishes, feelings, values, and beliefs would likely to have been had P had the capacity to make his or her own decisions. The IMCA represents P, and therefore his or her own personal opinion as to what should happen to P is irrelevant. If a dispute arises between P and the IMCA over what is in P's best interests, it is likely that the IMCA is not representing P appropriately and a complaint could be made to the service which contracted the IMCA. However a dispute could arise over whether in fact P lacks capacity. In this situation, it is open to P to apply to the CoP for a declaration that he or she has the requisite capacity to make his or her own decisions.

What about documentation by advocate?

The IMCA is required to prepare a report for the authorized person who instructed him.[28] It will therefore be essential for the IMCA to keep records on his discussions with P and with other people and the contents of

his submission and report to the relevant authorities. A4a produced a guide for IMCAs on report writing (2010)[29] (see note above).

Statutory situations where an IMCA must be appointed

Providing serious medical treatment (S.37)

There are statutory requirements for the instruction of IMCAs to be considered where serious medical treatment decisions have to be made on behalf of an adult who lacks the mental capacity to make that particular decision (S.37 of MCA) (see Statute Box 8.3). This is illustrated in Scenario 8.4.

Serious medical treatment is defined (S.37(6)) as "treatment which involves providing, withholding or withdrawing treatment of a kind prescribed by regulations" to be drawn up by the Secretary of State or National Assembly for Wales. Following the consultation on the IMCA service, the government stated that the definition of serious medical treatment in the regulations should not list specific treatments, but the regulations should set out the characteristics of the decision to be reached. As a consequence Regulation 4[30] defines serious medical treatment as follows:

Treatment which involves providing, withdrawing or withholding treatment in circumstances where:

a) in a case where single treatment is being proposed, there is a fine balance between its benefits to the patient and the burdens and risks it is likely to entail for him,

b) in a case where there is a choice of treatments, a decision as to which one to use is finely balanced, or

c) what is proposed would be likely to involve serious consequences for P.

Scenario 8.4 Serious medical treatment and the IMCA.

Brian has Down's syndrome and his eyesight is becoming weaker. He has very little sight in his right eye, and the pressure from glaucoma is reducing his sight in the other eye. There is also a cataract in the same eye. It is recommended by his ophthalmic surgeon that he should have an operation to remove the cataract and reduce the pressure. He warns the carers that there is a risk, even if all reasonable care were taken, that he could lose the sight in his left eye and would for all intents and purposes have almost no sight. His carers are concerned about the risks involved and feel that it may be preferable to retain the sight he now has and not risk the operation until there is no alternative.

The instruction of an IMCA must be made in the following circumstances:

- If serious medical treatment is being considered for P and P lacks capacity to consent to the treatment
- If there is no person, other than the person providing treatment in a professional capacity or for remuneration, whom it would be appropriate to consult to determine what would be in P's best interests

If these conditions exist then, under Section 37(3) before the treatment is provided, the NHS body must instruct an independent mental capacity advocate to represent P.

The NHS body has been defined in Regulation 3 of the Regulations[31] drawn up by the Secretary of State or the National Assembly for Wales (S.37(7)) as:

- *A Strategic Health Authority* (now abolished)
- An NHS Foundation Trust
- A clinical commissioning group
- The NHS Commissioning Board (i.e., NHS England)
- An LA acting in the exercise of public health functions under the NHS Act 2006
- *A primary care trust* (PCT) (now abolished)
- An NHS trust
- A care trust

Even though the regulations do not list the kinds of treatments which would come under the definition of serious medical treatment, the Code of Practice does give an illustrative list as follows:

- Chemotherapy and surgery for cancer
- Electroconvulsive therapy
- Therapeutic sterilization
- Major surgery (such as open-heart surgery or brain/neurosurgery)
- Major amputations (e.g., loss of an arm or leg)
- Treatments which will result in permanent loss of hearing or sight
- Withholding or stopping artificial nutrition and hydration
- Termination of pregnancy

But the Code of Practice warns that it depends on the actual circumstances and consequences as to whether these come within the definition in any particular case, and they are illustrative examples only. The Code of Practice points out that there are also many more treatments which will be defined as serious medical treatments under the Act's regulations.[32]

The NHS body has a statutory duty (S.37(5)) to take into account any information given, or submissions made, by the independent mental capacity advocate, in providing or securing the provision of treatment for P. See Scenario 8.4 for a situation involving an IMCA for serious medical treatment decisions.

Should an advocate be appointed?

This situation would come under Section 37 of the MCA, since a health services body is proposing to provide, or secure the provision of, serious medical treatment for Brian, who lacks capacity to consent to the treatment. The health services body must be satisfied that there is no person, other than one engaged in providing care or treatment for P in a professional capacity or for remuneration, whom it would be appropriate to consult in determining what would be in Brian's best interests. If therefore Brian's parents were still alive or there were other family members or friends who could be consulted over what are in Brian's best interests, there would be no duty on the health services organization to instruct an IMCA.

When must the IMCA be appointed?

The NHS trust is required to instruct an IMCA to represent Brian before the treatment is provided. If however the treatment must be provided as a matter of urgency, then different provisions apply (see "Urgent serious medical treatment").

Serious medical treatment

Does the eye operation proposed for Brian come within the definition of serious medical treatment? Regulation 4[33] defining serious medical treatment is set out above.

It would seem in Brian's case that "(a) in a case where single treatment is being proposed, there is a fine balance between its benefits to the patient and the burdens and risks it is likely to entail for him and (c) what is proposed would be likely to involve serious consequences for P" are both satisfied. There is a fine balance between the benefits, burdens, and risk of the eye operation and the possibility of total blindness, which would involve serious consequences for him.

In the case of *Newcastle-upon-Tyne Hospitals Foundation Trust* v. *LM* [2014][34] where a question of whether the NHS trust could withhold a blood transfusion from LM who was a Jehovah's Witness, the trust had approached the IMCA service, but it stated that they would not to be involved as church colleagues of LM were available to the medical team. The court held that LM when she had capacity made her views against a blood transfusion clear and these views were to be respected.

> **Scenario 8.5** Arrangements for LA accommodation.
>
> Justin had been injured in a road accident and was in a coma for several months. He recovered consciousness but was severely paralyzed with brain damage. He was transferred to a home for young people with disabilities. He has now been offered a transfer to sheltered accommodation owned by a charity which tries to create work in its industrial therapy unit for the residents. There is a dispute between the manager of his present residential home where he appears to be reasonably happy and his social worker who considers that he would benefit from the move.

Who would be appointed as the IMCA?

The same provisions on the suitability of the person to be appointed as the IMCA apply here as they do in Scenario 8.5 on the transfer of a person to new accommodation. These include the requisite training, independence, and also the criminal records clearance.

What actions must the IMCA take?

An IMCA appointed to represent and support a person who lacks the requisite mental capacity has the same powers and duties as one appointed in connection with accommodation arrangements (S.38 and 39) (see Scenario 8.5). However, in addition the IMCA is able to obtain a further medical opinion where treatment is proposed and the advocate thinks that one should be obtained.

What is the effect of the IMCA appointment?

The IMCA does not actually make the decision. For example, in Scenario 8.4 Brian's advocate might state that it appeared to be in Brian's best interests for the operation not to proceed, until there is evidence that his sight has deteriorated to the point that there is no alternative. However the consultant surgeon might disagree with that view. The NHS body must take into account any information given, or submissions made, by the IMCA. It is not obliged to accept the view of the IMCA. Its documentation, however, should show the

basis for its decision making and the reason why the IMCA's views were not followed. The IMCA has the power to challenge the decision of the statutory authority (see Scenario 8.1).

Best interests and reasonable medical opinion

In the past, in the absence of statutory provision, decisions on behalf of mentally incapacitated adults have been made on the basis of the common law (i.e., judge-made decisions or case law) and in particular the decision of the House of Lords in *Re F*.[35] This stated that where decisions had to be made on behalf of an adult who lacked the capacity to make his or her own decisions, then it should be in his or her best interests according to the reasonable professional practice of those involved in his or her care (see Chapter 5 on best interests).

The wider criteria in Sections 3 and 4 enable many other factors to be taken into account than medical ones, and it is possible that the NHS organization might decide differently from the consultant's view.

Who would make the decision within the NHS trust?

Prior to the implementation of the MCA, decisions on serious medical treatment for those lacking the capacity to make their own decisions were left to the clinical practitioner who would carry out the treatment. The requirement at common law was for these decisions to be made in the best interests of the mentally incapable patient, according to the reasonable standard of the medical practitioner (i.e., the Bolam test).

In contrast, following the implementation of the MCA the definition of best interests is much wider and would go beyond just the clinical best interests. The patient services officer, or some other person delegated with the responsibility of carrying out the duties of the health services organization under the MCA, will have the task of taking into account not only the clinician's opinion but also the information provided by the IMCA or other representative of the patient. The non-medical considerations should be more clearly enunciated and have a bigger impact upon the determination of best interests.

Urgent serious medical treatment

Where urgent serious medical treatment is required, such as immediate lifesaving treatment, then there is no requirement to appoint an IMCA (S.37(4)). The Code of Practice recommends that this decision must be recorded with the reason for the nonreferral to an IMCA. Responsible bodies will, however, still need to instruct an IMCA for any serious treatment that follows the emergency treatment.[36]

Section 37 does not apply if P's treatment is regulated by Part 4 or 4A of the Mental Health Act (MHA) 1983 as amended by MHA 2007 (S.37(2)) (see Chapter 13).

Extremely serious medical treatments and other decisions

Some treatments such as a nontherapeutic sterilization, ending artificial feeding of a PVS patient, and other decisions must be made by a declaration of the CoP. However an IMCA should still be appointed under the provisions of Section 37 when appropriate (see Code of Practice Para 10.48 and Chapter 8 of the Code of Practice).

Arranging accommodation by NHS body (S.38) (see Statute Box 8.4)

An NHS body (as defined earlier) must instruct an IMCA to represent P if it is proposing to make arrangements:

a) for the provision of accommodation in a hospital or care home for a person P who lacks capacity to agree to the arrangements, or

b) for a change in P's accommodation to another hospital or care home

and the NHS body is satisfied that there is no person, other than one engaged in providing care or treatment for P in a professional capacity or for remuneration, whom it would be appropriate for it to consult in determining what would be in P's best interests (S.38(1)).

An amendment to the MCA made by MHA 2007 (Para 4(2) of Schedule 8) makes it clear that a person appointed under Part 10 of Schedule A1 to be P's representative is not, by virtue of that appointment, engaged in providing care or treatment for P in a professional capacity or for remuneration.

Before making the arrangements, the NHS body must instruct an independent mental capacity advocate to represent P unless it is satisfied that:

a) the accommodation is likely to be provided for a continuous period which is less than the applicable period, or

b) the arrangements need to be made as a matter of urgency.

If the NHS body

a) did not instruct an independent mental capacity advocate to represent P before making the arrangements because it was satisfied that these subsections applied, but

b) subsequently has reason to believe that the accommodation is likely to be provided for a continuous period

- beginning with the day on which accommodation was first provided in accordance with the arrangements, and
- ending on or after the expiry of the applicable period

it must instruct an independent mental capacity advocate to represent P.

This requirement ensures that persons placed in accommodation for less than the prescribed periods will come under the provisions of Section 38 if their stay is extended beyond the prescribed period.

Where an independent mental capacity advocate is instructed, the NHS body must take into account any information given, or submission made, in deciding what arrangements to make for P (S.38(5)).

Applicable period means 28 days in relation to accommodation in a hospital and eight weeks in relation to accommodation in a care home (S.38(9)).

This statutory requirement for the NHS body to instruct an IMCA does not apply if P is accommodated as a result of an obligation imposed on him under the MHA (S.38(2)) (see Chapter 13). A new subsection (2A) to Section 38 has been added to the MCA by the MHA 2007 (Para 4(2) of Schedule 9), and Section 2A states:

This section [i.e. Section 38] does not apply if:

a) an independent mental capacity advocate must be appointed under Section 39A or 39C (see Chapter 14.) (whether or not by the NHS body) to represent P and

b) the hospital or care home in which P is to be accommodated under the arrangements referred to in this section is the relevant hospital or care home under the authorisation referred to in that section.

The definition of *NHS body* for the purpose of Section 38 is the same as that for Section 37 (see "Providing serious medical treatment (S.37)").

Arranging accommodation by an LA body (S.39) (see Statute Box 8.5)

Scenarios 8.5 and 8.6 illustrate the effect of this provision.

Advice from an IMCA must be sought by an LA if it is proposing to make arrangements:

a) for the provision of residential accommodation for a person ("P") who lacks capacity to agree to the arrangements, or

b) for a change in P's residential accommodation.

and the LA is satisfied that there is no person, other than one engaged in providing care or treatment for P in a professional capacity or for remuneration, whom it would be appropriate for them to consult about P's best interests (S.39(1)).

The section only applies if the accommodation is to be provided in accordance with:

a) Section 21 or 29 of the National Assistance Act 1948, or

b) Section 117 of the Mental Health Act,

as the result of a decision taken by the local authority under Section 47 of the National Health Service and Community Care Act 1990 (S.39(2)).

This statutory requirement for the LA to instruct an IMCA does not apply if P is accommodated as a result of an obligation imposed on him under the MHA (S.39(3)).

Amendments to the MCA are made by the MHA 2007 which makes provision for the appointment of an IMCA in situations where the DOLs arise. These are considered in Chapter 14. A new subsection (3A) to Section 39 states that Section 39 does not apply if:

a) an independent mental capacity advocate must be appointed under section 39A or 39C (whether or not by the local authority) to represent P, and

b) the place in which P is to be accommodated under the arrangements referred to in this section is the relevant hospital or care home under the authorisation referred to in that section.

It is therefore implied in this exception to the duty under Section 39 that Section 117 accommodation under the MHA 1983 is not accommodation as a result of an obligation imposed on him under the MHA (see

> **Scenario 8.6** Section 117 of the MHA and accommodation. Which legislation applies?
>
> Barbara has been detained in a psychiatric hospital under Section 3 of the Mental Health Act 1983. She is shortly to be discharged, and a meeting to consider aftercare to be provided under Section 117 is being convened. It is decided that she does not require aftercare under supervision. Thomas, her occupational therapist, considers that she is incapable of making decisions on accommodation and that she should be represented under the Mental Capacity Act (MCA) 2005. The consultant psychiatrist maintains that the MCA does not apply, because she comes under the provisions of the Mental Health Act 1983.

Chapter 13 on mental capacity and mental health and Scenario 13.6). Sections 39A, 39B, and 39C can be found in Chapter 14 (Statute Box 14.6).

Before making the arrangements, the local authority must instruct an independent mental capacity advocate to represent P unless they are satisfied that:

a) the accommodation is likely to be provided for a continuous period of less than eight weeks, or

b) the arrangements need to be made as a matter of urgency (S.39(4)).

If an IMCA was not instructed because one of these subsections was thought to apply, but subsequently the LA has reason to believe that the accommodation is likely to be provided for a continuous period that will end eight weeks or more after the day on which accommodation was first provided, then the LA must instruct an IMCA to represent P (S.39(5)). This provision ensures that those persons are covered by Section 39 if the initial period of the accommodation is outside the specified period but is later extended.

The LA must take into account any information given, or submission made, by the IMCA in deciding what arrangements to make for P (S.39(6)).

Should an independent mental capacity advocate be appointed for Justin? (Scenario 8.5 on page 148)

The first question to be answered is:

> "Does Justin have the mental capacity to make the decision for himself?"

The provisions of Section 2 apply (see Chapter 4 and scenarios in that chapter). If the answer to that question is *yes*, then Justin is entitled to make the decision.

If however the answer is *no*, then the consideration of the appointment of an IMCA should proceed.

It must be established whether these are the kind of circumstances envisaged by the Act, where an IMCA would be appointed, and whether there are any exceptions.

The decision to be made is about arrangements for accommodation being made by the LA. Section 39 covers the situation where the LA is to make arrangements for the provision of residential accommodation for a person who lacks capacity to agree to a change in the arrangements for his residential accommodation.

Is there an alternative?

The duty to appoint an IMCA does not apply if there is another person, not including a person engaged in providing care or treatment for P in a professional capacity or for remuneration, whom it would be appropriate for them to consult in determining what would be in P's best interests. Does Justin have a friend, relative, or some other person who could be consulted over the move? He may have struck up a close relationship with a member of staff, but this person is excluded from the possibility of being formally consulted under the section. If a deputy has been appointed by the CoP or Justin has appointed an attorney under a lasting power, then the appointment of an IMCA is not required. If there is no other person, other than the paid carers, whom the LA could consult, then the duty to provide an IMCA would apply unless any of the exceptions apply (see following text).

Is it the right kind of accommodation?

The duty of the LA to arrange for the appointment of an IMCA only applies to the provision of certain kinds of accommodation. This includes accommodation provided following an assessment by the LA under Section 47 of the National Health Service and Community Care Act 1990 (duty of the LA to carry out a community care assessment). In Justin's case his accommodation would be provided under Section 29 of the National Assistance Act 1948 (under this section the LA may make arrangements for promoting the

welfare of persons over 18 who are blind, deaf, or dumb or who suffer from mental disorder and other persons who are substantially and permanently handicapped by illness, injury, or congenital deformity or such other disabilities).

Do any of the exceptions apply?

The LA does not have to instruct an IMCA to represent Justin if it is satisfied that either the accommodation is likely to be provided for a continuous period of less than eight weeks or that the arrangements need to be made as a matter of urgency. Neither of these exceptions would appear to apply to Justin's case. If the exceptions apply and there is no duty to appoint an IMCA under the MCA, the LA should consider its duty to provide an independent advocate under the Care Act 2014 (see discussion in Scenario 8.3 on page 146).

Who should be the advocate?

There should be, in each area, an IMCA service which will provide advocates when required by the LA or health services organization. The IMCA services will select a person to represent Justin. The LA must follow the basic principle that the appropriate person to whom a proposed act or decision relates should, so far as practicable, be represented and supported by a person who is independent of any person who will be responsible for the act or decision. This means that the LA could not appoint one of its own staff or a person connected with either the residential accommodation in which Justin is currently living nor a person connected with the proposed accommodation.

Under the Regulations[37] a person would not be able to act as an IMCA unless he or she is approved by an LA as satisfying the appointment requirements or he or she belongs to a class of persons which is approved by an LA on the grounds that all persons in that class satisfy the appointment requirements.

Under these appointment requirements the proposed advocate must have the appropriate experience or training or an appropriate combination of experience and training. He or she must be a person of integrity and good character, and he or she must be able to act independently of any person who instructs him. Before deciding if a person is of integrity and good character, an enhanced criminal records certificate issued under Sections113A or B of the Police Act 1997 as amended by Section 163 of the Serious Organised Crime and Police Act 2005 is required.

What will Paul do as the advocate?

Paul is nominated as the IMCA for Justin. He has received the appropriate training and is on the panel of approved IMCAs held by the LA, and he has received clearance from the criminal records search. His specific function is to represent and support persons who lack capacity. He visits Justin and tries to explain to him all the options. He would possibly take Justin to visit the proposed accommodation. He would speak to the paid carers, Justin's fellow residents, and any others with whom Justin has had contact in the past and present, including any family and friends.

What powers does Paul as the IMCA have?

Paul may interview Justin in private and may, at all reasonable times, examine and take copies of any health record, any record of, or held by, a local authority and compiled in connection with a social services function, and any record held by a person registered under Part 2 of the Care Standards Act 2000, if the person holding the record considers it may be relevant to the IMCA's investigation. There may a dispute over what is considered to be relevant, and it would be difficult for Paul, without seeing a document which has been withheld, to maintain that it should be disclosed to him as being relevant to his role as IMCA.

What considerations should Paul take into account?

Paul is bound to observe the principles set out in Section 1 of the MCA 2005. He should also determine what are Justin's best interests in accordance with the criteria for best interests as set down in Sections 3 and 4

(see Chapter 5 and scenarios in that chapter). This means that he should be:

a) Providing support to Justin, so that Justin may participate as fully as possible in any relevant decision

b) Obtaining and evaluating relevant information

c) Ascertaining what Justin's wishes and feelings would be likely to be and the beliefs and values that would be likely to influence Justin if he had capacity to make that particular decision

d) Ascertaining what alternative courses of action are available in relation to Justin

In taking these steps Paul would be able to investigate Justin's history prior to the road traffic accident and find out from persons who once knew Justin about his beliefs and values, wishes, and feelings. He might, for example, find out that Justin always hated change and, once he was settled, preferred to stay.

What is the effect of Paul's report?

The LA must, in deciding what arrangements to make for Justin, take into account any information given, or submissions made, by the IMCA, that is, Paul. This does not mean that it has to follow the opinion or view of the IMCA, but it would have to show in its documentation that it had taken account of the submissions and information provided by the IMCA. If it decides not to follow the conclusion of the IMCA, it would have to show in its records the reasons why it decided on a different course of action. For example, it might be that the IMCA, having talked to Justin and the paid carers, decided that it was preferable for Justin to remain in the present accommodation, since he was settled and apparently very happy and would miss his fellow residents. On the other hand, the LA may place greater weight on the long-term benefits he would receive by being in a rehabilitative environment, with the future prospects of obtaining paid work and becoming independent, and therefore recommend the transfer.

Paul's remuneration

Paul is entitled to be paid according to the rates agreed by the local IMCA service.

Urgent transfer to new accommodation: No IMCA

What would be the situation in Scenario 8.5 if a decision on the new accommodation that was being considered for Justin had to be made within a week as other clients were considering moving there? In such a situation, the LA could make the decision that a transfer was in Justin's best interests and because of the urgency. In this case the LA would not be required to appoint an IMCA to represent and support Justin. However in this case if subsequently the LA has reason to believe that the accommodation will continue for over eight weeks from the date of transfer, then it must instruct an IMCA to represent Justin.

If Paul were to be appointed in this situation, he would have a very different task. Justin would be in the new accommodation, and Paul would have to ascertain whether it was in Justin's best interests to remain where he now was or whether it was preferable for him to return to his previous accommodation, assuming of course that that accommodation is still available.

An example of a case involving a report by an IMCA is that of Re EU (Appointment of deputy) *Suffolk County Council and JU and TU* [2014][38] where EU's two sons opposed the appointment of Suffolk County Council as a property and financial affairs deputy for their father, who was 80 years old with dementia. The report of the IMCA was significant to the decision made by the CoP. Senior Judge Lush stated that "The IMCA's report makes it abundantly clear that he (EU) wishes to remain in the residential care home in Suffolk, rather than be moved to Derbyshire and that he would like Suffolk County Council Adult Care Services to manage his property and affairs. He reiterated these wishes over the telephone at the hearing on 15 July 2014 and I can see no reason why they should not be implemented. Having regard to all the circumstances, therefore, I am satisfied that it is in EU's best interests to appoint Suffolk County Council to be his deputy for property and affairs and to dismiss his son's objections."

Sections 39A–39E added by MHA

Where a person has lost his or her liberty under the provisions for the deprivation of liberty as set out in Schedule A1 (as added to the MCA by the MHA 2007),

then an IMCA must be appointed in accordance with Sections 39A–39E. These sections are shown and discussed in Chapter 14 (Statute Box 14.6). Part 11 of Schedule A1 of the MCA (as added by MHA 2007 Schedule 7) sets out the details of 39A–39E (see Chapter 14).

Accommodation for those with mental health problems

Scenario 8.6 on page 151 illustrates a situation where a detained patient is being discharged and accommodation under Section 117 is being sought.

It is correct that Section 39(3) states that Section 39 (i.e., the duty to arrange for an IMCA where the LA is arranging accommodation) does not apply if P is accommodated as a result of an obligation imposed on him under the Mental Health Act." Is accommodation under Section 117 an obligation imposed under the MHA? Section 39(2) specifies that the duty under Section 39 only applies if the accommodation is to be provided in accordance with either Section 21 or 29 of the National Assistance Act 1948 or under Section 117 of the MHA, as the result of a decision taken by the LA under Section 47 of the National Health Service and Community Care Act 1990. Therefore the effect of Section 39(2) and Section 39(3) is that accommodation provided under Section 117 of the MHA, following a community care assessment under Section 47 of the National Health Service and Community Care Act, is not accommodation being provided under an obligation imposed by the MHA 1983.

Therefore if a person who has been detained under the MHA 1983 is discharged from hospital and comes under the requirements for aftercare set out in Section 117 of the MHA 1983, if that person has no close relatives, friends, or any other person to protect their interests, then the LA will have a duty to consult with an IMCA over any accommodation which is being planned. The situation would be different if Barbara was granted leave under S17 and was obliged to stay in specified accommodation.

It follows that the consultant psychiatrist is wrong in saying that an IMCA does not have to be appointed under the MCA. If Barbara is unable to make her own decisions about accommodation and if there is no unpaid appropriate adult who could be consulted about her best interests, then an IMCA should be appointed. Thomas cannot act as her advocate since he is providing care and treatment for her in a professional capacity and for remuneration.

Scenario 8.7 Appropriate for consultation?

Paula, 21 years old, lives with her father, with her mother having died several years before. She has severe learning disabilities, and social services are considering moving her from the family home to live in a small community home with four other young people with disabilities. Her father is opposed to the move. The social services are concerned that the father may be sexually abusing Paula. The police investigated similar allegations in relation to an older sister, but the CPS abandoned the prosecution for lack of evidence. Could Paula have an IMCA?

An appropriate adult for consultation

Scenario 8.7 illustrates a possible problem with a restricted view of the present MCA and regulations.

Under Section 39 social services, in determining the accommodation needs for Paula, have a duty to arrange for an IMCA to be appointed, if Paula lacks the capacity to agree to the arrangements, and are satisfied that there is no person, other than one engaged in providing care or treatment for Paula in a professional capacity or for remuneration, whom it would be appropriate for it to consult in determining what would be in Paula's best interests.

Once it is determined that Paula lacks the requisite mental capacity, then the next question is, does the father constitute *an appropriate* person for social services to consult in determining what is in Paula's best interests? From the social services perspective, it may consider that the father would not be an appropriate person because of the allegations about his conduct. It might therefore recommend that an IMCA is appointed. If the father were to protest, he would have to provide evidence that he was appropriate to be consulted and able to advise as to what was in Paula's best interests. Clearly any IMCA appointed would have to include in his or her report the father's evidence as to what he thought was in Paula's best interests. In the event that local agreement could not be obtained, an approach could be made to the OS giving the facts of the case. It may then be necessary for an application to be made to the CoP, with Paula being represented by the OS (see Chapter 7). If there is reasonable evidence that Paula is being abused by her father, then protection action can be taken by the LA and an IMCA can be appointed even though there is a person who could be consulted see page 155.

Review of accommodation arrangements by NHS body or LA (*care reviews*)

The duty to consider the appointment of an IMCA was extended to two further situations: (a) in a review of accommodation arrangements and (b) in adult protection situations.

Where a review is proposed or in progress for accommodation provided for P for a continuous period of 12 weeks or more, then the NHS body or LA *may* instruct an IMCA to represent P if it is satisfied that it would be of particular benefit to P to be so represented. This does not apply if there is an appropriate person who could be consulted.[39] This, unlike the duties under Sections 37, 38, and 39, is a discretionary duty, and the Code of Practice has given guidance on when the power to appoint an IMCA should be used in care reviews.[40] The power only applies where the person lacks the requisite mental capacity. The power does not apply where accommodation is provided under an obligation imposed by the MHA 1983 (see Scenario 8.6 and Chapter 14).

Adult protection cases

Where an NHS body or LA is proposing or has taken protection measures in relation to a person P who lacks capacity to agree to one or more of the measures, then the NHS body or LA *may* instruct an IMCA to represent P if it is satisfied that it would be of particular benefit to P to be so represented. The Code of Practice gives guidance on when this discretionary power may be used.[41] The regulations do not require the person in an adult protection situation to have no friends or family to consult. The protective measures must be proposed or taken as a result of an allegation that P is being abused or neglected or is abusing another person. "Protective measures includes measures to minimise the risk that any abuse or neglect of P, or abuse by P, will continue."[42] Scenario 8.8 illustrates the appointment of an IMCA when protective measures are being taken.

Under Regulations 4 and 5[43] in a situation where an adult lacking mental capacity is either the cause or the victim of abuse and an NHS body or an LA proposes to take or have taken protective measures in respect of that person, then an IMCA can be instructed if the NHS body or LA is satisfied that it would be of particular benefit for the person to be so represented. There is no requirement to ascertain if there is an appropriate person to represent P. An IMCA could therefore be instructed to represent Tom. Where an IMCA is instructed, then the NHS body or the LA must take into account any information provided or submissions made by the IMCA in making decisions about the protective measures. The definition of "protective measures" includes "measures to minimise the risk that any abuse or neglect of P, or abuse by P will continue." This regulation does not apply if Regulation 3 (dealing with review of arrangements as to accommodation), Section 37 (serious medical treatment), Section 38 (arrangements for accommodation by NHS body), or Section 39 (arrangements for accommodation by LA) applies.

Scenario 8.8 Protective measures.

A prosecution has been brought by the Crown Prosecution Service against the parents of Tom, who has severe learning disabilities. It is claimed that the parents abused Tom by failing to provide adequate care for him and by misappropriating his benefits and not using them to provide proper and sufficient food and clothing for him. The social services are considering taking protective measures for Tom. Is an IMCA required?

Guidance on adult protection and care reviews

Guidance has been provided by the DH on the regulations relating to adult protection and care reviews.[44] In care reviews, it suggests that the LA or NHS body should draw up a policy statement outlining the criteria to be applied when deciding for each eligible individual having an accommodation review whether there would be a benefit from having the safeguard of an IMCA. This policy statement should be made widely available, so that all relevant staff in the LA or NHS body are aware of the criteria to be applied, thus ensuring consistency in decision making in these cases.

For both care reviews and adult protection cases, the guidance emphasizes that where the qualifying criteria are met, it would be unlawful for the LA or NHS body not to consider the exercise of their power to instruct IMCAs for accommodation reviews and adult protection.

The Independent Mental Capacity Advocacy services

The Secretary of State (for England) and the National Assembly for Wales (for Wales) (i.e., the appropriate authority (S.35(7))) must make such arrangements as it considers reasonable to enable persons (IMCAs) to be available to represent and support persons to whom acts or decisions proposed under Sections 37, 38, and 39 (S.35(1)) relate and those specified in the regulations. Following the consultation, the government decided that the IMCA services were to be commissioned locally, with local social services authorities (LSSAs) having financial responsibility within joint commissioning arrangements with PCTs now replaced by clinical commissioning groups.[45]

How is it funded?

The DH estimated that the cost of funding the IMCA service[46] in England would be £6.5 m per annum and made this new resource available through the annual LA settlement using a population-based formula. The DH issued guidance that identifies some of the issues for LAs to consider when deciding how to commission the new IMCA service and published a best practice tool to assist organizations in testing their readiness to comply with the requirements of the Act and to assist local implementation initiatives.[47] The October 2010 spending review settlement protected funds to support the implementation of the MCA, including funding the IMCA service, and has an inflationary increase up to 2015.

The appropriate authorities (i.e., Secretary of State for England and National Assembly for Wales) have the responsibility of laying down the arrangements, which may include provision for payments to be made to, or in relation to, persons carrying out functions in accordance with the arrangements.

How is it managed?

The government in its response to the consultation stated that independent advocacy organizations that would be commissioned to provide the IMCA services should also have to meet appropriate organizational standards as part of the commissioning or contract arrangements. The government was to work with independent advocacy organizations, commissioners, and other stakeholders in developing these standards.

How is its independence secured?

Following the consultation, the government stated that:

> The Government believes that the independence of the IMCA can be achieved through national standards that will apply to all organisations offering an IMCA service and through the contracting process. Guidance on commissioning will be available to those responsible at local level. Guidance will recommend that engagement protocols should set out how to address situations where a conflict of interest may arise, whether organisational, financial or personal.

There are two key areas where independence is essential:

- The IMCA must not have any professional or paid involvement with the provision of care or treatment for any vulnerable person for whom they may be appointed to act.
- They must be completely independent of the person responsible for making the decision or doing the act in question.

These features and further guidance on the IMCA role are covered in Chapter 10 of the Code of Practice.

How is it held accountable?

Following the consultation the government stated that monitoring arrangements should be managed via local contracts/commissioning, but it would also produce an annual report on the IMCA service for the first three years.

It also stated that:

> The Government believes that all contracts or engagement protocols between the commissioner and IMCA service provider should include agreed complaints procedures. Complaints about the individual advocate providing the IMCA service should be directed in the first instance to the independent advocacy organisation employing the IMCA. All IMCA services should have a clear and accessible complaints procedure. They should be required to report complaints about them to their commissioning body.

The government will also consider whether the requirement to have agreed complaints procedures in place should be part of the national standards for independent advocacy organizations.

The government believes that compliance with standards should primarily be part of contract monitoring, validated by performance assessment and service inspection evidence gathered by commissioners and by the Commission for Social Care Inspection (CSCI) and/or the Healthcare Commission (both bodies now

replaced by the Care Quality Commission). We will discuss this with the regulatory bodies.

The Care Quality Commissioning monitors and reports annually on the DOLs including IMCAs (see Chapter 14).

What if it fails to provide advocates?

A situation might arise where an NHS organization or LA was making a decision for a person lacking the requisite mental capacity which was covered by the IMCA and where there was no appropriate person who could be consulted and yet an IMCA was not appointed. In such a case there would be a breach of the statutory duty under Sections 37, 38, or 39 as appropriate (see preceding text). If the situation were covered by the urgent provisions of Sections 38(3)(b) and 39(4)(b), then the respective authority has a duty to arrange for an IMCA to be appointed if the accommodation is required for more than the specified time. In the event of a breach of the statutory duty to appoint an IMCA, a complaint could be raised and attempts made to remedy the situation. If this could not be resolved and the complaint was not dealt with satisfactorily, then a judicial review of the failure to appoint an IMCA could be sought (see Chapter 2 on judicial review).

Who sets the standards?

The commissioning authorities are responsible for ensuring that the IMCA organizations who arrange for the appointment of individual IMCAs have to follow the standards which are developed nationally and which are incorporated into the individual contracts between the commissioning body and the IMCA service provider.

Who enforces the standards?

These standards are enforced by the commissioning authorities, who are ultimately responsible to the Secretary of State.

Who monitors?

Ultimately of course the government is responsible for the overall standards of the IMCA services and has stated in its response to the consultation on the IMCA service that:

> We will evaluate the IMCA service after the first year of implementation to determine if we have sufficiently addressed the advocacy needs of the unbefriended.

Does it have to provide an annual report?

The IMCA organizations commissioned by each LA have to provide an annual report on its activities to the commissioning authority. In addition the government has promised to provide an annual report on the overall situation relating to IMCAs. This report would be submitted to the Parliament. The sixth annual report covering the period 2012–2013 was published in February 2014 by the DH. It is available on the government website.[48] It showed that the number of appointments of IMCAs had doubled over 6 years to 12,381, a 4% increase over 2011/2012. However there continued to be wide disparities in the rate of IMCA instructions across different local areas which cannot wholly be explained by population differences. It is likely that in some areas the duties under the MCA are still not well embedded. The duty to refer people who are eligible to IMCAs is still not understood in all parts of the health and social care sector. Recommendations are made to improve the service and the awareness of IMCA's role, together with case studies and guidance in report writing. In its 7th report published in March 2015 and covering the period April 2013 to March 2014, IMCA referrals had increased by 10% over the previous year. 17% of DOLs cases involved an IMCA. It is noted that half of the people who lacked capacity did not have any support from an advocate, family member, or friend during the safeguarding referral. It also emphasized that if a person who lacks capacity wishes to appeal against a DOLs authorization, then they should be supported to do so even if the relevant person's representative (RPR) feels that the DOLs is in their best interests. The report recommended the following: improved awareness of the MCA and IMCA service among clinicians to be developed by the IMCA and MCA leads in hospitals, responsible bodies should have a documented policy on when safeguarding cases should be referred to an IMCA, all LAs should review their processes and procedures for providing IMCA support to unpaid RPR, and all IMCA providers should review the draft guidance on training and development set out in this annual report.

The responsible authorities

The appropriate authorities, that is, the Secretary of State for England and the National Assembly for Wales, have the responsibility of ensuring that IMCA services

> **Scenario 8.9** Representation in another area?
>
> In the situation discussed in Scenario 8.4, Jonathan is appointed as an IMCA to represent Paula on the proposed change in her accommodation. He obtains evidence from her father, her older sister, and Paula herself on whether the transfer to the new home would be in her best interests. While preparing his report he discovers that moneys which Paula is entitled to receive from a family trust fund and from social services are being used by Paula's father, who appears to have a gambling problem. He is advised by the LA social worker that his remit is only to concern himself with questions on accommodation and anything else is outside his remit.

are available and of laying down the more detailed functions and remit of the IMCAs.

Scope of the IMCA's remit

Scenario 8.9 illustrates a situation which could arise when the IMCA, who has been commissioned to represent a person incapable of making the requisite decision in a specific area, considers that they should be represented in other types of decision, where the authority is not yet obliged to appoint an IMCA.

Jonathan would seek advice from the IMCA service which has employed him and which has the contract to provide IMCAs on behalf of the LA and the NHS body. Depending upon the contract and the commissioning authority, the IMCA service could probably give Jonathan the authorization to report on other aspects of her care. What is being alleged is a criminal offence, and action should be taken by the LA to ensure that it is reported to the police and appropriately investigated. The situation could also give rise to an adult protection concern, since it would appear that Paula is being financially abused by her father. An IMCA could be appointed for protective measures to be taken.

Exceptions to the duty to instruct an IMCA (S. 40) (see statute Box 8.6 on page 138)

The duty to instruct an IMCA (under Sections 37(3), 38(3), 39(4) or (5), *39A(3), 39C(3) or 39D(2)* (italicized words added by MHA 2007 Schedule 8) does not apply if there is:

a) a person nominated by P (in whatever manner) as a person to be consulted in matters affecting his interests
b) a donee of a lasting power of attorney created by P
c) a deputy appointed by the court for P or
d) a donee of an enduring power of attorney (within the meaning of Schedule 4) which has been created by P, or if
e) the decision relates to treatment or accommodation provided under the Mental Health Act 1983.

The MHA 2007 has added a new subsection (40(2)):

> A person appointed under Part 10 of Schedule A1 to be P's representative is not, by virtue of that appointment, a person nominated by P as a person to be consulted in matters affecting his interests.

This means that an IMCA could still be appointed even though P has a representative. The appointment of an IMCA where a person is being deprived of his or her liberty under the DOLs is considered in Chapter 14.

Codes of Practice (see also Chapter 17)

Much of the detail about the way in which independent mental capacity advocates will operate is not contained in the regulations but is set out in the Code of Practice. This was a specific recommendation of the Joint Committee.[49]

The Joint Committee also recommended when in considering the standards and quality of advocacy services:

> All organisations commissioning or providing advocacy services to incapacitated adults should have satisfactory procedures in place to ensure that the standards and quality of independent advocacy services are monitored and maintained. (308)

The importance of the Code of Practice was emphasized in the House of Lords by Baroness Ashton of Upholland[50] who also noted that:

> Not everyone would want to feel obliged to have an advocate. There are real issues too about how families interact and the support that family members can provide for individuals. We should not presume that everyone wishes to have an advocate any more than we should insist that people have to use their relatives. I am not taken with the idea of making that a requirement.

Changes to the role of the IMCA (S41) (see Statute Box 8.7 on page 138)

The Secretary of State and the Welsh Assembly Government have the power to make regulations which:

a) Expand the role of the independent mental capacity advocate in relation to persons who lack capacity

b) Adjust the obligations to make arrangements imposed by Section 35 (see preceding text)

As noted earlier, regulations have already been made which prescribe different circumstances from those set out in Sections 37, 38, and 39, in which an IMCA must, or circumstances in which one may, be instructed by a person of a prescribed description to represent a person who lacks capacity, and include provisions similar to any made by Sections 37, 38, and 39. Further regulations may be made in due course.

Implementation

Pilot schemes were set up for the implementation of the IMCA service, and these are further considered in Chapter 17.

Nonstatutory advocacy

It must be recognized that across the country there are many groups—voluntary, charitable, not-for-profit, and other organizations—which provide an independent advocacy service for those needing support and advice. How do these differ from those who are appointed under the provisions of the MCA?

The main differences are as follows:

- There is a statutory duty in the situations specified in the MCA and regulations for an IMCA to be appointed unless there is an appropriate person who can be consulted.
- There are regulations prescribing what the IMCA is to do and what rights and powers they have (e.g., in relation to access to records).
- There is a statutory duty upon the NHS organizations or LAs to take into account any information given, or submissions made, by the IMCA.
- The IMCA has a statutory right to challenge any relevant decision.
- An annual report on the IMCA service is published.

In addition under the Care Act 2014 independent advocates must be appointed in specified circumstances (see page 146).

It may well be that as a consequence of these statutory powers regulating the appointment and use of IMCAs under the Act, these provisions will influence the use of advocates in other situations not specified in the statute; that the nonstatutory advocates will be given similar responsibilities; and that the NHS organizations and the LAs will take into account their reports and submissions. However in the meantime they may find it difficult without clear statutory authorization to obtain the same powers and rights that the statutory IMCA has (i.e., interview in private the person whom he or she has been instructed to represent and examine and take copies of the relevant records).

The role of an RPR, litigation friend, and OS is considered in Chapter 1.

The future

The House of Lords Select Committee on the Mental Capacity Act 2005

The House of Lords Select Committee on the Mental Capacity Act 2005[51] looked specifically at the use of IMCAs and made the following recommendations:

22 We recommend that local authorities use their discretionary powers to appoint IMCAs more widely than is currently the case. To support this, we recommend that the Government issues guidance to local authorities and health service commissioners about the benefits of wider and earlier use of IMCA services. We believe the costs of greater IMCA involvement should be balanced against the resources required in lengthy disputes or ultimately in litigation.

23 Given the importance of the role of the IMCA in the lives of vulnerable adults we believe that the role requires further professionalisation to ensure consistency of service. This should be achieved through national standards and mandatory training in the Mental Capacity Act and the role of the IMCA within that. We recommend that responsibility for such standards and training be undertaken by the independent oversight body which we recommend in Chapter 4, enabling peer support and consistency between IMCA services

24 We recommend that the Government consider the establishment of a form of self-referral for IMCA services to prevent the damaging delay that occurred in the case of Mr Steven Neary.[52]

Government response

The government[53] responded to these recommendations as follows:

6.38 Independent Mental Capacity Advocates (IMCAs) are one of the major success stories of the MCA and we endorse the House of Lords support for them. They do impressive work supporting people in some of the most vulnerable situations to achieve outcomes that suit them and enhance their well being.

6.38 (stet) We have considered how the benefits of the IMCA service could be promoted more widely and as such, have decided to build on the new duties to provide advocacy in the Care Act 2014, linking these to the existing duties to provide advocacy under the MCA. As a result, more people will benefit from advocacy and at an earlier stage. IMCAs and other advocates will be involved in supported decision making as part of the assessment of people's care needs, their care planning and their care reviews.

6.39 The statutory guidance for the Care Act will set out how to bring these two forms of advocacy together. The guidance will state that while there is no legal requirement for the same advocacy organisation to provide advocacy under the MCA and under the Care Act, there are nevertheless substantial benefits in the same organisations providing advocacy under both Acts. The guidance also indicates that self referral should be facilitated. We would ask any new Mental Capacity Advisory Board to consider the need for further guidance in this area (informed by the review of current guidance and materials to be undertaken by the Social Care Institute for Excellence).

6.40 We encourage local authorities to make all appropriate use of advocacy services. We are aware of variability across local authorities in terms of their use of advocacy and we would encourage local authorities with relatively low referral rates to consider whether this is a legitimate variance or whether action needs to be taken to improve awareness, understanding and use of advocates for the benefit of individuals resident in their areas. This extends to the need to ensure commissioners are aware of the role of statutory advocacy and that professionals in health and social care are alerted to the legal requirement to refer people to the IMCA service, for example, as part of their induction training and as part of supervision.

6.41 We agree with the House of Lords that the IMCA sector would benefit from further professionalism. The Government has drawn up draft regulations under the Care Act, under which a local authority must require advocates: to have a suitable level of relevant experience; to have appropriate training; to be competent to their task; to have integrity and be of good character; to demonstrate the ability to act independently of the local authority; and to have arrangements in place to receive appropriate supervision (now in place).[54]

6.42 Furthermore, we have commissioned the National Development Team for Inclusion (NDTi)[55] to undertake a review of the Advocacy Quality Performance Mark and the Code of Practice, which had previously been administered by Action for Advocacy. NDTi organised a series of workshops involving more than 60 organisations and had discussions with local authority commissioners, as part of the review, and the launch of the revised Quality Performance Mark, which took place in Parliament in March 2014. This is a highly innovative, sector led quality assurance programme, which assists advocacy organisations to professionalise and develop quality advocacy.

6.43 With the clarification by the Official Solicitor that his role is one of "last resort," IMCAs and Relevant Person's Representatives (RPRs) have increasingly been asked by the Court to act as litigation friend for people who lack capacity to litigate yet who wish to seek a Court decision on a best interests decision or who wish to challenge a deprivation of liberty (see Chapter 14). To better assist IMCAs and RPRs on their potential role as "litigation friends," we have commissioned guidance on this issue that we expect to be available in the autumn of 2014.

6.44 The Department of Health has already held a meeting of IMCA representatives to discuss the issues raised in the House of Lords report. The Department shall analyse the outputs of this meeting and look to meet jointly with all the main providers of IMCA services to discuss how we might progress the issues identified.

The Care Act is considered in Chapter 11. Care and Support Statutory Guidance was issued under the Care Act by the Department of Health in 2014 and is available on the government website.[56] Regulations have been issued under the Care Act on advocacy services.[57] Chapter 7 of the guidance covers independent advocacy and sees the benefits of the same advocate representing P for the purposes of the MCA and the Care Act.

Conclusions

The advocacy service provided under the MCA is a more limited provision than many organizations and individuals would have wished for. Even before the IMCA was established, regulations in England[58] provided for an extension to the service envisaged in the MCA (for Wales, see Chapter 18). The government has issued guidance under the Care Act 2014, suggesting that the same advocate could be appointed to act on behalf of P under both the MCA and the Care Act 2014. The service is monitored annually by the DH and the Care Quality Commission. The appointment of an IMCA when a patient is placed under the DOLs is considered in Chapter 14.

Checklist for the appointment of an IMCA under the MCA

1. Is P lacking the requisite mental capacity?
2. If the answer to 1 is *no*, then P can make his or her own decisions.
3. If the answer to 1 is *yes*, then question 4 must be asked.
4. Does the decision relate to serious medical treatment, accommodation arranged by an NHS body or LA, a review of such accommodation, or an adult protection issue?
5. If the answer to 4 is *yes*, does it come within the discretion of the NHS body or LA to arrange for the appointment of an IMCA?
6. If the answer to 4 is *no*, then an IMCA cannot be appointed under the MCA provisions, but consideration should be given to the possibility of appointing an independent advocate under the Care Act 2014.
7. If the answer to 4 is *yes*, is there an appropriate unpaid adult who can be consulted over P's best interests? (This question need not be asked in adult protection cases.)
8. If the answer to 7 is *yes*, then an IMCA under the MCA would not be appointed.
9. If the answer to 7 is *no*, then an IMCA can be appointed, provided that a deputy or lasting power of attorney has not been appointed.

Quick fire quiz, QFQ8

1. What is the philosophy behind the principle of appointing an advocate?
2. In what situations should the appointment of an IMCA be considered?
3. What are the exceptions to the appointment of an IMCA?
4. If a detained patient is being discharged from psychiatric hospital and being provided with accommodation under Section 117 of the Mental Health Act 1983, does an IMCA have to be appointed?
5. Who pays the IMCA?
6. Which are the two areas where the independence of the IMCA is considered essential?

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CHAPTER 9
Advance decisions

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Introduction

The most hotly debated and contentious provisions of the Mental Capacity Bill were those relating to advance decisions and the fear that the provisions were legalizing euthanasia. The Bill allowed for a person nominated by the patient to be able to make decisions on behalf of the patient (at a time when the patient lacked the requisite mental capacity), and it has been argued by opponents that if this power were not limited, it could lead to the death of a patient by food, water, and other necessities being withdrawn. In addition it was argued that there was no provision to cover the possibility that a person who had drawn up a living will had changed his or her mind. An amendment proposed by Iain Duncan Smith was defeated, but the Government promised that when the Bill was discussed in the House of Lords in January 2005, changes would take place to make it explicit that the Bill did not allow decisions to be made which are aimed at killing the patient.

The Government response on safeguards on withdrawal of life-sustaining treatment led to changes to the Bill to make

> it absolutely clear that no person, whether doctor, attorney, deputy or court, can, when making a best interests determination, have the motive of causing death, regardless of what would be in his best interests. [Para 41]

As a consequence Subsection 5 was added to Section 4:

> (5) Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.

Legal Aspects of Mental Capacity: A Practical Guide for Health and Social Care Professionals, Second Edition. Bridgit Dimond.
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Further safeguards were introduced to tip the legislation in favor of preserving life. Tough tests of validity and applicability have been set that must be satisfied if an advance decision is to be binding.

Eventually the final amendments made provision for many of these concerns and gave statutory recognition to the situation, which had already been recognized at common law in the Tony Bland case,[1] that a person when mentally capacitated could make advance decisions refusing treatment in a specified set of circumstances at a later time when he or she lacked capacity. In the case of *HE* v. *NHS Trust A and AE*[2] (see Case Study 9.3), the High Court held that the anticipatory refusal of a patient to have blood at a subsequent time when he or she no longer had mental capacity was valid at common law (i.e., judge made/case law) and binding on health professionals. This common law principle has now been given statutory recognition in the Mental Capacity Act 2005 (see Statute Box 9.1).

Advance decision to refuse treatment: General

The statutory provisions are set out in Statute Box 9.1.

Definition

An *advance decision* means a decision made by a person, who is over 18 years and has the capacity to make the decision, that if at a later time and in such circumstances

Statute Box 9.1 Sections 24–26 MCA

24 Advance decisions to refuse treatment: general

1 "Advance decision" means a decision made by a person ("P"), after he has reached 18 and when he has capacity to do so, that if—
  a) at a later time and in such circumstances as he may specify, a specified treatment is proposed to be carried out or continued by a person providing health care for him, and
  b) at that time he lacks capacity to consent to the carrying out or continuation of the treatment,
  the specified treatment is not to be carried out or continued.
2 For the purposes of subsection (1)(a), a decision may be regarded as specifying a treatment or circumstances even though expressed in layman's terms.
3 P may withdraw or alter an advance decision at any time when he has capacity to do so.
4 A withdrawal (including a partial withdrawal) need not be in writing.
5 An alteration of an advance decision need not be in writing (unless section 25(5) applies in relation to the decision resulting from the alteration).

25 Validity and applicability of advance decisions

1 An advance decision does not affect the liability which a person may incur for carrying out or continuing a treatment in relation to P unless the decision is at the material time—
  a) valid, and
  b) applicable to the treatment.
2 An advance decision is not valid if P—
  a) has withdrawn the decision at a time when he had capacity to do so,
  b) has, under a lasting power of attorney created after the advance decision was made, conferred authority on the donee (or, if more than one, any of them) to give or refuse consent to the treatment to which the advance decision relates, or
  c) has done anything else clearly inconsistent with the advance decision remaining his fixed decision.
3 An advance decision is not applicable to the treatment in question if at the material time P has capacity to give or refuse consent to it.
4 An advance decision is not applicable to the treatment in question if—
  a) that treatment is not the treatment specified in the advance decision,
  b) any circumstances specified in the advance decision are absent, or
  c) there are reasonable grounds for believing that circumstances exist which P did not anticipate at the time of the advance decision and which would have affected his decision had he anticipated them.
5 An advance decision is not applicable to life-sustaining treatment unless—
  a) the decision is verified by a statement by P to the effect that it is to apply to that treatment even if life is at risk, and
  b) the decision and statement comply with subsection (6).
6 A decision or statement complies with this subsection only if—
  a) it is in writing,

b) it is signed by P or by another person in P's presence and by P's direction,
c) the signature is made or acknowledged by P in the presence of a witness, and
d) the witness signs it, or acknowledges his signature, in P's presence.

7 The existence of any lasting power of attorney other than one of a description mentioned in subsection (2)(b) does not prevent the advance decision from being regarded as valid and applicable.

26 Effect of advance decisions

1 If P has made an advance decision which is—
a) valid, and
b) applicable to a treatment,
c) the decision has effect as if he had made it, and had had capacity to make it, at the time when the question arises whether the treatment should be carried out or continued.

2 A person does not incur liability for carrying out or continuing the treatment unless, at the time, he is satisfied that an advance decision exists which is valid and applicable to the treatment.

3 A person does not incur liability for the consequences of withholding or withdrawing a treatment from P if, at the time, he reasonably believes that an advance decision exists which is valid and applicable to the treatment.

4 The court may make a declaration as to whether an advance decision—
a) exists;
b) is valid;
c) is applicable to a treatment.

5 Nothing in an apparent advance decision stops a person—
a) providing life-sustaining treatment, or
b) doing any act he reasonably believes to be necessary to prevent a serious deterioration in P's condition,

while a decision as respects any relevant issue is sought from the court.

as he may specify, a specified treatment is proposed to be carried out or continued by a person providing healthcare for him, and at that time he lacks the capacity to consent to the carrying out or continuation of the treatment, then the specified treatment is not to be carried out or continued.

An advance decision has also been known as a living will or advance refusal or advance direction. The Law Commission in its report in 1995[3] used the term advance refusal rather than advance decision. It considered that the document would constitute a refusal for the commencement or continuation of treatment, but the possibility of an advance decision requiring treatment to be given has been considered in a recent case, *Burke* v. *GMC* (see **Burke decision, Case Study 9.7**).

The advantages of an advance decision are shown in the following case.

Case Study 9.1 *RGB* v. *Cwm Taf Health Board and others* [2013].[4]

A husband applied for contact with his wife who was 70 and suffered from very advanced Alzheimer's disease. She had been in hospital since June 2012, and he had been refused permission to visit her. The husband sought a declaration that the action of the health board was an unlawful breach of Article 8. The judge found that the wife had expressed a clear wish to leave him and had left the matrimonial home and wished to divorce him. In addition in 2011 when she had the requisite capacity, she drew up an advance decision saying that she did not want the husband contacted if she became unwell and if she went into hospital. If she was discharged, she wanted to live with her daughter and did not want to live with husband. She had issued divorce proceedings in 2011 which were subsequently stayed because of the lack of capacity. The judge held that the actions of the health board were justified in relying on the wishes she expressed before she lost mental capacity and the feelings she expressed in the advance statement were central to the matter.

Who can draw up an advance decision?

Age of person

The person preparing the advance decision must be over 18 years. This is because there have been situations where the refusal of a person under 18 years has been overruled by the court on the grounds that it was life-saving treatment and in the best interests of the young person, and therefore their refusal could be overruled. This occurred in the case of *Re W*[5] a girl of 16 years suffering from anorexia nervosa, who was refusing treatment. The Court of Appeal held that it was in her best interests to receive life-saving treatment

and her refusal could therefore be overruled (see Chapter 12 on children). As a result of Section 40 of the Mental Health Act 2007, a parent can no longer overrule the refusal of a young person of 16 and 17 years with the requisite mental capacity to be admitted to a psychiatric hospital. This reduction in parental powers may eventually lead to the recognition of the right of autonomy of the mentally capacitated 16- and 17-year-old.

The present situation contrasts with the situation for a mentally capacitated person over 18 years, as can be seen from the case of *Re B*[6] an adult patient, who was tetraplegic but who had the requisite mental capacity and who was therefore able to refuse ventilation. The case is considered in detail in Chapter 2.

Scenario 9.1 The statutory provisions.

Rita Davis was suffering from multiple sclerosis and was anxious to ensure that as her disease progressed and she became incapable of making her own treatment decisions, she would not receive artificial feeding and hydration and ventilation or be resuscitated. She therefore arranged to draw up a living will (i.e., advance decision) in which she gave an advance refusal of such treatments. The document was duly signed and witnessed. Only three months after signing the living will, she was severely injured when she fell down some steps and was brought into hospital unconscious. She was carrying her living will in her handbag and doctors were concerned to know whether, if they operated and she required ventilation in intensive care, the advance decision would prevent their providing such treatment and care. What are the statutory provisions?

Rita Davis must have been 18 years and have had the requisite mental capacity at the time she signed the advance decision for it to be valid. If the document specifies that she had the necessary mental capacity and is signed and witnessed, there would be a presumption that it was valid, but this could be rebutted if evidence was produced to the contrary. However there are problems relating to the circumstances envisaged by Rita. She drew it up in the context of her multiple sclerosis and that condition deteriorating so much that she would not wish to receive life-sustaining treatments. This is not the situation which has occurred here. The doctors would therefore have very real doubts as to the applicability of Rita's advance decision to the situation following her fall. In this uncertainty they would be justified in taking any life-saving measures while an application to the Court of Protection for a declaration on the validity of her advance decision to the present situation was considered.

How is it to be drawn up?

Layman's language

The decision may be regarded as specifying a treatment or circumstances, even though expressed in layman's terms (S.24(2)).

The fact that the patient is not required to use the jargon of the health professional is important, but this could present some difficulties in determining exactly what the patient wants covered by the advance decision. Clearly help by a health professional in drawing up the advance decision would greatly assist in identifying what is covered by the advance refusal. In the case of *W Healthcare NHS Trust* v. *H*,[7] the Court of Appeal held that a statement that a person would not wish to be kept alive by machines was not an advance directive sufficiently clear to be a valid refusal of food and drink.

What are the legal formalities?

There are very few formalities which are required to constitute a valid advance decision. A written document is only required if the advance decision is intended to cover situations where life-sustaining treatment is being refused (see section "Conditions for an Advance Decision to Cover Life-Sustaining Treatment to be Valid" on page 171). The statutory provisions are minimal, but the Code of Practice suggests recommended procedures[8]:

> A written document can be evidence of an advance decision. It is helpful to tell others that the document exists and where it is. A person may want to carry it with them in case of emergency, or carry a card, bracelet or other indication that they have made an advance decision and explaining where it is kept.

The Code of Practice para 9.19 says "there is no set form for written advance decisions, because contents will vary depending on a person's wishes and situation." But it is helpful to include the information shown in Box 9.1.

More formalities are required if the advance decision is to cover life-sustaining treatments (see section "Conditions for an Advance Decision to Cover Life-Sustaining Treatment to be Valid").

The Law Commission in 1995 was concerned not to insist that specific formalities were followed:

> To disregard valid decisions on that account would be contrary to our aims of policy. Matters of form and execution are essentially questions of evidence in any particular case.

Box 9.1 Information which the Code of Practice recommends should be included in an advance decision.

- full details of the person making the advance decision, including date of birth, home address and any distinguishing features (in case healthcare professionals need to identify an unconscious person, for example)
- the name and address of the person's GP and whether they have a copy of the document
- a statement that the document should be used if the person ever lacks capacity to make treatment decisions
- a clear statement of the decision, the treatment to be refused and the circumstances in which the decision will apply
- the date the document was written (or reviewed)
- the person's signature (or the signature of someone the person has asked to sign on their behalf and in their presence)
- the signature of the person witnessing the signature, if there is one (or a statement directing somebody to sign on the person's behalf).

The important point for the health professional is that the patient's wishes should be clear, and it should be understood to which treatments the patient is referring and the circumstances envisaged for the instruction to apply.

This contrasts very starkly with the strict formalities required for an ordinary will which comes into operation after the patient's death.

Oral advance decisions

Instructions by word of mouth may be given in advance by a mentally competent patient relating to a future refusal. There is no legal requirement that these should be made in writing, unless they are intended to refer to life-sustaining treatments. The Code of Practice[9] suggests that where a patient has given instructions by word of mouth, the health professional should document this and certain information should be recorded in the patient's notes, which will produce a written record that could prevent confusion about the decision in the future. The record should include:

- a note that the decision should apply if the person lacks capacity to make treatment decisions in the future
- a clear note of the decision, the treatment to be refused and the circumstances in which the decision will apply
- details of someone who was present when the oral advance decision was recorded and the role in which they were present (for example, healthcare professional or family member), and
- whether they heard the decision, took part in it or are just aware that it exists.

The situation is illustrated in Scenario 9.2.

How can it be changed?

"P may withdraw or alter an advance decision at any time when he or she has capacity to do so" (S.24(3)). It is not necessary for the withdrawal or a partial withdrawal to be in writing (S.24(4)) nor need an alteration of an advance decision be in writing unless it is applicable to life-sustaining treatment (S.24(5); see section "Conditions for an Advance Decision to Cover Life-Sustaining Treatment to be Valid" on page 171).

In a case heard prior to the implementation of the Mental Capacity Act (MCA), the Family Division decided that a woman of 24, mentally incapable of giving consent to treatment, could be given a blood transfusion, in spite of the existence of an advance decision created at a time when she was a Jehovah's Witness, since there was evidence that she had rejected her faith as a Jehovah's Witness and intended to marry a Muslim. It emphasized the importance of the hospital referring any case of uncertainty about the validity of an advance decision to the court for a declaration.[10] The case is further discussed in Case Study 9.3 and Scenario 9.2.

Scenario 9.2 A change of mind.

Bill had drawn up an advance decision which stated that in the event of his suffering from cancer, he would not wish to be resuscitated or receive artificial nutrition and hydration (ANH). He was told that cancer of the throat had been diagnosed and was advised that he would need a gastric tube to be inserted for food. He told the nurse that in that case, he would change his advance refusal so that the refusal of ANH would be deleted. Before he had a chance of changing the document, he became unconscious. The health professionals are in conflict over what treatments Bill should be given. The consultant considers himself to be bound by the advance refusal; the staff nurse holds that his instructions by word of mouth were sufficient to change the advance decision.

Withdrawing or altering an advance decision

The MCA permits a person to withdraw or alter an advance decision at any time when he has capacity to do so (S.24(3)). In Scenario 9.2 if Bill had the requisite mental capacity at the time that he told the staff nurse that he was prepared to accept the gastric tube to be inserted, then this would constitute an alteration to his advance decision and would be valid. A withdrawal (including a partial withdrawal) need not be in writing (S.24(4)) nor need an alteration of an advance decision be in writing. However if the alteration of the advance decision meant that P was now wishing life-sustaining treatments to be refused by means of the advance decision, then the requirements of Section 25(5) would apply (S.24(5); see Scenario 9.3.).

Scenario 9.3 A change of faith.

Jake, who belonged to a religious group which disagreed with any surgical procedures, drew up an advance decision which reflected these beliefs and refused all surgical intervention in the event of his becoming mentally incapacitated and needing such treatments. Subsequently Jake was converted to another faith which did not hold those beliefs. It did not occur to him to change his advance decision. A few years later Jake lost the mental capacity to make treatment decisions. Doctors said that he required an appendectomy. A relative showed his advance decision to the staff and pointed out that for the last few years Jake had gone to a different church which was not opposed to surgery. Does the fact that Jake had not destroyed the advance decision mean that it is still valid and reflects views which he would still have held and expressed had he not lost his mental capacity? Alternatively is it an oversight that Jake has not changed or destroyed his advance decision?

Validity and applicability of advance decisions

An advance decision must be valid and applicable to the treatment proposed at a particular time in order to give rise to liability on the part of a defendant (S.25(1)). For example, P in an advance decision may refuse a blood transfusion, but ventilation and artificial feeding may still be administered.

An advance decision is not valid if P:

a) has withdrawn the decision at a time when he had capacity to do so

b) has, under a lasting power of attorney which was created after the advance decision was made, conferred authority on the donee (or, if more than one, any of them) to give or refuse consent to the treatment to which the advance decision relates, or

c) has done anything else clearly inconsistent with the advance decision remaining his fixed decision (S25(2)).

One of the crucial concerns for any health professional or carer who finds that a now mentally incapacitated patient has drawn up a living will is knowing whether or not it is valid (see Scenario 9.1). Although treatment can continue to keep the patient alive while the validity of the advance decision is determined by the Court of Protection, the health professional would not wish to have to go to court every time an advance decision is produced. The important requisite in law is that the advance decision should reflect the patient's wishes so that at the time it comes into play, it is absolutely clear what the now mentally incapacitated patient would wish to happen to him or her.

The Act states that any action clearly incompatible with the advance decision taken by the patient after it has been drawn up would negate the applicability of the advance decision. So appointing a lasting power of attorney with powers to consent or refuse treatments, which are covered by the advance decision, after the advance decision was drawn up would indicate that the person no longer wished to keep to the advance decision, which would therefore be treated as withdrawn.

Other actions may also imply an intent on the patient's part to withdraw the advance decision. For example, see Scenario 9.3.

Even if an advance direction is invalid, for example, it has been drawn up by a person under 18 years or the statutory provisions have not been followed, its existence may still be of value in ascertaining P's best interests under Section 4 (see Chapter 5) and in providing evidence of P's past and present wishes and feelings, beliefs, and values. Section 4(6) specifically refers to "any relevant written statement made by him when he had capacity."

Where a patient is subject to the treatment provisions of the Mental Health Act 1983 (as amended), an advance decision can be overridden, unless it applies to ECT (S.58A, MHA 1983) S.28, MCA (see Chapter 13).

What situations would an advance decision cover?

See Scenario 9.3.

In such a situation as shown in Scenario 9.3, health professionals would probably have to apply to the Court of Protection for a declaration as to the validity of the advance decision. The court could take into account his change of religion and the new beliefs and decide if Jake would have intended the advance decision to apply to the situation in which he now found himself and, if not, what was in his best interests.

In a situation like that in Scenario 9.4, an application would be made to the Court of Protection to determine the validity of the advance decision in the changing circumstances. Evidence would have to be taken as to whether Peter was aware of the scientific progress before he lost his mental capacity. In the meantime treatment could be given to him to sustain him, until the court had made its decision.

Capacity of P

P must have the necessary mental capacity to create a valid advance decision and to withdraw or alter it. The advance decision does not come into effect until P lacks mental capacity. As long as P is capable of giving or refusing consent, the advance decision remains ineffective.

Scenario 9.4 Applicability of an advance decision.

Peter drew up a living will shortly after he was diagnosed with a chronic debilitating disease. It stated that in the event of his losing his mental capacity, he would not wish to be given life-sustaining treatment, even though he could die as a consequence. Ten years later the disease had progressed to the point where Peter no longer had the mental capacity to make any decisions relating to his care and treatment. His relatives ensured that the health professionals were aware of his advance decision. However in the ensuing years, significant progress had been made in curing the specific disease he suffered by genetic means, and the doctors were hopeful that if he could be kept alive, then the new treatments would make considerable improvements to his mental and physical well-being. They therefore wished the advance decision to be ignored or overruled.

An advance decision is not applicable to the treatment in question if at the material time, P has capacity to give or refuse consent to it (S.25(3)).

Relevance of the advance decision

An advance decision is not applicable to the treatment in question if:

a) that treatment is not the treatment specified in the advance decision

b) any circumstances specified in the advance decision are absent, or

c) there are reasonable grounds for believing that circumstances exist which P did not anticipate at the time of the advance decision, and which would have affected his decision had he anticipated them (S.25(4)).

See Scenarios 9.1, 9.3, 9.4, and 9.5 on the relevance and applicability of an advance decision.

Life-sustaining treatment

Special provisions apply to advance decisions and life-sustaining treatment. An advance decision is not applicable to life-sustaining treatment unless P specified in the decision that it was to apply to such treatment (S.25(5)) and that the decision or statement complies with Section 25(6) (see Statute Box 9.1).

What are life-sustaining treatments?

These are defined in Section 4(10) as

> treatment which in the view of a person providing health care for the person concerned is necessary to sustain life.

Nutrition, hydration, and ventilation obviously come into the definition, but at some point even such day-to-day treatments and care as nail cutting, dental care, or bodily cleansing could, if neglected for too long, become life-threatening. True elective surgery, such as a face-lift, would not usually become life-threatening.

The Explanatory Memorandum states (Para 89)[11] that *life* includes the life of an unborn baby, and the draft clause which became Section 4(10) was amended to

delete *his* before life so that it included the unborn baby. This has significant implications for the pregnant woman (see discussion on pregnant woman and advance decisions on page 198).

Conditions for an advance decision to cover life-sustaining treatment to be valid

It must be clear in the advance decision that P intends the refusal to apply to treatments, even though his or her life would be at risk. In addition Subsection 5 of Section 25 states that Subsection 6 must be complied with:

The decision or statement complies with subsection (6) only if:

a) it is in writing
b) it is signed by P or by another person in P's presence and by P's direction
c) the signature is made or acknowledged by P in the presence of a witness
d) the witness signs it, or acknowledges his signature, in P's presence.

The stipulations of Subsections 5 and 6 are strict and were designed to meet the concerns of those who felt that a person could inadvertently, through an advance decision, fail to receive the appropriate treatment, because they had not realized that it could be a life-threatening situation.

These formalities also apply to any alteration of an advance decision which requires life-sustaining treatment to be withheld or withdrawn. An alteration must be in writing, signed by P or by another person in P's presence and by P's direction, and P's signature acknowledged in the presence of a witness who signs it or acknowledges his signature in P's presence (see Scenario 9.5 on page 172).

In writing

In a memorandum submitted to the Joint Committee on Human Rights in response to their letter on November 18, 2004, the Joint Committee of the Houses of Parliament questioned why advance directives did not carry the additional safeguard of having to be made in writing.

In the light of this comment and also in the light of comments by the Joint Scrutiny Committee, the Government amended the Bill to say that advance decisions relating to the withdrawal of life-sustaining treatment should be put in writing and should be witnessed (the Government response can be downloaded from the Parliamentary website).[12]

The importance of making advance decisions as clear as possible cannot be exaggerated. It must be clear that the patient knows what he or she is doing and is aware of the implications. Otherwise a doctor may not be satisfied that an advance decision (1) exists, (2) is valid, and (3) is applicable.

Specifying treatments in an advance decision

If a person has not specified that the refusal is to apply where artificial nutrition and hydration (ANH) is necessary to sustain life, then ANH (if in the person's best interests) will have to be given. It is not necessary for a patient to spell out all treatment options which he or she is refusing. However it is essential that the patient makes it clear that the refusal applied to treatments necessary to sustain life. This requirement could be easily met where a person is suffering from a specific disease such as motor neurone disease and draws up an advance decision which makes it clear that if the disease progresses and they cease to have the mental capacity to make a decision on treatment, then certain forms of specified treatment (e.g., resuscitation, ventilation, and artificial feeding) should not be given.

However where the patient has not made it clear what treatments he or she is refusing and in what circumstances the refusal would apply, a health professional caring for that person would, with that uncertainty, have no alternative but to provide treatments in the best interests of the patient. An application could be made to the Court of Protection for a declaration on the validity of the advance decision to the patient's particular circumstances and treatment (see Scenario 9.5).

In such circumstances where P has not satisfied the strict conditions for the validity of the advance refusal of life-sustaining treatment, the National Council for Palliative Care has suggested that the refusal should be called an *advance statement* as opposed to an advance decision and should be taken note of when the best interests of P are being determined, as evidence of P's past wishes and feelings.[13]

Scenario 9.5 illustrates the problems which could arise with an advance decision.

Scenario 9.5 Advance decision completed in hospital.

Polly was seriously ill with cancer and feared a prolonged, painful death. Staff nurse Davidson asked her about whether she would wish to be resuscitated in the event of a cardiac arrest. Polly said that she would welcome such an event and would not wish to be resuscitated. Staff nurse Mavis Davidson wrote this up in Polly's records and asked her to sign it. She said that she felt too ill to write or sign anything. Mavis therefore wrote a note in Polly's records that she would not wish to be resuscitated in the event of an arrest and said that she would sign it in Polly's name with her approval. Polly agreed to that and Mavis wrote that she was completing it on behalf of Polly and asked another nurse, Beryl, to witness what was happening. Polly gave a sign that she was happy with what was taking place. Beryl then wrote a note in the records that she had witnessed Polly acknowledging the decision and Mavis's signing on her behalf. Beryl signed the note. Subsequently Polly became very confused and dipped in and out of consciousness. The consultant queried what Mavis had done and said that the decision against resuscitation should have been recorded on a hospital form, not just in Polly's records and doubted its validity. What is the law?

The legal requirements for setting up an advance decision refusing life-sustaining treatments are in Sections 25(5) and (6) of the MCA as shown in Statute Box 9.1. While an advance decision relating to life-sustaining treatment must be in writing, the Act does not require the writing to be written by the person making the decision. The formalities are satisfied if a person writes it up on behalf of a mentally capacitated patient. The fact that Mavis wrote up Polly's wishes satisfies the legal requirements. In addition the fact that Polly did not sign it herself is acceptable provided that someone signed it on her behalf in her presence, and Mavis satisfies this requirement. The final formality that a witness should be present for the signing and that the witness signs this (or acknowledges it) in Polly's presence is satisfied by Beryl's presence and signature. The legal formalities required by Section 25(6)(a), (b), (c), and (d) are therefore all satisfied. The consultant would therefore be wrong in maintaining that the record of Polly's advance decision was invalid. In law it would be acceptable. It may of course be possible that Mavis did not follow the hospital procedures in what she did, but this is a separate issue and would not necessarily invalidate Polly's instructions in law. The issue of course may arise as to whether Polly had the requisite mental capacity at the time she gave her instructions, and Mavis would have to give evidence as to why she believed Polly to be capable at the time she recorded the advance decision. There would have been advantages in securing the opinion of an independent health professional on the issue of Polly's mental capacity at the time. It is also advisable for the assessment of competence to be documented by the person who made it.

What would the situation be if the hospital used electronic records?

Writing would probably include electronic records. However there would have to be facilities for signatures to be incorporated as required by the conditions of Section 25(6)(b) and (d), where the advance decision referred to life-sustaining treatments.

In Case Study 13.1 (*A local authority* v. *E and others* [2012][14]) which is discussed in Chapter 13, Mr Justice Peter Jackson held that for an advance decision relating to life-sustaining treatment to be valid and applicable, there should be clear evidence establishing on the balance of probability that the maker had the capacity at the relevant time. Where the evidence of capacity is doubtful or equivocal, it is not appropriate to uphold the decision. In this case P suffered from anorexia, and the judge declared that it was lawful for her to be given life-saving treatment.

Advance decisions and best interests

A valid and applicable advance decision where P is unable to make his own decisions removes the possibility of using the best interests criteria to determine what treatments P should have. It may be difficult for health and social services professionals and relatives to accept, but they have no option other than to ensure that the wishes of P are carried out, as Scenario 9.6 illustrates.

The answer to the question in Scenario 9.6 depends entirely upon the clarity of the advance decision which Rachel signed and how apparent it is that it applies to the situation she is now in. She became mentally incapacitated because of a mishap during surgery, not because of her underlying condition. Does this mean that the advance decision is not applicable? From the

Scenario 9.6 Contrary to her best interests.

Rachel was 19 years old and her lungs were severely damaged by cystic fibrosis. She was assisted by the mother of another patient in drawing up an advance decision. In this she stated that in the event of her losing her mental capacity to make her own treatment decisions and in the event of her facing the terminal stage of her illness, she would not wish to be resuscitated, have any operative procedure, or be given artificial nutrition and hydration, even though her life was at stake. She arranged for this statement to be witnessed. She agreed to have surgery under a mild anesthetic for the insertion of a shunt to take future treatments of antibiotics. During the operation she regurgitated some substance into her lungs and had to be placed on a ventilator. The staff were aware of her advance decision. However her relatives were anxious that she should be kept alive. In addition it appeared that compatible lungs were available for transplant. Should Rachel be kept on a ventilator and be transferred for the transplant to take place?

staff and relatives point of view, it would appear to be in Rachel's best interests for her to be kept alive. However this does not appear to accord with her wishes as set out in the advance decision. Section 25(4)c states that if "there are reasonable grounds for believing that circumstances exist which P did not anticipate at the time of the advance decision and which would have affected his decision had he anticipated them, then the advance decision is not applicable to the treatment in question." This may be the situation in this scenario. The Court of Protection would have to determine the question of its applicability, and in the meantime steps could be taken to keep Rachel alive.

Where there is no valid and relevant advance decision, the decision makers must act in the best interests of the patient according to the principles set out in Section 1 and the steps to be taken to determine the best interests of the patient set out in Section 4. The Supreme Court held in the Aintree case[15] (see Chapter 11, Case Study 11.9) that in determining whether it was in a person's best interest to have life-sustaining treatment, the focus should be on whether it was in the best interests of the patient to give the treatment, rather than on whether it was in his best interests to withhold or withdraw it.

Case Study 9.2 *Re E (N and another* v. *E and others)* [2014].[16]

The case was concerned with whether M, a carer, could claim her legal costs from the estate. E had drawn up a living will, but her LPA was not registered till later, so it therefore invalidated the advance decision, and with the ending of the attorneys authority (by disclaimer), there was a danger that the treatment preferences expressed by E in her advance decision and in the LPA would be lost and consigned to oblivion. To remedy this the court made a declaration under 26(4) of the Act which after reciting the events which had happened and the guidance which E had recorded in her LPA for person welfare stated that "the advance decision made by E in the living will and set out in the Schedule to this declaration continue to exist and to be valid and to be applicable to her treatment."

Advance decisions and lasting powers of attorney

Where P has created a lasting power of attorney after an advance decision was made, which conferred authority on the donee (or, if more than one, any of them) to give or refuse consent to the treatment to which the advance decision relates, then the advance decision is invalid. However any other lasting power of attorney does not prevent the advance decision from being regarded as valid and applicable (S.25(7)).

It is only in these circumstances that the advance decision is overruled. Where a lasting power of attorney does not refer to treatments or refers to different treatments, it can exist side by side with the advance decision (S.25(7)). In the above case (Case Study 9.2), P drew up an advance decision before the registration of an LPA.

Effect of a valid advance decision

"If P has made an advance decision which is valid and applicable to a treatment, then the decision has effect as if he had made it, and had had the capacity to make it, at the time when the question arises whether the treatment should be carried out or continued" (S.26(1)).

Therefore anyone who believed that a valid advance decision exists which covers the treatment in question, yet ignored the provisions of that refusal and carried on giving the treatment, could be liable for the tort of trespass to the person in the civil courts and also, in

Scenario 9.7 Advance decision unknown.

In a Canadian case,[17] an unconscious patient was given a life-saving blood transfusion, in spite of the fact that she was carrying a card refusing such treatment. She was awarded C$20 000. The doctor had ignored her written request not to give her blood, and this constituted a trespass to her person. However, what would have been the situation if the nurse had not shown to the doctor the card on which the advance refusal was recorded and witnessed?

some circumstances, the criminal offences of assault and battery (see Chapter 11).

A person does not incur liability for carrying out or continuing the treatment unless, at the time, he is satisfied that an advance decision exists which is valid and applicable to the treatment (S.26(2)).

Where a health professional gave life-sustaining treatment to a mentally incapacitated patient in ignorance that there was a valid advance decision, he or she would not be liable in the tort of trespass or be criminally liable.

This is illustrated in Scenario 9.7 which explores the situation where staff were not aware of the existence of an advance decision.

In such a revised situation, the doctor could not have been successfully sued for trespass to the person since he would not have known of the advance refusal, and therefore in fulfilling his duty of care to the patient, he would not have realized that she had refused to have a blood transfusion. Action could of course be taken against the nurse if it was established that she had deliberately withheld information about the existence of an advance decision.

Reasonable belief on the validity of an advance decision

"A person does not incur liability for the consequences of withholding or withdrawing a treatment from P if, at the time, he reasonably believes that an advance decision exists which is valid and applicable to the treatment" (S.26(3)).

Court declaration on the validity of an advance decision

The court may make a declaration as to whether an advance decision:

a) exists
b) is valid
c) is applicable to a treatment (S.26(4)).

Scenario 9.8 Keeping alive.

A woman who was a Jehovah's Witness drew up an advance decision, which stated that if at a future time she no longer had mental capacity, she would not wish to be given blood, even in a life-saving situation. After the advance decision was created, she changed her faith. She did not however withdraw or alter the advance decision. She was seriously injured in a road accident and needed a life-saving blood transfusion. There was concern by her family and friends because she was no longer a Jehovah's Witness as to whether her advance decision was still valid. An application to the court to consider the validity of the advance decision was made.

It should be noted that if the Court of Protection concludes that the advance decision is valid and applicable, it does not have the power to overrule it.

Nothing in an apparent advance decision stops a person:

a) providing life-sustaining treatment, or
b) doing any act he reasonably believes to be necessary to prevent a serious deterioration in P's condition.
c) while a decision as respects any relevant issue is sought from the court (S.26(5)).

This could of course give rise to problems, as illustrated in Scenario 9.8, when the treatment being refused is the very treatment required to keep the patient alive while the validity of the advance decision is being considered.

In Scenario 9.8 it would be possible under Section 26(5) for life-sustaining treatment to be carried on while the decision of the court is awaited. This section enables action to be taken to provide life-sustaining treatment or to do something which is reasonably believed to be necessary to prevent a serious deterioration in P's condition. However in the circumstances, giving blood would completely defeat the wishes of the woman, if subsequently the court were to declare her advance decision was valid. In such circumstances it is hoped that the woman could be kept alive with non-blood products, and the court in an emergency session could make a very speedy declaration on the validity of the advance decision. In Case Study 9.3 the judge had to decide if an advance decision was still valid.

The judge held that there was no reason in law why an advance directive could not be withdrawn without any formalities. He stated that it is fundamental that an advance directive is, of its very essence and nature,

Case Study 9.3 HE and (1) a Hospital NHS Trust and (2) AE 2003.[18]

AE was brought up as a Muslim but following the separation of her parents went to live with her mother and became a Jehovah's Witness. She signed a preprinted form refusing a blood transfusion in February 2001. She suffered from a congenital heart defect. She was taken seriously ill in April 2003 and admitted to hospital. Her mother told the hospital that AE was a Jehovah's Witness and would not want to have a blood transfusion and that the advance directive should be followed. AE's condition deteriorated and a blood transfusion became a life-saving necessity. Her mother opposed a transfusion, but her father believed it should be given. He stated that his daughter had become engaged to a Muslim and agreed to give up her Jehovah's Witness faith as a condition of the marriage. She had subsequently ceased to attend Jehovah's Witness meetings. The father applied to court for a declaration that a blood transfusion could be given. AE was represented by the Official Solicitor.

inherently revocable. He accepted the father's evidence that, as a matter of fact, AE had ceased to be a Jehovah's Witness. The burden of proof lay on those who sought to establish the continuing validity and applicability of the advance directive. Where life is at stake, the evidence must be scrutinized with especial care. Clear and convincing proof is required. The continuing validity and applicability of the advance directive must be clearly established by convincing and inherently reliable evidence. If there is doubt, that doubt falls to be resolved in favor of the preservation of life. Once it was held that the advance directive was no longer valid, then the doctors had to treat AE in the way that in their clinical judgment best accorded with her interests, and her best interests required her to have the blood transfusion. The judge made a declaration accordingly.

As a postscript the judge criticized the fact that the father was compelled to take action himself and considered that where there was a doubt as to the validity of an advance directive, then the doctors and health authorities should not hesitate to apply to the courts for assistance. This case was heard before the implementation of the MCA, but similar principles would apply. However from October 1, 2007, the case would be heard in the Court of Protection. The following case (Case Study 9.4) was the first reported case under the MCA on the validity of an advance decision.

Case Study 9.4 *X primary care trust* v. *XB and YB* [2012].[19]

Mrs Justice Theis was asked to consider an application by X PCT for a declaration under S.26(4) as to the validity of an advance decision made by XB that he wished to have his ventilation removed in certain defined circumstances. XB suffered from motor neurone disease. The carer raised concerns that XB had not consented to the advance decision because she did not see him move his eyes. It was later found that she had not been present at the crucial time. The judge granted the declaration. The case illustrates the speed with which the CoP can operate: the case was listed to be heard at short notice on Friday, April 27, 2012, and heard on Tuesday, May 1, 2012. The case also illustrates the problem which can rise if the advance decision contains time limits. In this case the advance decision was made on November 2, 2011, and contained a review date for May 2, 2012, and the same date was put against the part stating *valid until*. The judge warned of the dangers of inserting an end date for the validity of an advance decision. She also emphasized the importance of the health authorities and others investigating the validity of the advance decision as a matter of urgency.

See also Case Study 13.2 (*Nottinghamshire Healthcare NHS Trust and RC* [2014][20]) which is considered in Chapter 13 where a patient detained under the Mental Health Act was able to refuse blood transfusion through an advance decision.

Application to the Court of Protection

The Code of Practice considers the situations where an application to the Court of Protection may be necessary.[21]

> The Court of Protection can make a decision where there is genuine doubt or disagreement about an advance decision's existence, validity or applicability. But the court does not have the power to overturn a valid and applicable advance decision.
>
> 9.68 The court has a range of powers (sections 16–17) to resolve disputes concerning the personal care and medical treatment of a person who lacks capacity (see Chapter 8 of the Code of Practice). It can decide whether:
>
> - a person has capacity to accept or refuse treatment at the time it is proposed
> - an advance decision to refuse treatment is valid
> - an advance decision is applicable to the proposed treatment in the current circumstances.
>
> 9.69 While the court decides, healthcare professionals can provide life-sustaining treatment or treatment to stop a

Scenario 9.9 Relatives dispute.

Following a road traffic accident, Steve is brought unconscious into the Accident and Emergency (A&E) department. He is carrying a card which makes it clear that he would not wish to have any surgical intervention or blood. The card is not witnessed. His situation is life-threatening, and the doctor examining him knows that if he does not have blood or surgery within the next few hours, he will die. He consults the directorate manager on the validity of the card and is told that it is a valid advance decision. He therefore does not give Steve a transfusion or arrange for an operation. Relatives who arrive in the A&E department are horrified to be told that Steve is dying and no operation has been carried out. They are prepared to sue for breach of the duty of care by the doctor.

serious deterioration in their condition. The court has emergency procedures which operate 24 hours a day to deal with urgent cases quickly.

Examples of the concerns which might arise over the validity of an advance decision include:

- a disagreement between relatives and healthcare professionals about whether verbal comments were really an advance decision
- evidence about the person's state of mind raises questions about their capacity at the time they made the decision (see Code of Practice, paras 9.7–9.9)
- evidence of important changes in the person's behaviour before they lost capacity that might suggest a change of mind.

In cases where serious doubt remains and cannot be resolved in any other way, it will be possible to seek a declaration from the court.[22]

The possibility of a dispute over an advance decision is considered in Scenario 9.9.

In such a situation as Scenario 9.9, the relatives could argue that the statutory provisions for refusing life-sustaining treatments have not been satisfied by Steve, and the advance decision is not therefore valid. The doctor could rely upon the statement of the directorate manager that the advance decision is valid, if that were reasonable to do. However it fails to comply with the statutory requirements of refusing life-sustaining treatments. It does not appear that Steve has mentioned that he is refusing these treatments, even though his life is at risk and the statement has not been witnessed.

Case Study 9.5 *An NHS Trust* v. *D* [2012].[23]

D drew up a document, making it clear that he would not want invasive medical treatment where he could not make decisions if the purpose was to extend a reduced quality of life. The document was not signed and did not comply with the MCA. D fell into vegetative state following surgery. The court held that it was not in his best interests for artificial nutrition and hydration to continue. 50% of costs of official solicitor were to be met by the NHS trust. The failure of D to comply with the statutory requirements for an advance decision to refuse life-sustaining treatment resulted in the clinicians being unable to act on his wishes for 9 months.

Case Study 9.6 *Newcastle upon Tyne Foundation Trust* v. *LM* [2014].[24]

The lawfulness of withholding blood transfusions from a gravely ill Jehovah's Witness was considered by the court. LM died before the decision of the court handed down. Judge Peter Jackson found that LM had made it clear when she had mental capacity that she would not want a blood transfusion. These decisions were not contained in a document complying with the MCA requirements. However, even if she hadn't he would still have made an order for a declaration not to give blood since it was not in her best interests and was contrary to her wishes and feelings (S.4(6)).

The doctor might be able to maintain that he had a reasonable belief in its validity and applicability and therefore was not liable under the Act. If the directorate manager had queried the validity or the applicability of the advance decision of Steve and referred the issue of its validity to court, then the doctor could have continued life-sustaining treatment until the court had ruled on its validity.

In the above case (Case Study 9.5), the statutory requirements of an advance decision refusing life-sustaining treatment were not satisfied, and the Court of Protection had to decide if the declaration stating the wishes and views of the incapacitated person could be relied upon for life-sustaining treatment to be withheld.

In the above case (Case Study 9.6), the court was able to rely upon the previous expressed views of the patient when mentally competent, even though an advance decision had not been drawn up.

What can be refused?

The Law Commission had recommended in its 1995 report[25] that a person drawing up an advance decision should not be able to opt out of basic care. Basic care was defined as "care to maintain bodily cleanliness and to alleviate severe pain, and the provision of direct oral nutrition and hydration." There is no such provision in the MCA, and therefore in theory P could refuse any kinds of treatment, including pain relief, by means of an advance decision. However the effect of Section 25(5) is that life-sustaining treatment cannot be withheld or withdrawn unless P specified in writing that the advance decision was to apply, even if life is at risk and all the procedural requirements of Section 25(6) are satisfied.

Refusal to have pain relief is considered in Scenario 9.10.

Section 5 refers to the provision of care and treatment, and an advance decision can only cover treatment, so it follows that an advance decision cannot include care. This is the view taken by the Code of Practice,[26] which suggests that Section 5 is intended to cover basic care and would prevent a patient refusing basic care in an advance decision.

> An advance decision cannot refuse actions that are needed to keep a person comfortable (sometimes called basic or essential care). Examples include warmth, shelter, actions to keep a person clean and the offer of food and water by mouth. Section 5 of the Act allows healthcare professionals to carry out these actions in the best interests of a person who lacks capacity to consent (see Chapter 6 of the Code of Practice). [Para 9.28]

Scenario 9.10 Refusing pain management.

Patrick is a Buddhist and believes in mind over matter. He had drawn up an advance decision which stated that if he were to be in a situation where he no longer had mental capacity to make his own decisions, he would not wish to be given any treatment including life-sustaining treatments, including ventilation or resuscitation. He is in the late stages of pancreatic cancer and had refused all pain relief. He gradually lost his mental capacity to make decisions and was clearly in severe pain. Health professionals caring for him were aware of his advance decision but felt that it would not cover the administration of pain relief. A dispute arose between the clinical team and his relatives over whether pain relief could be administered.

There is in the Act no definition of care, and Section 64 on interpretation states that *treatment* includes a diagnostic or other procedures. There is therefore room for doubt as to what would come within the definition of *care* and could not therefore be excluded by an advance decision and what will come under the definition of *treatment* and could therefore be excluded. Section 5(4) states that:

> Nothing in this section affects the operation of sections 24–26 (advance decisions to refuse treatment)

Eventually case law will determine the extent to which, if any, an individual can, when he or she has the requisite mental capacity, refuse specific types of care at a future time, when the capacity is lost. Scenario 9.10 illustrates the dilemma.

Had the earlier draft of the Mental Incapacity Bill been enacted, there would have been no difficulties in deciding what action to take in Scenario 9.10, since Patrick could not, through an advance direction, advance decision, or advance refusal, refuse pain relief. However in the absence of such provision in the MCA, the court would have to determine whether Patrick's advance decision could include alleviation of pain. Account would have to be taken of the Buddhist views on pain management.

If pain relief is considered to be *care*, then the fact that Patrick has included it in his advance decision does not mean that it cannot be given, since an advance decision can only cover *treatment*. However if pain relief is seen as a *treatment*, then its inclusion within an advance decision would be appropriate and, if all the other statutory requirements are satisfied, then pain relief could be withheld from Patrick.

Conscientious objection

Could a health professional ignore an advance decision on the grounds that he or she has a conscientious objection to withholding or withdrawing life-sustaining treatment? There is no such provision in the MCA. The Law Commission in its report in 1995 considered that it was inappropriate to include such a provision. Treating a patient despite a refusal of consent will constitute the civil wrong of trespass to the person and may constitute a crime.[27] Just as it would be a civil wrong of trespass to the person and even a criminal wrong of assault for a health professional to insist on providing treatment against the wishes of a mentally capacitated person, so it would be a

civil wrong or an offence to ignore an advance decision made by a mentally capacitated person which applied to the treatment in question and complied with the statutory requirements. In the words of the Law Commission:

> If the principle of self-determination means anything, the patient's refusal must be respected. There is therefore no need for any specific statutory provision.

Where a health professional had a conscientious objection to letting a person die in such circumstances, it would be advisable for him or her to raise the matter with a senior manager, who if possible could arrange the allocation of staff so that his conscientious objections were respected. There is however no statutory right for the objector to insist upon that (as there is with a conscientious objection to participation in a termination of pregnancy or in fertilization treatment), and in the event of a health professional failing to respect a valid advance decision refusing treatment, the health professional could face disciplinary action, fitness to practice proceedings before his or her registration body, civil proceedings, and even criminal prosecution (see Chapter 11).

If necessary an application to the Court of Protection could secure the appointment of another person to take responsibility for the patient's healthcare under Section 17(1)(e) which gives the Court of Protection the power to give "a direction that a person responsible for P's health care allow a different person to take over that responsibility."

Excluded decisions

The MCA excludes certain decisions being made on behalf of a person such as marriage or sexual relationships (S.27). Section 28 excludes the authorization of medical treatment to a patient for mental disorder under the MCA from the Act, and Section 29 prevents reliance on the MCA for voting rights on behalf of a person. (These are considered in Chapter 5.)

Pregnant women and advance decisions

There is no specific statutory provision in the MCA covering the situation where P is pregnant. In the Law Commission's draft Mental Incapacity Bill,[28] a clause was included that, in the absence of any indication to the contrary, made it a presumption that an advance refusal does not apply if it endangers the life of the fetus, of a pregnant woman. No such provision is included in the MCA, and therefore problems could arise. Section 4(10) was amended to delete *his* before life so that the section could apply to a fetus. Section 4 (10) states:

> "Life-sustaining treatment" means treatment which in the view of a person providing health care for the person concerned is necessary to sustain life.

The difficulty is discussed in Scenario 9.11.

> **Scenario 9.11** Refusal of blood.
>
> Pamela, a Jehovah's Witness, drew up an advance decision stating that if a situation arose where she lacked the mental capacity to make a decision, she would not want to be given a blood transfusion, even it is was a life-sustaining necessity. The document was signed and witnessed. Several years later she was involved in an explosion and was severely injured and incapable of making decisions. On arrival at the A&E department, the consultant stated that she was pregnant, and if she did not have blood, the fetus would die. Is the advance decision binding upon the health professionals?

The situation in Scenario 9.11 is another example where it may be necessary to seek a declaration from the court, since it is not clear from the advance decision whether or not it would cover the situation where Pamela is pregnant. However since it does cover a life-saving situation, the court is likely to hold that it is valid and binding in those current circumstances. The fact that it does not explicitly refer to the possibility of a pregnancy would not necessarily invalidate its effect. It would be a different situation if there were specific statutory provision as the Law Commission had recommended in 1995. However, good practice in drawing up advance decisions would suggest that women of childbearing age should take into account the possibility of their being pregnant at the time an advance decision came into effect and decide, in drawing up the document, the effect of the pregnancy on their advance decision.

The Explanatory Memorandum[29] suggests that

> The reference to "life" includes the life of an unborn child. [Para 89]

However this is open to a different interpretation by the courts. In 2014 the Court of Appeal held that a fetus did not constitute "any other person" for the purposes of Section 23 of the Offences against the Person Act 1861, so the mother was not guilty of a criminal offence when drinking alcohol when pregnant with the result that the child when born suffered from fetal alcohol spectrum disorder.[30] The child was therefore unable to obtain compensation from the criminal injury compensation scheme.

Implications for health and social services professionals

Criminal offences

Section 62 makes it clear that:

> For the avoidance of doubt, it is hereby declared that nothing in this Act is to be taken to affect the law relating to murder or manslaughter or the operation of section 2 of the Suicide Act 1961 (assisting suicide).

Vital to the legality of a health professional withholding or withdrawing treatment on the basis of a valid advance decision is the distinction in law between killing and letting die. Respecting the autonomy of a person expressed in an advance decision which explicitly refuses life-saving treatment and on that basis withholding or withdrawing life-sustaining treatment is not killing the patient but letting the patient die. Nor is it an offence of aiding and abetting a suicide under the Suicide Act 1961. These distinctions are explored in Chapter 11. An Assisted Dying Bill failed to complete its stages before Parliament was dissolved in March 2015. An Assisted Dying (No 2) Bill, introduced by a private member did not pass its second reading in September 2015.

Refusal to follow a valid, applicable advance decision

If a valid advance decision has been made and is applicable to a specific treatment, then a person who is aware of that advance decision but ignores it would be liable in civil and criminal law, just as they would if the person had the mental capacity to refuse that treatment at the time. Section 26(2) makes it clear that a person is not liable for carrying out or continuing to give the treatment unless he is satisfied that an advance decision exists which is valid and applicable to the treatment.

On the other hand, if treatment is withheld or withdrawn and the person concerned reasonably believed that a valid advance decision applied to the treatment, then that person does not incur liability.

Advance request to initiate or continue treatment

The statutory provisions only cover refusals. Should they have been extended to cover the request of a patient, when mentally incapacitated, to have specific treatments provided at a subsequent time when he or she was without capacity? The issue was discussed in the Burke Case Study 9.7.

Burke decision

The facts of the Burke case are set out in Case Study 9.7.[31] Mr Burke challenged the guidance provided by the General Medical Council (GMC) on withholding or withdrawing treatment in respect of a mentally incapacitated adult and claimed the right to insist that specific treatment were provided for him, even though it was contrary to the professional discretion of the medical staff. The Court of Appeal upheld the GMC's appeal against the High Court decision. The result is that a person has no legal right to insist on specific treatment being given at a later time, when he or she lacks the requisite mental capacity. While a person can refuse specific treatments, a person cannot insist on specific treatments being given. The patient is of course entitled to basic care.

House of Lords Scrutiny of the Mental Capacity Act 2014

In 2014 the House of Lords published the results of its post-legislative scrutiny of the Mental Capacity Act 2005.[33] The Government responded speedily and positively,[34] and the HL recommendations and Government response on advance decisions are shown later.

Recommendation 26 of the House of Lords scrutiny:

> We recommend that the Government, working with the independent oversight body: urgently address the low level of awareness among the general public of advance decisions to refuse treatment; promote better understanding among health care staff of advance decisions, in order to ensure that they are followed when valid and applicable; promote early engagement between health

Case Study 9.7 Burke case.[32]

A patient suffering from cerebellar ataxia, a progressive degenerative condition, and of full capacity, challenged the General Medical Council (GMC) guidelines, *Withholding and Withdrawing Life-prolonging Treatments: Good Practice in Decision-making*. He argued that the guidelines were contrary to the Articles of the European Convention on Human Rights. He applied for judicial review and sought clarification as to the circumstances in which ANH would be withdrawn. He did not want ANH to be withdrawn until he died of natural causes.

The judge granted judicial review, holding that once a patient had been admitted to an NHS hospital, there was a duty of care to provide and go on providing treatment, whether the patient was competent or incompetent or unconscious. This duty of care, which could not be transferred to anyone else, was to provide that treatment which was in the best interests of the patient. It was for the patient if competent to determine what was in his best interests. If the patient was incompetent and had left no binding and effective advance directive, then it was for the court to decide what was in his best interests. To withdraw ANH at any stage before the claimant finally lapsed into a coma would involve a clear breach of both Articles 8 and 3, because he or she would thereby be exposed to acute mental and physical suffering. The GMC guidelines were therefore in error in emphasizing the right of the claimant to refuse treatment but not his right to require treatment.

The GMC appealed against this ruling and the Court of Appeal's reserved judgment was given on July 29, 2005. The Court of Appeal held that doctors are not obliged to provide patients with treatment that they consider to be futile or harmful, even if the patient demands it. Autonomy and the right of self-determination do not entitle the patient to insist on receiving a particular medical treatment regardless of the nature of the treatment. However where a competent patient says that he or she wants to be kept alive by the provision of food and water, doctors must agree to that. Not to do so would result in the doctor not merely being in breach of duty but guilty of murder.

care staff and patients about advance decisions to ensure that such decisions can meet the test of being valid and applicable when the need arises; promote the inclusion of advance decisions in electronic medical records to meet the need for better recording, storage and communication of such decisions.

The Government response was:

6.31 The MCA should be at the heart of care assessment and planning for those who may lack mental capacity. In keeping with the ethos of person centred care and choice, professionals must seek to support those who lack capacity to make their own decisions about the nature of the care they receive. Where this is not possible, professionals should explore (with the individual, family, friends and others) the likely preferences, views and beliefs of that individual to arrive at a best interests decision.

6.32 So much flows from the initial assessment of needs and care planning that it is simply essential that the principles of the MCA are fully integrated into this process – not to do so could mean that an individual may spend years receiving care that is not in their best interests and which therefore does not enhance their well-being as should be expected. The introduction of the Care Act 2014 (which came into force in April 2015) provides a huge opportunity to embed the MCA into care planning and we urge all care providers and local authorities to take advantage of this.

6.33 The Department of Health has commissioned the Social Care Institute of Excellence (SCIE) to produce a report detailing how MCA principles can be embedded into the process of care planning. We expect this to be ready in early 2015. In tandem, the Department has commissioned a multi-media tool to complement this work and provide local authorities, providers and those using services with an easy-access tool to assist them realise the potential positive impact of integrating the MCA into care planning.

6.34 Advance decisions to refuse treatment (ADRTs) form an important part of the care and treatment planning process as do health and welfare Lasting Powers of Attorney (LPAs). We support the House of Lords recommendation that further work be done to raise awareness and understanding of ADRTs. The report of the Select Committee quite rightly draws attention to current best practice in some hospital trusts. For example, the standard operating procedure introduced in Warrington and Halton Hospitals NHS Foundation Trust. This is exactly the type of best practice that the national level needs to capture and help disseminate across the wider NHS.

6.35 We would ask the new Mental Capacity Advisory Board to include advance decision-making in its program of work and we urge our system partners to use their networks to increase information on ADRTs so that more individuals may realise the right to assert their wishes in this manner.

Conclusions

Tragic cases such as those of Diane Pretty, Annie Linsall, and Nicklinson (see Chapter 11) are likely to have raised the profile and the perceived value of advance decisions

for those who are facing a chronic deteriorating illness. The use of advance decisions will probably increase. It is therefore important for health professionals, across all specialities, to be aware of the existence and implications of an advance decision. Early action may be necessary in the event of any doubts arising about the validity of the advance decision or about its applicability to a given situation or to specific treatments and in particular its validity and applicability in relation to life-sustaining treatments. A website, independent of the NHS, has been set up to provide advice and information on advance decisions.[35]

Checklist to determine whether one is bound by an advance decision

- Is there evidence that P had the requisite mental capacity when making the advance decision?
- Was P at least 18 years at the time he made the advance decision?
- Is P now lacking the mental capacity to make decisions for himself?
- Does the advance decision cover the situation which P is now in?
- Does the advance decision cover the treatments which have been recommended as being in P's best interests?
- Is there any evidence that the advance decision has been withdrawn or altered?
- Has P drawn up a lasting power of attorney?
- If so, was it drawn up before or after the advance decision?
- If it was drawn up after the advance decision, does it cover the same treatment and circumstances as the advance decision and does it conflict with the advance decision?
- Is life-sustaining treatment being refused?
- If so, has P specified in writing in the advance decision that the refusal is to apply to such treatment and are the statutory requirements for such a refusal satisfied? These are as follows: the advance decision must be made by a person over 18 years; it is in writing; it is signed by P or by another person in P's presence and by P's direction; the signature is made or acknowledged by P in the presence of a witness; the witness signs it or acknowledges his signature, in P's presence; and it must be clear in the advance decision that P intends the refusal to apply to treatments, even though his or her life would be at risk.
- Is there a reasonable doubt about the validity or applicability of the advance decision? If so clarification must be sought from the Court of Protection.
- Is immediate treatment necessary to keep the patient alive while a declaration on the validity or the applicability of the advance decision is being sought from the Court of Protection?

Quick fire quiz, QFQ9

1 Can a young person of 17 create a valid advance decision?
2 What legal requirements must be followed to refuse life-sustaining treatment in an advance decision?
3 What legal action would a health professional face if he or she ignored the existence of a relevant valid advance decision?
4 In what circumstances can an advance decision be altered or withdrawn?
5 Can an advance decision refuse pain relief?
6 Can the advance decision require specific treatment to be given to the patient?

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CHAPTER 10
Research

THIS CHAPTER CONSIDERS THE FOLLOWING TOPICS

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Introduction: Research principles

The Joint Committee of Parliament[1] considered the issue of medical research and the adult who lacks mental capacity and was concerned at the absence of any provision in the draft Mental Incapacity Bill relating to research, since it considered that if properly regulated research involving people who may lack capacity was not possible, then treatments for incapacitating disorders would not be developed. The Joint Committee examined the importance of local research ethics committees (RECs) for the protection of the rights of those participating in research and the significance of the Helsinki Declaration by the World Medical Association in 1964 (and subsequently updated) to prevent the abuse of vulnerable people through medical experimentation. Those principles relating to research on those who lack the capacity to give a valid consent set out in the Helsinki Declaration (as revised in Edinburgh in 2000) are shown in Box 10.1. The full Declaration can be found in the appendix to (DH) guidance on local RECs[2] and on the World Medical Association website.[3]

The Joint Committee recommended that the Bill should set out the key principles governing research, such as those enshrined by the World Medical Association. These key principles should include the following:

- Research involving people who may be incapacitated must be reviewed by a properly established and

Legal Aspects of Mental Capacity: A Practical Guide for Health and Social Care Professionals, Second Edition. Bridgit Dimond.

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Box 10.1 Research principles set out in the Helsinki Declaration relating to those unable to give consent.

23 When obtaining informed consent for the research project the physician should be particularly cautious if the subject is in a dependent relationship with the physician or may consent under duress. In that case the informed consent should be obtained by a well-informed physician who is not engaged in the investigation and who is completely independent of this relationship.

24 For a research subject who is legally incompetent, physically or mentally incapable of giving consent or is a legally incompetent minor, the investigator must obtain informed consent from the legally authorised representative in accordance with applicable law. These groups should not be included in research unless the research is necessary to promote the health of the population represented and this research cannot instead be performed on legally competent persons.

25 When a subject deemed legally incompetent, such as a minor child, is able to give assent to decisions about participation in research, the investigator must obtain that assent in addition to the consent of the legally authorised representative.

26 Research on individuals from whom it is not possible to obtain consent, including proxy or advance consent, should be done only if the physical/mental condition that prevents obtaining informed consent is a necessary characteristic of the research population. The specific reasons for involving research subjects with a condition that renders them unable to give informed consent should be stated in the experimental protocol for consideration and approval of the review committee. The protocol should state that consent to remain in the research should be obtained as soon as possible from the individual or a legally authorised surrogate.

independent ethics committee and can only proceed if ethical permission is granted.

- Where a person has the capacity to consent, then his decision whether or not to partake in research must be respected.
- Considerable care should be taken to ensure that under these circumstances consent to participate was freely given and not a consequence of coercion.
- The inclusion of people in research, who lacked the capacity to consent, must only occur when such research has the potential for direct benefit to those with that particular problem, and could not have been done through the involvement of those with capacity.
- Those undertaking research involving people lacking the capacity to consent must respect any indications that a person did not wish to participate (i.e. was dissenting).
- Any discomfort or risk involved in the research must be, at the most, minimal.

In addition the Joint Committee on Human Rights[4] questioned certain provisions in relation to research on persons lacking mental capacity. The Government response stated that:

> We want to achieve a balance between allowing important research to proceed whilst not exposing an extremely vulnerable group of individuals to unacceptable interference with the rights and freedom of action or privacy. People who lack capacity must not be denied the benefits that can be obtained through carefully regulated research. Without such research, the development of appropriate treatments and improvements in services may not be possible. [Para 53]
>
> The Government wishes to provide a strict but enabling system of safeguards to cover this entire breadth of research. [Para 54]

Statutory provisions

Statutory protection of those unable to give a valid consent to research was thus introduced at a late stage into the Mental Capacity Act (MCA) draft legislation. Sections 30–34 contain the provisions relating to research and the mentally incapacitated adult and are shown in Statute Box 10.1.

Conditions for intrusive research

The MCA prohibits intrusive research being carried out on, or in relation to, a person who lacks the capacity to consent unless certain conditions are met. These conditions are shown in Statute Box 10.2 on page 187.

Scenario 10.1 on page 187 discusses the implications of these provisions.

Mental capacity of the proposed research data subject

The first issue to be determined is the mental capacity of Donald. Preferably (though this is not a statutory requirement) an independent person (one who is not involved in the research project) who is trained to test

Statute Box 10.1 Sections 30–34 Mental Capacity Act Research.

30 (1) *Intrusive research carried out on, or in relation to, a person who lacks capacity to consent to it is unlawful unless it is carried out—*

a) as part of a research project which is for the time being approved by the appropriate body for the purposes of this Act in accordance with section 31, and

b) in accordance with sections 32 and 33.

(2) Research is intrusive if it is of a kind that would be unlawful if it was carried out—

a) on or in relation to a person who had capacity to consent to it, but

b) without his consent.

(3) A clinical trial which is subject to the provisions of clinical trials regulations is not to be treated as research for the purposes of this section.

(3A) Research is not intrusive to the extent that it consists of the use of a person's human cells to bring about the creation *in vitro* of an embryo or human admixed embryo, or the subsequent storage or use of an embryo or human admixed embryo so created.

(3B) Expressions used in subsection (3A) and in Schedule 3 to the Human Fertilisation and Embryology Act 1990 (consents to use or storage of gametes, embryos or human admixed embryos etc) have the same meaning in that subsection as in that Schedule.

(Subsections 3A and 3B added by Human Fertilisation and Embryology Act 2008)

(4) "Appropriate body", in relation to a research project, means the person, committee or other body specified in regulations made by the appropriate authority as the appropriate body in relation to a project of the kind in question.

(5) "Clinical trials regulations" means—

a) the Medicines for Human Use (Clinical Trials) Regulations 2004 (S.I. 2004/1031) and any other regulations replacing those regulations or amending them, and

b) any other regulations relating to clinical trials and designated by the Secretary of State as clinical trials regulations for the purposes of this section.

(6) In this section, section 32 and section 34, "appropriate authority" means—

a) in relation to the carrying out of research in England, the Secretary of State, and

b) in relation to the carrying out of research in Wales, the National Assembly for Wales.

31 Requirements for approval

1 The appropriate body may not approve a research project for the purposes of this Act unless satisfied that the following requirements will be met in relation to research carried out as part of the project on, or in relation to, a person who lacks capacity to consent to taking part in the project ("P").

2 The research must be connected with—

a) an impairing condition affecting P, or

b) its treatment.

3 "Impairing condition" means a condition which is (or may be) attributable to, or which causes or contributes to (or may cause or contribute to), the impairment of, or disturbance in the functioning of, the mind or brain.

4 There must be reasonable grounds for believing that research of comparable effectiveness cannot be carried out if the project has to be confined to, or relate only to, persons who have capacity to consent to taking part in it.

5 The research must—

a) have the potential to benefit P without imposing on P a burden that is disproportionate to the potential benefit to P, or

b) be intended to provide knowledge of the causes or treatment of, or of the care of persons affected by, the same or a similar condition.

6 If the research falls within paragraph (b) of subsection (5) but not within paragraph (a), there must be reasonable grounds for believing—

a) that the risk to P from taking part in the project is likely to be negligible, and

b) that anything done to, or in relation to, P will not—

i) interfere with P's freedom of action or privacy in a significant way, or

ii) be unduly invasive or restrictive.

7 There must be reasonable arrangements in place for ensuring that the requirements of sections 32 and 33 will be met.

32 Consulting carers etc.

1 This section applies if a person ("R")—
  a) is conducting an approved research project, and
  b) wishes to carry out research, as part of the project, on or in relation to a person ("P") who lacks capacity to consent to taking part in the project.
2 R must take reasonable steps to identify a person who—
  a) otherwise than in a professional capacity or for remuneration, is engaged in caring for P or is interested in P's welfare, and
  b) is prepared to be consulted by R under this section.
3 If R is unable to identify such a person he must, in accordance with guidance issued by the appropriate authority, nominate a person who—
  a) is prepared to be consulted by R under this section, but
  b) has no connection with the project.
4 R must provide the person identified under subsection (2), or nominated under subsection (3), with information about the project and ask him—
  a) for advice as to whether P should take part in the project, and
  b) what, in his opinion, P's wishes and feelings about taking part in the project would be likely to be if P had capacity in relation to the matter.
5 If, at any time, the person consulted advises R that in his opinion P's wishes and feelings would be likely to lead him to decline to take part in the project (or to wish to withdraw from it) if he had capacity in relation to the matter, R must ensure—
  a) if P is not already taking part in the project, that he does not take part in it;
  b) if P is taking part in the project, that he is withdrawn from it.
6 But subsection (5)(b) does not require treatment that P has been receiving as part of the project to be discontinued if R has reasonable grounds for believing that there would be a significant risk to P's health if it were discontinued.
7 The fact that a person is the donee of a lasting power of attorney given by P, or is P's deputy, does not prevent him from being the person consulted under this section.
8 Subsection (9) applies if treatment is being, or is about to be, provided for P as a matter of urgency and R considers that, having regard to the nature of the research and of the particular circumstances of the case—
  a) it is also necessary to take action for the purposes of the research as a matter of urgency, but
  b) it is not reasonably practicable to consult under the previous provisions of this section.
9 R may take the action if—
  a) he has the agreement of a registered medical practitioner who is not involved in the organisation or conduct of the research project, or
  b) where it is not reasonably practicable in the time available to obtain that agreement, he acts in accordance with a procedure approved by the appropriate body at the time when the research project was approved under section 31.
10 But R may not continue to act in reliance on subsection (9) if he has reasonable grounds for believing that it is no longer necessary to take the action as a matter of urgency.

33 Additional safeguards

1 This section applies in relation to a person who is taking part in an approved research project even though he lacks capacity to consent to taking part.
2 Nothing may be done to, or in relation to, him in the course of the research—
  a) to which he appears to object (whether by showing signs of resistance or otherwise) except where what is being done is intended to protect him from harm or to reduce or prevent pain or discomfort, or
  b) which would be contrary to—
    i) an advance decision of his which has effect, or
    ii) any other form of statement made by him and not subsequently withdrawn, of which R is aware.
3 The interests of the person must be assumed to outweigh those of science and society.
4 If he indicates (in any way) that he wishes to be withdrawn from the project he must be withdrawn without delay.
5 P must be withdrawn from the project, without delay, if at any time the person conducting the research has reasonable grounds for believing that one or more of the requirements set out in section 31(2) to (7) is no longer met in relation to research being carried out on, or in relation to, P.
6 But neither subsection (4) nor subsection (5) requires treatment that P has been receiving as part of the project to be discontinued if R has reasonable grounds for believing that there would be a significant risk to P's health if it were discontinued.

34 Loss of capacity during research project

1 This section applies where a person ("P")—
 a) has consented to take part in a research project begun before the commencement of section 30, but
 b) before the conclusion of the project, loses capacity to consent to continue to take part in it.
2 The appropriate authority may by regulations provide that, despite P's loss of capacity, research of a prescribed kind may be carried out on, or in relation to, P if—
 a) the project satisfies prescribed requirements,
 b) any information or material relating to P which is used in the research is of a prescribed description and was obtained before P's loss of capacity, and
 c) the person conducting the project takes in relation to P such steps as may be prescribed for the purpose of protecting him.
3 The regulations may, in particular,—
 a) make provision about when, for the purposes of the regulations, a project is to be treated as having begun;
 b) include provision similar to any made by section 31, 32 or 33.

Statute Box 10.2 Conditions required for research on those lacking the requisite mental capacity to give consent.

- that the research is part of a research project
- which is approved by an appropriate body as defined in Section 31
- complies with the conditions laid down in Section 31 (see Statute Box 10.1), and
- complies with conditions relating to the consulting of carers and additional safeguards (i.e. Sections 32 and 33; see Statute Box 10.1).

Scenario 10.1 Research on mood swings.

Donald who has Down's syndrome has been asked to take part in a research project designed to determine whether a form of behavioral therapy would be effective in controlling his mood swings. The researcher, Ben, is studying for a PhD under a research grant provided by a charity. Donald's mother is concerned because she considers that Donald does not have the capacity to give consent. What is the legal situation?

mental capacity should be asked to assess Donald's mental competence.

Capacity to consent exists

If the assessment results in a conclusion that Donald has the mental capacity to give consent, then the common law relating to the giving of consent, including the right to withdraw consent at any time, would apply. The rules relating to the approval of the research by the local REC must also be followed. All relevant information about any risks or benefits of the research must also be provided to Donald.

Lack of capacity to consent

If on the other hand the assessment concludes that Donald lacks the capacity to give consent, then the provisions of the MCA 2005 apply. It is assumed that behavioral therapy does not come within the definition of clinical trial (if it does then the Clinical Trials Regulations will apply).

Conditions necessary for the research to proceed

The research must have been approved by a regional or local ethics committee established by the appropriate body.

The appropriate body is defined in the Regulations and means the REC.[5] It cannot approve the research involving those lacking capacity to consent unless the conditions insert specified in Statue Box 10.2 before are satisfied.

Is the research intrusive?

If the research would be unlawful if it were carried out without the consent of a mentally capacitated person, then it is intrusive. Would carrying out behavioral research on a mentally capacitated person require that person's consent? The answer to that question would be *yes*. The other statutory provisions must therefore be followed.

The research can only proceed with Donald as a research subject, if the following can be shown:

- The research must be connected with
- an impairing condition affecting Donald, or
- its treatment.

Is Down's syndrome an *impairing condition*? "'Impairing condition' means a condition which is (or may be) attributable to, or which causes or contributes to (or may cause or contribute to), the impairment of, or disturbance in the functioning of, the mind or brain."

Down's syndrome would appear to come within that definition.

Could the research be carried out on others who were capable of giving consent?

Are there "reasonable grounds for believing that research of comparable effectiveness cannot be carried out if the project has to be confined to, or relates only to, persons who have capacity to consent to taking part in it?"

This is difficult to answer, since there may well be others who have Down's syndrome who are capable of giving consent to involvement in this behavioral research. However they may not suffer from the mood swings which is the area of research. How thorough a search must be made for alternative data subjects? In practice of course, it is the local ethics committee which has had to answer these questions, since unless it is satisfied that all the statutory conditions are met, it cannot approve the research proposal. The researcher would however have to provide the evidence about alternative data subjects.

Will Donald benefit?

It must be shown that the research has the potential to benefit Donald without imposing on Donald a burden that is disproportionate to the potential benefit to Donald.

The answer to this in relation to Donald would depend upon the exact details of the behavioral research: would it involve time out (see glossary)? Would he be subjected to any negative or upsetting treatment? The ethics committee approved under the regulations would have to question the researcher on the detailed contents and implications of the research proposals.

Benefit to others affected by the same or a similar condition

If the balance of benefits to burdens is not favorable to Donald, then it must be shown that the research is "intended to provide knowledge of the causes or treatment of, or of the care of persons affected by, the same or a similar condition." In this situation there must be reasonable grounds for believing that there are negligible risks to Donald from taking part and that anything done to, or in relation to, Donald will not interfere with Donald's "freedom of action or privacy in a significant way, or be unduly invasive or restrictive."

However there is an additional safeguard set out in S.33(3) that:

> the interests of the person must be assumed to outweigh those of science and society.

It could not therefore be argued that the potential benefits to society from the research are such that Donald's own interests and rights can be ignored (see Scenario 10.5 on page 194).

Consultation with others

Ben the researcher must take reasonable steps to identify a person who, otherwise than in a professional capacity or for remuneration, is engaged in caring for P or is interested in P's welfare and is prepared to be consulted by R about Donald being involved in this research. Donald's mother would be the obvious person to consult with, but if for some reason she was not willing to be consulted, then Ben would have to find someone else who was involved in caring for Donald or interested in Donald's welfare and was prepared to be consulted (but who was not a professional nor paid carer).

If there were no such person, then Ben would have to look further afield. He would have to nominate a person

who is prepared to be consulted by him but has no connection with the project. Guidance has been issued by the Secretary of State and the Welsh Ministers on how the process and procedures for this nomination should be undertaken.[6]

The person consulted could be the donee of a lasting power of attorney given by Donald (unlikely in this situation since Donald has probably not had the requisite capacity to appoint one) or a deputy appointed by the Court of Protection for Donald.

What must Ben tell the person who is consulted or nominated?

Ben must inform Donald's mother if she has agreed to be consulted or any person who has been nominated for consultation about the project. There are no statutory provisions governing the kind of information which must be made known by the researcher, but Paragraph 11.27 of the Code of Practice states:

The researcher must provide the consultee with information about the research project and ask them:

- for advice about whether the person who lacks capacity should take part in the project, and
- what they think the person's feelings and wishes would be, if they had capacity to decide whether to take part.

Researchers are listed as one of those persons required to have regard to the Code of Practice under Section 42(4)(c) "as a person carrying out research in reliance on any provision made by or under this Act" (see Sections 30 to 34).

What are the effects of the consultation?

Ben must ask those consulted for advice as to whether Donald should take part in the project and what, in their opinion, Donald's wishes and feelings about taking part in the project would be likely to be if Donald had capacity in relation to the matter.

If the opinion given to Ben is that Donald would not wish to take part, then Ben would have to accept that refusal. He would have an obligation to make sure that Donald did not take part.

Withdrawal from project

If however Donald has already been involved in the research project and Ben is advised by anyone who has been consulted that Donald would wish to withdraw from it if he were able to make his own decisions on participation, then Ben must ensure that the withdrawal takes place immediately. For example, if Donald indicates by showing signs of resistance or in any other way that he objects to the research, then he must be withdrawn from the project without delay. There is a major exception to this immediate withdrawal:

> The immediate withdrawal of Donald from the project is not required if Ben has reasonable grounds for believing that there would be a significant risk to Donald's health if his involvement in the project were discontinued.

The advice from the person consulted by Ben, whether a carer or an independent person specifically nominated, can be given at any time while the research is taking place. It is not just a once-and-for-all opinion given at the start of the involvement of Donald in the research project. There must therefore be practical arrangements for those giving their advice to the researcher on the involvement of the person without the requisite mental capacity to be in contact whenever necessary throughout the whole of Donald's participation. While the wishes and feelings of Donald could probably be more easily monitored by a carer, the nominated independent person would have to ensure that they are kept advised of Donald's situation and of his wishes and feelings.

Intrusive research

Intrusive research is defined in Section 30(2) as:

> research which would be unlawful if carried out on a person capable of giving consent, but without that consent.

Clinical trials which come under the Clinical Trials Regulations are excluded from the statutory provisions.[7] These are considered on page 196.

The Code of Practice[8] notes that the Act does not have a specific definition for *research,* and it quotes the definitions used by the DH and National Assembly for Wales

(NAW) publications, *Research Governance Framework for Health and Social Care*:

> research can be defined as the attempt to derive generalisable new knowledge by addressing clearly defined questions with systematic and rigorous methods.[9]

The Code of Practice points out that research may:

- provide information that can be applied generally to an illness, disorder or condition
- demonstrate how effective and safe a new treatment is
- add to evidence that one form of treatment works better than another
- add to evidence that one form of treatment is safer than another, or
- examine wider issues (for example, the factors that affect someone's capacity to make a decision).

The Code of Practice notes that[10]:

> It is expected that most of the researchers who ask for their research to be approved under the Act will be medical or social care researchers. However, the Act can cover more than just medical and social care research. Intrusive research which does not meet the requirements of the Act cannot be carried out lawfully in relation to people who lack capacity.

Nonintrusive research

Nonintrusive research could include research of anonymized records or the use of anonymous tissue or blood left over after it had been collected for use in other procedures. While such research is excluded from the provisions of the MCA 2005, it could come under other legislative provisions such as the Data Protection Act 1998 and regulations under the Data Protection Act and the Human Tissue Act 2004 (see Chapter 15). Research could also be carried out without following the MCA procedures where confidential information is being used following an application under Section 251 of the NHS Act 2006 (see page 196).

Requirements for approval

The appropriate body (i.e., the person, committee, or other bodies specified by the Secretary of State in regulations)[11] may not approve a research project relating to a person lacking the capacity to consent unless the conditions shown in Statute Box 10.1, Section 31, are present.

Scenario 10.1 on page 187 illustrates the workings of the conditions set out in Section 31.

Impairing condition

The Code of Practice discusses the meaning of impairing condition and the underlying cause[12]:

> It is the person's actual condition that must be the same or similar in research, not the underlying cause. A '*similar condition*' may therefore have a different cause to that suffered by the participant. For example, research into ways of supporting people with learning disabilities to live more independently might involve a person with a learning disability caused by a head trauma. But its findings might help people with similar learning disabilities that have different causes.

The Code of Practice gives the example of a man with Down's syndrome who appears to be showing the symptoms of Alzheimer's disease, and his consultant is seeking to involve him in a research project to investigate the cause and treatment of dementia in people with Down's syndrome.

The Code of Practice also notes that[13]

> Benefits may be direct or indirect (for example, the person might benefit at a later date if policies or care packages affecting them are changed because of the research). It might be that participation in the research itself will be of benefit to the person in particular circumstances. For example, if the research involves interviews and the person has the opportunity to express their views, this could be considered of real benefit to a particular individual.

Balancing risks against benefits

These provisions require ethical committees to be sure that the research on the mentally incapacitated person is justified in terms of its scientific value, and there is no valid alternative by carrying out the research on a person who does have the capacity to give consent. There must be a balancing exercise in contrasting the risks against the benefits to the mentally incapacitated person.

The Code of Practice in discussing this balancing of the risks against the benefits of research involving adults who lack capacity gives the following examples of possible benefits[14]:

Potential benefits of research for a person who lacks capacity could include:

- developing more effective ways of treating a person or managing their condition
- improving the quality of healthcare, social care or other services that they have access to

- discovering the cause of their condition, if they would benefit from that knowledge, or
- reducing the risk of the person being harmed, excluded or disadvantaged.

The research could include both an analysis of the disease which has caused the mental incapacity and also the effects of the mental incapacity on his health and day-to-day life.[15]

Paragraph 101 of the Explanatory Memorandum suggests the following interpretation of Subsections 5 and 6 of Section 31, which deal with the anticipated benefits and risks of the research:

> There are two alternatives: either the research has the potential to benefit the person without imposing a burden disproportionate to that benefit (this type of research is sometimes called 'therapeutic research'); or the research is to provide knowledge of the causes of the person's condition, its treatment or the care of people who have the same or similar condition now or who may develop it in the future. In relation to this latter category, there must be reasonable grounds for believing that the risk to the person is negligible and the research must not interfere with the person's freedom of action or privacy in a significant way or be unduly invasive or restrictive. This latter category of research might include indirect research on medical notes or on tissue already taken for other purposes. It may also include interviews or questionnaires with carers about health or social-care services received by the person or limited observation of the person. And it could include taking samples from the person, e.g. blood samples, specifically for the research project.

The potential benefit to P is perhaps more loosely defined than some would wish. The Government justified departing from the Oviedo Convention (to which the United Kingdom is not a signatory) because it was too narrow in coverage. The Government did not accept the criteria from the Oviedo Convention that research must be of real and direct benefit to P, because for some research such as clinical and in a wider social care setting, it may be hard to show that it will definitely benefit a person directly, even though it may generate valuable knowledge about their condition.

Consulting carers (Section 32)

The researcher *R* is required to take reasonable steps to identify a person who is not engaged in a professional capacity nor receiving remuneration but is engaged in caring for P or is interested in P's welfare and is prepared to be consulted by the researcher under Section 32 (see Statute Box 10.1).

Subsection (7) makes it clear that "the fact that a person is the donee of a lasting power of attorney given by P, or is P's deputy, does not prevent that person from being the person consulted" under Section 32.

If such a person cannot be identified, then R must, in accordance with guidance issued by the Secretary of State or the Welsh Assembly, nominate a person who is prepared to be consulted by R but has no connection with the project.

At present there appears to be no provision for the health service body or local authority to be required to instruct the Independent Mental Capacity Advocacy service to provide a person to support and represent the person incapable of giving consent to participation in research, before research can be carried out using that person. The guidance to be produced might recommend an IMCA, but subordinate legislation would be necessary if it were to become a requirement that an IMCA should be appointed (in the absence of an appropriate person) where the person was being involved in research to which he or she could not give consent.

R must provide the carer or nominee with information about the project and ask him for advice as to whether P should take part in the project and what, in his opinion, P's wishes and feelings about taking part in the project would be likely to be if P had capacity in relation to the matter. If the person consulted advises R that in his opinion P's wishes and feelings would be likely to lead him to decline to take part in the project (or to wish to withdraw from it), if he had the capacity, then R must ensure that P does not take part or, if he is already taking part, ensure that he is withdrawn from it.

If treatment has commenced it is not necessary to discontinue the treatment if "R has reasonable grounds for believing that there would be a significant risk to P's health if it were discontinued." An example of the discontinuation of research is given in Scenario 10.2 on page 192.

Joan has the responsibility of deciding if in her opinion Bob's wishes and feelings would be likely to lead him to wish to withdraw from the project if he had capacity in relation to the matter. She should advise Tom if she considers that this is the case. Tom would

Scenario 10.2 Carer advises in favor of the discontinuation of research.

Bob has Prader–Willi syndrome and Tom, a researcher, has received a grant to consider a dietary regime which is designed specifically for those persons who have this condition and is aimed at reducing their appetite. It is claimed that the research would assist in the treatment and care of such sufferers.

Bob lives with four residents who have similar disorders in a community home, and Tom approaches the home manager to assess whether Bob could take part in the research. Tom consulted the home manager John, but since John was a paid carer, Tom was advised to seek out Bob's sister, Joan, who was a regular visitor to him. Joan says that it is clear that Bob could not give consent himself and she was concerned to see the research ethics committee's approval for the project and have further information about the research.

Joan is given all the information she requests and notifies Tom that it is her opinion that Bob had the mental capacity to make his own decision; Bob's wishes and feelings would be in favor of his taking part. She therefore advises Tom that Bob could take part in the project.

After 1 week, it is clear that Bob is becoming very distressed by being on the dietary regime and wants to come off it. There is no evidence at this stage that Bob's appetite has been reduced. Tom says that it is still early days and too soon to see any result and urges Joan to let him continue with the diet for another 3 days. What does Joan do?

therefore have to assess whether coming off the diet straightaway would cause harm to Bob.

Tom has the responsibility of removing Bob from the research project immediately. However if Tom has reasonable grounds for believing that there would be a significant risk to Bob's health if it were discontinued, then Bob could continue to stay on the research project until that risk is removed. Joan should be consulted on the need to continue the treatment in order to prevent harm to Bob.

Additional safeguards (Section 33)

There are additional safeguards to protect the interests of the person lacking the requisite mental capacity. These are shown in Statute Box 10.1.

- nothing may be done to, or in relation to a person taking part in the research project who is incapable of giving consent,

Scenario 10.3 Evidence of resistance (S.33(2), Safeguard in practice).

A research project conducted by Tony has been approved for the reduction of headbanging in clients suffering from severe learning disabilities. The project involves the use of a special helmet which makes headbanging more uncomfortable. Brian is taking part in this research and gives signs that he is not happy to be wearing the helmet. Tony, the researcher, claims that the research is designed to protect him from harm and should continue despite his resistance. What action should be taken?

- to which he appears to object (whether by showing signs of resistance or otherwise) except where what is being done is intended to protect him from harm or to reduce or prevent pain or discomfort, or
- which would be contrary to an advance decision of his which has effect or any other form of statement made by him and not subsequently withdrawn and R is aware of this.

Scenario 10.3 illustrates the effect of resistance by a research participant who lacks the requisite mental capacity.

The MCA expressly states (S.33(3)) that the interests of the person must be assumed to outweigh those of science and society.

Scenario 10.5 on page 194 illustrates the conflict between the interests of society and those of the participant.

If P indicates (in any way) that he wishes to be withdrawn from the project, he must be withdrawn without delay. He must also be withdrawn without delay if R has reasonable grounds for believing that one or more of the requirements set out in Section 31(2)–(7) (see Statute Box 10.1) are no longer met in relation to the research being carried out on P.

The research is not to be discontinued under Section 33(4) or (5) "if R has reasonable grounds for believing that there would be a significant risk to P's health if it were discontinued."

Evidence of resistance (Scenario 10.3)

Tony has the responsibility for deciding if the research is intended to protect Brian from harm or to prevent Brian suffering pain and discomfort. He would have to contact

the person he consulted when it was first agreed that Brian could take part. The fact that science and society would benefit from the knowledge which this research project could generate would be irrelevant. If Brian shows that he wishes to withdraw from the project and it is not established that the project is designed to protect him from harm or prevent pain and discomfort, then he should be withdrawn without delay. Only if Tony has reasonable grounds for believing that there would be a significant risk to P's health if it were discontinued could Brian's involvement continue.

Constant monitoring

The researcher must be constantly watchful to ensure that all the conditions, which had to be met before the REC could approve the research project, are still present. If, for example, it becomes apparent that research of comparable effectiveness could be carried out using persons who have the capacity to consent, then the research using a person incapable of giving consent should be discontinued. Only if the researcher had reasonable grounds for believing that there would be a significant risk to P's health if it were discontinued could the project be carried on.

Urgent research (S.32(8)(9))

Special provisions apply where treatment is to be provided as a matter of urgency and R considers that "it is also necessary to take action for the purposes of the research as a matter of urgency, but it is not reasonably practicable to consult under the previous provisions of this section."

In these circumstances R must have the agreement of a registered medical practitioner who is not concerned in the organization or conduct of the research project, or "where it is not reasonably practicable in the time available to obtain that agreement, he acts in accordance with a procedure approved by the appropriate body at the time when the research project was approved under Section 31." When R "has reasonable grounds for believing that it is no longer necessary to take the action as a matter of urgency," he cannot continue to act in reliance on these urgent provisions (S.32(10)).

Scenario 10.4 Situation of urgent treatment which is also research.

Mohammad has been severely injured in a road traffic accident and has suffered head injuries and damage to the lungs. It is clear that he requires an immediate operation, but Howard, the anesthetist, is uncertain about which method of anesthesia would be preferable, given his lung damage. Howard is currently researching a particular kind of equipment and believes that this would be beneficial to Mohammad. He therefore wishes to include Mohammad in his research project. Can he take the benefit of Section 32(8) and (9) relating to urgent treatment and research?

Scenario 10.4 discusses the implications of the provisions relating to urgent research.

Clearly the operation which Mohammad requires is urgent, and therefore a decision on the appropriate means of carrying out the anesthetic is urgent. It is necessary to take action for the purposes of the research as a matter of urgency. Is it reasonably practicable for Howard to consult Mohammad's informal carer or an independent nominated person? The use of the word *reasonable* means that the time, the cost, and the likelihood of success can all be taken into account in determining whether the person should be consulted. What Howard wishes to undertake is of potential benefit to Mohammad (Section 31(5)(a)). If he knew it would have direct benefit, then it would be considered to be treatment rather than research.

Clearly any delay in carrying out a vital operation may have serious consequences for Mohammad. If Howard decides that it is not reasonably practicable to consult the appropriate person, then he has to have the agreement of a registered medical practitioner who is not involved in the organization or conduct of Howard's research project on methods of anesthetic administration. If it is not reasonably practicable in the time available to obtain that agreement, then Howard can continue the research if he acts in accordance with a procedure approved by the REC (i.e., the appropriate body) at the time when the research project was approved. Once the emergency is over, Howard cannot continue to rely on these *urgency* provisions.

Personal vis-à-vis benefits to science and society

The MCA 2005 expressly states (S.33(3)) that the interests of the person must be assumed to outweigh those of science and society (see Statute Box 10.1).

Clearly in Scenario 10.5 the owner has not checked whether the project has been approved by the appropriate REC, because he does not believe it to be a research project. Yet a new product is being tested out, and those without the capacity to consent are being used as the data subjects. Before the home commenced receiving the water, it should have obtained approval from the appropriate REC. All the conditions in Sections 30–34 of the MCA should be satisfied (see Statute Box 10.1). Since the research could be carried out with those with the capacity to give consent and it is not directly related to the learning disabilities of the residents, it is unlikely that approval could be given. The fact that society would benefit from this project is irrelevant.

Loss of capacity during research project

Section 34 applies if P had "consented to take part in a research project begun before the commencement of Section 30" (October 1, 2007) but, "before the conclusion of the project, loses capacity to consent to continue to take part in it." In such a situation regulations may provide that despite his loss of capacity, research of a prescribed kind may be carried out on, or in relation to, P if:

a) the project satisfies the prescribed requirements
b) any information or material relating to P which is used in the research is of a prescribed description and was obtained before P's loss of capacity, and
c) the person conducting the project takes in relation to P such steps as may be prescribed for the purpose of protecting him.

The regulations may "make provision about when, for the purposes of the regulations, a project is to be treated as having begun" and "include provision similar to any made by Sections 31, 32 and 33."

Regulations[16] covering the situation where an adult who had given consent to participation in research lost the requisite mental capacity during the research project were enacted in 2007. They provide that in such circumstances, despite P's loss of capacity, research for the purposes of the project may be carried out using information or material relating to him if certain specified conditions exist:

a) the project satisfies the requirements set out in Schedule 1
b) all the information or material relating to P which is used in the research was obtained before P's loss of capacity, and
c) the person conducting the project ('R') takes in relation to P such steps as are set out in Schedule 2.

Schedule 1 is shown in Statute Box 10.3, and Schedule 2 is shown in Statute Box 10.4.

These are transitional regulations in the sense that they only apply if the person gave consent to participate

Scenario 10.5 Exploited for society's benefit.

Jim Hansom, the owner of a residential care home for those with severe learning disabilities, was told by a water company, Cleaneau, that he would obtain a financial benefit if Cleaneau could supply the home with water from its new water processing plant. It believed that the residents would benefit from the different methods of water purification. There was a possibility that the new process could also reduce gastroenteric diseases in the residents. Jim Hansom offered the carers of potential residents a discount to the usual fees because of the income provided by the water company. A parent challenged the owner on the legal basis of this project, and the owner stated that he did not consider that it was a research project, but the home was being offered a benefit not yet available to the general population. It was simply a new service which he was receiving for the benefit of the residents.

Statute Box 10.3 Schedule 1 to the Regulations on loss of capacity during the research project.

Requirements which the project must satisfy:

1 A protocol approved by an appropriate body and having effect in relation to the project makes provision for research to be carried out in relation to a person who has consented to take part in the project but loses capacity to consent to continue to take part in it.
2 The appropriate body must be satisfied that there are reasonable arrangements in place for ensuring that the requirements of Schedule 2 will be met (see Box 10.4 for Schedule 2).

Statute Box 10.4 Schedule 2 to the Regulations on loss of capacity during the research project.

Steps which the person conducting the project must take:

1 R must take reasonable steps to identify a person who – (a) otherwise than in a professional capacity or for remuneration, is engaged in caring for P or is interested in P's welfare, and (b) is prepared to be consulted by R under this Schedule.
2 If R is unable to identify such a person he must, in accordance with guidance issued by the Secretary of State, nominate a person who – (a) is prepared to be consulted by R under this Schedule, but (b) has no connection with the project.
3 R must provide the person identified under paragraph 1, or nominated under paragraph 2, with information about the project and ask him – (a) for advice as to whether research of the kind proposed should be carried out in relation to P, and (b) what, in his opinion, P's wishes and feelings about such research being carried out would be likely to be if P had capacity in relation to the matter.
4 If, any time, the person consulted advises R that in his opinion P's wishes and feelings would be likely to lead him to wish to withdraw from the project if he had capacity in relation to the matter, R must ensure that P is withdrawn from it.
5 The fact that a person is the donee of a lasting power of attorney given by P, or is P's deputy, does not prevent him from being the person consulted under paragraphs 1–4.
6 R must ensure that nothing is done in relation to P in the course of the research which would be contrary to – (a) an advance decision of his which has effect, or (b) any other form of statement made by him and not subsequently withdrawn, of which R is aware.
7 The interests of P must be assumed to outweigh those of science and society.
8 If P indicates (in any way) that he wishes the research in relation to him to be discontinued, it must be discontinued without delay.
9 The research must be discontinued without delay if at any time R has reasonable grounds for believing that one or more of the requirements set out in Schedule 1 is no longer met or that there are no longer reasonable arrangements in place for ensuring that the requirements of this Schedule are met in relation to P.
10 R must conduct the research in accordance with the provision made in the protocol referred to in paragraph 1 of Schedule 1 for research to be carried out in relation to a person who has consented to take part in the project but loses capacity to consent to take part in it.

in the research which started before October 1, 2007, but loses capacity before the research project ends. The research could of course carry on for many years beyond 2007 and the regulations would still apply.

NHS RECs

The research must be approved by an appropriate body for the purposes of a research project. This has been defined in the Regulations[17] as a committee (or other body)—

a) established to advise on, or on matters which include, the ethics of research investigations of the kind conducted, or intended to be conducted, as part of the project, including the ethics of intrusive research in relation to people who lack capacity to consent to it; and

b) recognised for those purposes by or on behalf of the Secretary of State.

The regulations defining appropriate body came into force on July 1, 2007, for the purpose of enabling applications for approval to be made and on October 1, 2007, for all other purposes.

Local RECs were established by the DH in 1991.[18] Multicentre Research Ethics Committees (MRECs) were established in 1997.[19] A Central Office for NHS Research Ethics Committees (COREC) was established in 2000. The following year the DH published the Research Governance Framework for Health and Social Care. A policy document, *Governance Arrangements for NHS Research Ethics Committees*, was published in August 2001.[20] COREC was placed under the National Patient Safety Agency in 2005 and relaunched as the National Research Ethics Service (NRES) in March 2007.

An ad hoc advisory group was set up to review the operation of National Health Service RECs. Its report[21] was published in June 2005. Its conclusions ranged widely over the need to change the system of RECs, the need to address perceived weaknesses in the REC system, and the need to provide better support for Chairs, members, and administrative staff. The aim of its recommendations was to raise the status and profile of RECs and lay the firm foundation for a REC system that can be more responsive to changing requirements in the future in a UK-wide context. It recommended that significant changes to the National Health Service REC

system should be made. Changes were implemented under the new NRES (see NPSA website).

The National Institute of Health Research[22] (NIHR) was established in 2006 and funded through the Department of Health to improve the health and wealth of the nation through research. It has four main strands:

1 NIHR Faculty: supporting individuals carrying out and participating in research
2 NIHR Research: commissioning and funding research
3 NIHR Infrastructure: providing facilities for a thriving research environment
4 NIHR Systems: creating unified, streamlined, and simple systems for managing research and its outputs

In 2010 a White Paper *Equity and Excellence: Liberating the NHS* was published as a vision for the NHS. It emphasized the core role of research in the NHS, the role of the NHS Commissioning Board (NHS England) in promoting research, the importance of clinical research, and the NIHR and the success of NIHR clinical research networks.

NHS Health Research Authority

In 2011 the NHS Health Research Authority[23] was established as a Special Health Authority to protect and promote the interests of patients and the public in health research and to streamline the regulation of research. The NRES was a core function and directorate within the Health Research Authority.

The Care Act 2014 (S.109–116 and Schedule 7) established HRA as a body corporate, non-departmental public body, with responsibility for the UK-wide Research Governance Framework. It is responsible for RECs, the Gene Therapy Advisory Committees, and the Confidentiality Advisory Group which advises on Section 251 of the NHS Act 2006. This section enables applications to be made for confidential patient information to be used. The RECs are managed through the NRES. (Further information on the HRA can be found on its website.[24])

The main functions of the HRA (S.110 Care Act) are:

a) functions relating to the co-ordination and standardisation of practice relating to the regulation of health and social care research (see section 111 Care Act);
b) functions relating to research ethics committees (see sections 112 to 115 Care Act);
c) functions as a member of the United Kingdom Ethics Committee Authority (see section 116 and the Medicines for Human Use (Clinical Trials) Regulations 2004 (S.I. 2004/1031));
d) functions relating to approvals for processing confidential information relating to patients (see section 117 Care Act and the Health Service (Control of Patient Information) Regulations 2002 (S.I. 2002/1438)).

Its main objectives in exercising its functions are:

a) to protect participants and potential participants in health or social care research and the general public by encouraging research that is safe and ethical, and
b) to promote the interests of those participants and potential participants and the general public by facilitating the conduct of research that is safe and ethical (including by promoting transparency in research).

It is required to publish guidance on good practice in the management and conduct of health and social care research. Under Section 112 it must ensure that RECs it recognizes or establishes provide an efficient and effective means of assessing the ethics of health and social care research.

Clinical trials

Clinical trials which come under the Clinical Trials Regulations are excluded from the statutory provisions of the MCA 2005, Section 30(3). These regulations were drawn up as a consequence of the European Directive.[25] Article 5 makes provisions for clinical trials on incapacitated adults not able to give informed legal consent. The regulations were enacted in 2004.[26] The exclusion covers any future regulations to be enacted for the purposes of this section.

The Clinical Trial Regulations Schedule 1 states that if any subject:

a) is an adult unable by virtue of physical or mental incapacity to give informed consent, and
b) did not, prior to the onset of incapacity, give or refuse to give informed consent to taking part in the clinical trial, then the conditions and principles specified in Part 5 apply in relation to that subject.

Part 5 of Schedule 1 to the Clinical Trials Regulations is shown in Statute Box 10.5.

Statute Box 10.5 Part 5 of Schedule 1 to the clinical trial regulations.

Conditions and principles which apply in relation to an incapacitated adult

Conditions

1. The subject's legal representative has had an interview with the investigator, or another member of the investigating team, in which he has been given the opportunity to understand the objectives, risks and inconveniences of the trial and the conditions under which it is to be conducted.
2. The legal representative has been provided with a contact point where he may obtain further information about the trial.
3. The legal representative has been informed of the right to withdraw the subject from the trial at any time.
4. The legal representative has given his informed consent to the subject taking part in the trial.
5. The legal representative may, without the subject being subject to any resulting detriment, withdraw the subject from the trial at any time by revoking his informed consent.
6. The subject has received information according to his capacity of understanding regarding the trial, its risks and its benefits.
7. The explicit wish of a subject who is capable of forming an opinion and assessing the information referred to in the previous paragraph to refuse participation in, or to be withdrawn from, the clinical trial at any time is considered by the investigator.
8. No incentives or financial inducements are given to the subject or their legal representative, except provision for compensation in the event of injury or loss.
9. There are grounds for expecting that administering the medicinal product to be tested in the trial will produce a benefit to the subject outweighing the risks or produce no risk at all.
10. The clinical trial is essential to validate data obtained –
    a) in other clinical trials involving persons able to give informed consent, or
    b) by other research methods.
11. The clinical trial relates directly to a life-threatening or debilitating clinical condition from which the subject suffers.

Principles

1. Informed consent given by a legal representative to an incapacitated adult in a clinical trial shall represent that adult's presumed will.
2. The clinical trial has been designed to minimise pain, discomfort, fear and any other foreseeable risk in relation to the disease and the cognitive abilities of the patient.
3. The risk threshold and the degree of distress have to be specially defined and constantly monitored.
4. The interests of the patient always prevail over those of science and society.

Conclusions

It remains to be seen if the MCA has achieved the balance wanted by the Government, between allowing important research to proceed and not exposing an extremely vulnerable group of individuals to unacceptable interference with their rights and freedom of action or privacy. Monitoring of the work of RECs may show the extent to which the MCA protects the interests of those lacking the mental capacity to give consent to research participation. However there needs also to be extensive involvement by those consulted under Section 32 to ensure that the participation or the discontinuation of those lacking the requisite mental capacity is closely monitored. The House of Lords select committee in its review of the MCA[27] did not make any recommendations relating to research on those lacking the requisite mental capacity to consent.

Checklists

1 Participation in research
- Does P have the requisite mental capacity to make his own decisions on participation in a research project?
- If so, the decision as to whether or not to participate can be left to P (if P gives consent but subsequently loses capacity during the research project—see point 3 on page 198).
- Has P drawn up an advance decision or made an advanced statement when competent, opposing participation in such a research project?
- If so, the research should not proceed.
- If P does not have the requisite mental capacity and has not made an advance decision or advance statement covering the research, then the following questions must be asked:

- Does the research come under the definition of a clinical trial?
- If so, then it is subject to the clinical trial regulations.
- If not, then the following questions must be asked:
- Has the research ethics committee approved the project and therefore been satisfied that the statutory conditions are met?
- Is the research connected with a condition which affects P (the person lacking mental capacity)?
- Is the research connected with an impairing condition affecting P or its treatment? (An impairing condition is defined in Section 31(3) as a condition which is (or may be) attributable to, or which causes or contributes to, the impairment of, or disturbance in the functioning of, the mind or brain.)
- Are there reasonable grounds for believing that the research would not be as effective if carried out only on, or only in relation to, persons who have the capacity to consent to taking part in the project?
- If *no*, then there would be no justification in using a person who lacks the capacity to give consent.
- If *yes*:
- Does the research have the potential to benefit P without imposing on P a burden that is disproportionate to the potential benefit to P (this condition can be dispensed with if the risk to P is negligible and anything done to P will not interfere with his "freedom of action or privacy in a significant way or be unduly invasive or restrictive")? or
- Are the benefits to P greater than the burdens in participating?
- Is the research "intended to provide knowledge of the causes or treatment of, or of the care of persons affected by, the same or a similar condition"?
- Are any risks to P from taking part likely to be negligible?
- Will anything to be done to or in relation to P interfere with his "freedom of action or privacy in a significant way, or be unduly invasive or restrictive"?
- Is there a carer who could be and is prepared to be consulted?
- If not, can a nominated independent person be consulted?
- Has the consultee been given the appropriate information?
- What is the opinion of the consultee on what P's wishes and feelings would have been had he had the requisite mental capacity?

2 Once the research has commenced
- Does P appear to object by showing signs of resistance or otherwise?
- If *yes*, is this because what is being done is intended to protect him from harm or to reduce or prevent pain or discomfort?
- Does P indicate that he wishes to be withdrawn from the project?
- If so, he must be withdrawn without delay unless "R has reasonable grounds for believing that there would be a significant risk to P's health if it were discontinued."
- Is the researcher satisfied that the conditions for the research to be carried out on a person who lacks capacity are still present?
- If *no*, then P must be withdrawn from the project without delay (subject to the proviso about risks to his health).

3 Loss of capacity during research project
- If P consented to participation before October 1, 2007, and then loses capacity during the research project, it can only be continued if it satisfies the regulations.
- Has Schedule 1 of the Regulations,[28] as shown in Statute Box 10.3, been complied with?
- Is Schedule 2 of the Regulations, as shown in Statute Box 10.4, relating to the steps which the person conducting the project must take, been complied with?
- Is any information or material relating to P and used in the research of a prescribed description and was it obtained before P's loss of capacity?

4 Urgent research
- Is treatment being or about to be provided for P as a matter of urgency?
- Does R consider that, having regard to the nature of the research and of the particular circumstances of the case, it is also necessary to take action for the purposes of the research as a matter of urgency?
- Is it reasonably practicable to consult an informal carer or nominee?
- If *yes*, then the consultation must take place.

- If *no*, then R may take action if either he has:
  - the agreement of a registered medical practitioner not involved in the organization or conduct of the research project, or
  - it is not reasonably practicable in the time available to obtain that agreement,
  - but he acts in accordance with a procedure set by the appropriate body, that is, the ethics committee at the time the research project was approved.
- Does the action continue to be required as a matter of urgency?
- If no, then R can no longer act in reliance on these provisions.

Quick fire quiz, QFQ10

1 What is meant by intrusive research?
2 What conditions must be satisfied before intrusive research can be carried out on a mentally incapacitated adult?
3 What is meant by the requirement in S.33(3) that the interests of the person must be assumed to outweigh those of science and society?
4 In the absence of an unpaid carer for P, does the researcher have to ensure that an independent mental capacity advocate is appointed?
5 What are the conditions for urgent research to take place?
6 Can the research continue if a person with the requisite mental capacity gave consent to participation in the project before October 1, 2007, but subsequently before completion of the project lost the requisite mental capacity?

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CHAPTER 11

Protection of vulnerable adults and accountability

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Introduction

In its Mental Incapacity Bill,[1] following on from its Consultation Paper,[2] the Law Commission drafted statutory provisions for vulnerable adults to provide a similar framework for protection as that provided for children under the Children Act 1989. However these provisions were not included within the Mental Capacity Bill. The Mental Capacity Act (MCA) 2005 does however introduce a new criminal offence of ill-treating or wilfully neglecting a person who lacks capacity. This chapter explores this new offence and also considers those existing laws, both criminal and civil, which provide some protection for the mentally incapacitated adult. The discussion includes the provisions of the Care Act 2014 and its significance for those

Legal Aspects of Mental Capacity: A Practical Guide for Health and Social Care Professionals, Second Edition. Bridgit Dimond.

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lacking the requisite mental capacity. The chapter also considers the accountability of those involved in the care of those lacking mental capacity.

Criminal offence to ill-treat or wilfully neglect a person who lacks capacity

Under Section 44(2) it is an offence to ill-treat or wilfully neglect a person who lacks capacity. The offence arises if a person D:

a) has the care of a person P who lacks, or whom D reasonably believes to lack, capacity
b) is the donee of a lasting power of attorney, or an enduring power of attorney (within the meaning of Schedule 4), created by P, or
c) is a deputy appointed by the court for P (S.44(1)).

A person who is guilty of an offence under Section 44 is liable on summary conviction to imprisonment for a term not exceeding 12 months or a fine not exceeding the statutory maximum or both; on conviction on indictment, to imprisonment for a term not exceeding 5 years or a fine or both.

The Joint Committee recommended that the scope of the new offence should be extended to include the misappropriation of the person's property and financial assets[3] (and not just physical ill-treatment), but they appreciated the difficulties of obtaining evidence when the victim lacks mental capacity.[4] It urged the Home Office and other departments to continue to cooperate to ensure that the state's positive obligation to provide for the protection of vulnerable people is complied with.[5]

As noted previously the new offence is not so extensive as might be thought, since it does not explicitly cover financial abuse of a mentally incapacitated person. Decided cases have shown how difficult it has been to interpret the section as can be seen in the following.

Carer of the mentally incapacitated person

There is no definition of *a person who has the care of P* in the MCA. While it is clear that the term would cover all professional and paid carers, and would also cover relatives who provide care and others who live with the person lacking mental capacity, would the term cover an individual who did the occasional shopping for a person living in a flat on the floor below? See Scenario 11.1.

Carer in the Carers (Recognition and Services) Act 1995 is defined as "an individual who provides or intends to provide a substantial amount of care on a regular basis for the relevant person" (S.1(1)(b)), and this same definition is used in the Carers and Disabled Children Act 2000, where the individual is over 16 years and provides a substantial amount of care on a regular basis for another individual aged 18 or over (S.1(1)(a)). In the absence of a statutory definition within the MCA, case law will determine whether a substantial amount of care (and if so what is meant by substantial) is required for the offence to be committed. Under Section 13(6) of the Care Act 2014, a *carer* means an adult who provides or intends to provide care for another person, and the same definition is used in Section 102(5). Under Section 10(3) *Carer* means an adult who provides or intends to provide care for another adult (an *adult needing care*); but this is subject to subsections (9) and (10).

Subsection (9) states that an adult is not to be regarded as a carer if the adult provides or intends to provide care—

a) under or by virtue of a contract, or
b) as voluntary work

Section 10 subsection 9 is however subject to subsection 10 which states:

> But in a case where the local authority considers that the relationship between the adult needing care and the adult providing or intending to provide care is such that it would be appropriate for the latter to be regarded as a carer, that adult is to be regarded as such (and subsection (9) is therefore to be ignored in that case).

Subsection (11) states that the references in this section to providing care include a reference to providing practical or emotional support.

In the case of *D* v. *Barnet Healthcare Trust and another* [2000][6] which is discussed in Chapter 5, the Court of Appeal held that a person is caring for another where the services provided are more than minimal and they need not have been provided for the long term. This was with reference to the definition of nearest relative under mental health legislation where the relative who ordinarily resides with or cares for the patient would be deemed the nearest relative.

What is covered by ill-treatment and wilful neglect?

The Code of Practice cites many forms of abuse, but not all of them would come under the provisions of this new offence.[7]

- *Financial abuse*: such as theft, fraud, undue pressure, or the misuse or dishonest gain of property, possessions, or benefits.
- *Physical abuse*: such as slapping, pushing, and kicking. It also includes the misuse of medication (e.g., giving someone a high dose of medication in order to make them drowsy) and inappropriate punishments (e.g., not giving someone a meal because they had been *bad*).
- *Sexual abuse*: such as rape and sexual assault. It also includes sexual acts without consent (this includes if a person is not able to give consent or the abuser used pressure).
- *Psychological abuse*: such as emotional abuse, threats of harm, restraint or abandonment, refusing contact with other people, intimidation, and threats to restrict someone's liberty.
- *Neglect and acts of omission*: such as ignoring the person's medical or physical care needs, failing to get healthcare or social care, and withholding of medication, food, or heating.

The draft Code of Practice also listed **discriminatory abuse** such as racist or sexist abuse or abuse that is based on a person's disability and other forms of harassment, slurs, or similar treatment. This would have included making decisions based upon an unfavorable view of a person's sex, age, race, or religion. This type of abuse may arise as an aspect across all the forms mentioned previously but is not specifically mentioned in the finalized Code of Practice.

Not all of these forms of abuse would be covered by the new offence but could come under existing criminal offences (see section "Acts in Connection with Care or Treatment" on page 214).

A situation illustrating the offence is shown in Scenario 11.1.

Scenario 11.1 Carer or neighbor?

Janice lived in a house which was divided into six separate dwellings with shared bath and toilet facilities. She would occasionally do shopping for an elderly widow, Beryl, living in the basement flat and sometimes stop to have a coffee with her. Infrequently she would take her a hot meal if she had been cooking. She noticed that Beryl seemed to be becoming more absent minded. Janice was studying for examinations and had not seen her for several weeks and was told by the police that she had died. The police were concerned to establish how often Janice had contact with Beryl and if she could be described as Beryl's carer.

It is unlikely in this situation that Janice could be seen as Beryl's carer, though the question arises as to whether the definition of carer could be seen simply as a question of frequency of contact. So that, for example, if Janice saw Beryl every day could she then be seen as a carer, but if her contact was less regular or frequent, would she not be seen as a carer? Given the fact that there was no other relationship between Janice and Beryl, it is unlikely that Janice would be seen as a carer for the purposes of Section 44(2). However the mere fact that a person voluntarily takes on a duty of caring for a mentally incapacitated person would not prevent that person becoming by law a carer and therefore liable to prosecution under Section 44(2) for failure to fulfil that duty. Even if Janice is defined as a carer of Beryl, it would still have to be established that her failure to provide care was *wilful neglect*. *Wilful* implies a knowledge of the result of her failure to care and a decision to neglect her oblivious of the consequences. The interpretation of Section 44 has caused some difficulties both on the nature of P's incapacity for an offence to arise and the definition of carer, neglect, and willful. Cases on Section 44 are considered on pages 203–4. In spite of these difficulties of interpretation, the Court of Appeal has shown its determination to make the offence effective. In addition the provisions of the Care Act 2014 place new responsibilities upon local authorities to protect vulnerable adults. The Disclosure and Barring Service set up in 2012 also provides protection. There are of course existing laws protecting those who lack specific mental capacities, and these are discussed on pages 210–214.

The House of Lords[8] in its post-legislative scrutiny of the MCA made the following recommendation in relation to Section 44:

Recommendation 35:

We recommend that the Government initiate a review of whether the offence in section 44 of the Act meets the test of legal certainty; and if it does not, to bring forward new legislative provisions. The results of this

review should be published within 12 months of publication of our Report.

The Government[9] responded as follows:

9.16. We want to ensure that the criminal offence contained in the Act is used correctly.

9.17. We are grateful for the evidence supplied to the Committee which highlights the potential under use of the criminal offence contained in Section 44 of the Act. We will undertake a review to be completed this year, to assess whether this is the case and to consider other factors which affect charging decisions.

9.18. The Ministry of Justice is committed to protecting vulnerable individuals from ill treatment and neglect and wants to ensure that anyone responsible is dealt with appropriately by the criminal justice system.

Cases on criminal liability under Section 44 of the MCA

Case Study 11.1 *R* v. *Patel* [2013].[10]

A nurse in a care home failed to attempt resuscitation on a man who stopped breathing. She was convicted of an offence under S 44 and was sentenced to a community order for 12 months with a requirement to perform 100 h of unpaid work. She appealed on 2 grounds 1 that the judge failed to direct the jury properly in relation to the meaning of neglect in S 44. The judge had wrongly directed the jury that neglect could be established even if it was unlikely that the appellant's inaction caused any adverse consequence and 2 that the judge failed to direct the jury properly about the meaning of wilfully. In particular the judge wrongly directed the jury that if the appellant acted out of stress or panic that would not constitute a defense.

Her appeal was dismissed: the basic agreed position was that it was unlikely that if CPR had been administered that this would have prolonged the life of the man; there was no DNR notice in the man's room or over his bed; proper medical practice required CPR in these circumstances; standard practice at the nursing home required CPR to be administered—when in doubt resuscitate. On her first ground of appeal, it was held that the actus reus of S.44 is complete if a nurse or medical practitioner neglects to do that which should be done in the treatment of the patient. There was a clear distinction between S.44 and gross negligent manslaughter (see *R* v. *Adomako* later) where causation would be an issue.

On her second ground of appeal, it was held that it was not possible to say if the appellant was in a state of stress or panic, but no witness suggested that she was in a hysterical state or unable to talk rationally or act in a rational way.

> neglect is willful if a nurse or medical practitioner knows that it is necessary to administer a piece of treatment and deliberately decides not to carry out that treatment, which is within their power but which they cannot face performing … if the appellant was acting at a time of stress, that would be a matter which the judge could take into account at the time of sentencing.

33 Essex Street Chambers in their comment on the case noted that S.44 was notoriously badly drafted and there were three other cases where the section was criticized by the Court of Appeal. (Dunn, Hopkins and Priest, and Ligaya (see below) The chambers stressed the importance of identifying what is clinically required in order to be able to determine if the accused fell below that standard.

Case Study 11.2 *Ligaya Nursing* v. *R* [2012].[11]

In this case the Nursings, a trained nurse and her husband, ran a nursing home, and when it closed one of the residents, Miss Gill, went to live in a property owned by the appellant and was cared for by her. The nurse was prosecuted under S.44 on the grounds that she failed to provide adequate care in relation to personal hygiene, failed to maintain rooms in a clean condition and replace dirty bed linen, failed to administer medication correctly and at the right time, and failed to provide a proper diet and make sure that Miss Gill's personal habits did not create problems with food hygiene.

The appellant said that Miss Gill was able to make decisions—she would try and offer her help and she felt it wrong to override her wishes, for example, she had a strong dislike for having her toenails cut until they became painful. CA accepted that Miss Gill had a mental age of a 7-year-old.

After the prosecution case, the defense submitted that there was no case to answer—Section 44 was uncertain in its ambit but this submission was rejected. The Court of Appeal held that Section 44 was a difficult section because of the need to determine incapacity in the light of Section 2 and

Section 3. However the purpose of S.44 was clear: "Those in need of care are entitled to protection against ill-treatment or willful neglect. The question of whether they have been neglected must be examined in the context of the statutory provisions which provide that, to the greatest extent possible, their autonomy should be respected…." Those in care who still enjoy some level of capacity for making their own decisions are entitled to be protected from wilful neglect which impacts on the areas of their lives over which they lack capacity. However S.44 did not create an absolute offence. Therefore, actions or omissions, of a combination of both, which reflect or are believed to reflect the protected autonomy of the individual needing care do not constitute wilful neglect.

The CA allowed the appeal because of a misdirection of the judge to the effect that if the appellant had been motivated by the autonomy principle, then any neglect which was proved "would not … necessarily have been proved to be willful." The CA felt use of *necessarily* was a misdirection. "If the jury were to conclude that the defendant may have been motivated by the wish or sense of obligation to respect Miss Gill's autonomy any area of apparent neglect so motivated would not be willful for the purposes of this offence."

Case Study 11.3 *R* v. *Heaney* [2011].[12]

Dawn Heaney was a senior carer in a Leicester care home. She was convicted of two offences under S.44. In one the resident, a man with Alzheimer's complained of a lack of sugar in his tea and she put in 7–8 spoonfuls of sugar in plus vinegar and watched him drink it; in the other case a woman in her 90s with dementia who was very confused and unable to indicate her needs was slapped across the back of her head by Heaney, when asked why, Heaney laughed and walked on. The Court of Appeal granted the appeal so that the two consecutive sentences of 3-month and 6-month imprisonment should be concurrent rather than consecutive. Neither victim had sustained any distress or injury; the incidents were short-lived, and the appellant had lost and had no realistic prospect of returning to her chosen livelihood.

Author's note

(For a prosecution under Section 44 to succeed, it must be proved that the victim lacked the requisite mental capacity. However it could be suggested that the behavior shown by Heaney should be criminal whatever the victim's mental capacity.)

Case Study 11.4 *R* v. *Dunn* [2010].[13]

MS Dunn was charged with three counts of ill-treatment of persons falling within the scope of S 44 while manageress of a residential care home. She was convicted and appealed on the basis that the directions given by the Recorder to the jury about the constituent elements of the offence and in particular the concept of absence of capacity for the purposes of the offence. The Court of Appeal held that the Recorder properly expressed the issues which the jury were required to address and resolve by putting the direction clearly within the ambit of Section 3. It was unnecessary for the jury to be referred to Section 3. The test of capacity for the purposes of Section 44 was the person's ability to make decisions in relation to his or her care.

Case Study 11.5 *R* v. *Hopkins*; *R* v. *Priest* [2011].[14]

On the basis of the decision in *R* v. *Dunn*, the Court of Appeal held that capacity was to be determined in the light of "the person's ability to make decisions concerning his or her own care." Proving the question of incapacity was to be determined on a balance of probabilities. The prosecution must prove to the criminal standard that the defendant ill-treated or wilfully neglected those in his care and that on a balance of probabilities that the person was a person who at the material time lacked capacity. The facts of the case were that the owner and manager of a care home appealed against convictions under S.44. One of grounds of appeal was the vagueness of the offence. The Court of Appeal did not accept this but criticized the judges' failure to deal with the evidence and the issues which cumulatively led it to believe that the verdicts could not be sustained and it allowed the appeal.

Fraud Act

The Fraud Act 2006 (which came into force in 2007) creates a new offence of *fraud by abuse of position*. This new offence may apply to a range of people, including:

- Attorneys under a lasting power of attorney (LPA) or an enduring power of attorney (EPA)
- Deputies appointed by the Court of Protection to make financial decisions on behalf of a person who lacks capacity

Attorneys and deputies may be guilty of fraud if they dishonestly abuse their position, intend to benefit

themselves or others, and cause loss or expose a person to the risk of loss. People who suspect fraud should report the case to the police.[15]

Multiagency cooperation

The Code of Practice describes the multiagency cooperation in protecting vulnerable adults.[16] Guidance on protecting vulnerable people from abuse has been issued by the DH for England, namely, *No Secrets*[17], and by the National Assembly for Wales, namely, *In Safe Hands*.[18] Both documents define abuse as:

> Any violation of an individual's human and civil rights by any other person or persons.

Both documents describe a variety of forms of abuse, such as sexual, physical, verbal, financial, or emotional abuse. It can be a single act, a series of repeated acts or failure to act, or neglect. Abuse can take place in any setting, for example, in a person's own home, a care home, or a hospital. *No Secrets* and *In Safe Hands* set out multiagency procedures that must be followed when allegations of abuse are made or suspected.

A Dignity in Care campaign was launched in November 2006 by the Minister for Care Services.[19] The campaign aimed to stimulate a national debate around dignity in care and create a care system where there is zero tolerance of abuse and disrespect for older people. An online practice guide was developed with the Social Care Institute for Excellence (SCIE) and the Care Services Improvement Partnership (CSIP) and is available from the DH website.[20] In 2013 there were 109 000 referrals to social services of suspected elder abuse, a rise of 2 000 on 2012. A quarter of cases involved a spouse, partner, or family member and the abuse ranged from neglect to physical violence.[21] The charity Action on Elder Abuse is concerned at the Government's slowness in acknowledging the problem.

Valuing People

The White Paper on learning disabilities, *Valuing People: A New Strategy for Learning Disability for the 21st Century*,[22] calculated that there are about 210 000 people with severe learning disabilities in England and about 1.2 million with a mild or moderate disability. Health and social services expenditure on services for adults with learning disabilities stands at around £3 billion. The White Paper recognized four key principles, Rights, Independence, Choice, and Inclusion, as lying at the heart of the Government's proposals. The White Paper set out the aim of investing at least £1.3 million a year for the next 3 years to develop advocacy services for people with learning disabilities in partnership with the voluntary sector in order to enable people with learning disabilities to have as much choice and control as possible over their lives and the services and support they receive. The eligibility for direct payments was to be extended through legislation. In addition a national forum for people with learning disabilities was to be set up to enable them to benefit from the improvement and expansion of community equipment services now under way. New guidance on person-centered planning was to be issued with resources for implementation through the Learning Disability Development Fund.

To ensure implementation of the White Paper, the following initiatives were envisaged:

- Learning Disability Task Force
- Implementation Support Team
- Learning Disability Research Initiative: People with Learning Disabilities: Services, Inclusion, and Partnership

In December 2007 the Department of Health published a consultation document "Valuing People Now,"[23] which set out the next steps on the Valuing People policy and its delivery. It saw the main priorities for 2008–2011 to be personalization, what people do during the day, better health, access to housing, and making sure that change happened. The wider agenda would include an emphasis on advocacy and human rights, partnership with families, ensuring all those with learning disabilities were included, working with the criminal justice system and the department of transport and local groups to ensure those with learning disabilities can become full members of their local communities, providing the same opportunities as others in the transition from childhood to adulthood, and supporting those who work with those with learning disabilities. The consultation ended in March 2008 and a summary of the responses was published by the Government in 2009.[24] One of the conclusions was that:

> There were consistent worries about whether Valuing People Now will make a real difference to people's lives, particularly in terms of funding and legislative "teeth." Many respondents felt that Valuing People Now was strong on vision but

short on the detailed implementation plans to make the vision a reality, particularly compared to the "view from the ground" that many respondents were experiencing.

It is a sad reflection on the impact of the White Paper and subsequent documents that the Confidential Inquiry (commissioned by the Department of Health in 2010) published in 2013 reported that one third of the deaths investigated could have been prevented if good quality healthcare had been provided. The Mencap website provides a summary of the report.[25] In a formal response to the report, the Department of Health admitted unacceptable inequalities and said that it would look at making a series of improvements around coordination, record keeping, and best practice. Mencap stated that it was hugely disappointed that key recommendations in the report were ignored.[26]

The scandal of Winterbourne View home which was closed following a BBC program which revealed abuse of residents with learning disabilities led to a review by the CQC in 2012 of learning disability services and also a review led by Sir Stephen Bubb on services for those with learning disabilities.[27] Recommendations included a charter of rights for those with learning disabilities; measures for commissioners of services to follow a mandatory commissioning framework, closing in-patient institutions and holding people to account.

Eligibility criteria for continuing care

The DoH announced the implementation of a national framework for long-term NHS healthcare to begin in October 2007. A single system for determining people's eligibility for long-term NHS healthcare was to be introduced and would reduce the disputes between NHS and social services and individuals over the payment of fees.[28]

The National Framework on NHS Continuing Healthcare and NHS-funded Nursing Care, published in October 2007,[29] revised in 2009 and 2012, and updated in 2013, set out the national framework; the legal framework; the primary health need, core values, and principles; eligibility considerations; links to other policies, care planning and provision; review; dispute resolution; and governance. It stated that primary health need should be assessed by looking at all of the care needs and relating them to four key indicators:

- *Nature*: the type of condition or treatment required and its quality and quantity
- *Complexity*: symptoms that interact, making them difficult to manage or control
- *Intensity*: one or more needs which are so severe that they require regular interventions
- *Unpredictability*: unexpected changes in condition that are difficult to manage and present a risk to the patient or to others.

To be eligible for continuing healthcare, the person must be assessed as having a primary health need and have a complex medical condition and substantial and ongoing care needs.[30]

Funding of long-term care

With Respect to Old Age,[31] the Royal Commission Report, made radical recommendations for future care of older people. It suggested that "The costs of long-term care should be split between living costs, housing costs and personal care. Personal care should be available after assessment, according to need and paid for from general taxation; the rest should be subject to a co-payment according to means." A minority of two members of the Royal Commission, in a note of dissent, stated that they could not support the majority view that personal care should be provided free of charge, paid for from general taxation, on the basis of need. The Government did not accept the Royal Commission's recommendation that personal care should be met from public funds, although it made various recommendations to reduce the hardship of means-tested payment of fees. The disputes between the demarcation of NHS-funded care (and therefore free at the point of delivery) and means-tested social services care continued to give rise to many concerns and complaints.

Green Paper on the funding of long-term care in the future

In July 2009 the long awaited Green Paper[32] was published. It identified six features that everyone was entitled to expect. These were:

1. The right support to help you stay independent and well for as long as possible and to stop your care and support needs getting worse.
2. Wherever you are in England, you will have the right to have your care and support needs assessed in the

same way, and you will have a right to have the same proportion of your care and support costs paid for wherever you live.

3. All the services that you need will work together smoothly, particularly when your needs are assessed…. You will only need to have one assessment of your needs to gain access to a whole range of care and support services.
4. You can understand and find your way through the care and support system easily.
5. The services you use will be based on your personal circumstances and need. Your care and support will be designed and delivered around your individual needs. As part of your care and support plan, you will have much greater choice over how and where you receive support, and the possibility of controlling your own budget wherever appropriate.
6. Your money will be spent wisely and everyone who qualifies for care and support from the state will get some help meeting the cost of care and support needs.

Following the Green Paper a White Paper was published in March 2010.

White Paper on social care[33]

This recommended a National Care Service which would be free at the point of delivery to be set up within 5 years. There would be three stages: (1) free care at home for the elderly and the infirm with critical needs, (2) a guarantee by 2014 that residential care will be free after the first 2 years, and (3) a universal system free at the point of delivery with the necessary legislative changes contained in a Personal Care at Home Bill. Criticisms of the White Paper included the absence of a clear plan on meeting the costs and time scale.[34] The Personal Care at Home Act 2010 was passed and was seen as the first stage in the development toward a National Care Service. It would have amended the Community Care (Delayed Discharges) to include the provision of free personal care at home and would have provided free personal care for 280 000 people with the highest needs—including those with serious dementia or Parkinson's disease. However, the Coalition Government stated on May 20, 2010 that it did not intend to implement the provision of free personal care and instead appointed Andrew Dilnot to chair a Commission to review the funding of care for the elderly.

The Dilnot report on social care[35]

In 2011 the Independent Commission chaired by Andrew Dilnot reported on the funding of social care. It found that the current system was confusing, unfair, and unsustainable. It made the following recommendations:

Capping lifetime individual contributions to care at £35,000

Providing free care for those who develop needs before they reach 40

Raising the means-tested threshold for savings below which people become eligible for state-funded residential care from £23 250 to £100 000

Standardizing contributions to board and lodging costs in residential care at between £7 000 and £10 000 a year

Introducing a national system of assessment and eligibility, initially set at substantial need

Giving free state support to people who enter adulthood with a care and support need immediately rather than being subjected to a means test

Caring for our future: Reforming care and support

A White Paper[36] on social care and funding was published by the Government in 2012. It can be accessed on the Government website[37] and sets out the key actions which it intended to take to reform the provision and payment for social care. The Law Commission which had conducted a 3-year review into adult social care law published its final report in May 2011[38] (accessible on the Law Commission website[39]). It recommended a single, clear modern statute, and code of practice paving the way for a coherent social care system. The Government response was published in July 2012.[40] The Care and Support Bill (enacted in 2014 as the Care Act) was published to implement the White Paper recommendations (including modified Dilnot recommendations), those of the Law Commission, and also some of the recommendations of the Francis Inquiry into Mid Staffs Hospital. The Dilnot cap was raised to £75 000 but led to controversy over the deferred payment scheme, since people would not be eligible for a deferred payment if they had more than £23 000 in assets excluding the value of their home. The deferred payment scheme required LAs to pay care fees up front, to be reimbursed later from the estate, thus freeing

families from the burden of paying care home fees until after their loved ones had died. As a result of the Care Act 2014 in April 2016 (implementation has since been delayed till 2020) the threshold for self-funding will increase to £118 000 and lifetime care costs will be capped at £72 000.

Care Act 2014

The Care Act 2014 came into force in April 2015 and covered the provisions shown in Statute Box 11.1:

Statute Box 11.1 Care Act 2014.

Part 1 Care and Support

General responsibilities of local authorities:

1 Promoting individual well-being
2 Preventing needs for care and support
3 Promoting integration of care and support with health services etc.
4 Providing information and advice
5 Promoting diversity and quality in provision of services
6 Co-operating generally
7 Co-operating in specific cases

Meeting needs for care etc.:

8 How to meet needs

Assessing needs:

9 Assessment of an adult's needs for care and support
10 Assessment of a carer's needs for support
11 Refusal of assessment
12 Assessments under sections 9 and 10: further provision
13 The eligibility criteria

Charging and assessing financial resources:

14 Power of local authority to charge
15 Cap on care costs
16 Cap on care costs: annual adjustment
17 Assessment of financial resources

Duties and powers to meet needs:

18 Duty to meet needs for care and support
19 Power to meet needs for care and support
20 Duty and power to meet a carer's needs for support
21 Exception for persons subject to immigration control
22 Exception for provision of health services
23 Exception for provision of housing etc.

Next steps after assessments:

24 The steps for the local authority to take
25 Care and support plan, support plan
26 Personal budget
27 Review of care and support plan or of support plan
28 Independent personal budget
29 Care account
30 Cases where adult expresses preference for particular accommodation

Direct payments:

31 Adults with capacity to request direct payments
32 Adults without capacity to request direct payments
33 Direct payments: further provision

Deferred payment agreements, etc.:

34 Deferred payment agreements and loans
35 Deferred payment agreements and loans: further provision
36 Alternative financial arrangements

Continuity of care and support when adult moves:

37 Notification, assessment, etc.
38 Case where assessments not complete on day of move

Establishing where a person lives, etc.:

39 Where a person's ordinary residence is
40 Disputes about ordinary residence or continuity of care
41 Financial adjustments between local authorities

Safeguarding adults at risk of abuse or neglect:

42 Enquiry by local authority
43 Safeguarding Adults Boards
44 Safeguarding adults reviews
45 Supply of information
46 Abolition of local authority's power to remove persons in need of care
47 Protecting property of adults being cared far away from home
48 Provider Failure; market oversight; transition for children to adult care; independent advocacy and miscellaneous

Part 2 Care Standards
Part 3 Health: Health Education England and Health Research Authority
Part 4 Health and Social Care; Better Care Fund established
Part 5 General

The key features of the Care Act 2014 include the following:

1 The local authority has a statutory duty to promote people's well-being not only of the users of the services but also of the carers. Well-being includes physical, mental, and emotional needs. Users and carers have a right to receive support once it has been determined that they have eligible needs (Sections 1, 18, and 20).

2. A local authority also has a statutory duty to provide preventative services to maintain people's health (Section 2).
3. A local authority has a statutory duty to ensure the integration of care and support provision with health provision and health-related provision in performing its functions (Section 3). This is comparable to the reciprocal duty placed upon NHS England and the clinical commissioning groups under S.13N and S.14Z1 of the amended NHS Act 2006.
4. A minimum eligibility threshold is introduced—a set of criteria that makes it clear when local authorities have to provide support (Section 13).
5. People can appeal against council decisions on eligibility and funding for care and support (Section 72 and regulations).
6. Local authorities are required to provide information and advice (Section 4). A new website for NHS Choices will give information on provider profiles to help people choose, compare, and comment on care homes and other care services.
7. All those receiving care and support, whether in residential care or home, are now covered by the Human Rights Act, except those who pay for their own care (Section 73).
8. There will be a cap of £72 000 on reasonable care costs and financial support (not including accommodation) enabling people to plan their finances. Councils must offer a deferred payment scheme so that people do not have to sell their home in their lifetime (Sections 24 to 30 and 34 to 36).
9. Legal right for those with care and support plan to have a personal budget which can be received as a direct payment (Sections 28 and 31 to 33).
10. Moving to a different authority will not lead to loss of care and support (Sections 37 and 38).
11. Greater independence for the CQC is enacted.
12. Health Education England to be the first ever non-departmental public body with responsibility for training and education of staff in the NHS (Sections 96–102).
13. A duty of candor on healthcare organizations is introduced through regulations (Section 81).
14. The Care Act also incorporates many of the principles and definitions set out in the MCA into the provision of care. S 80(2) a reference in Part 1 Care and Support to having or lacking capacity, or to a person's best interests, is to be interpreted in accordance with the MCA 2005; S 80(3) A reference in Part 1 (Care and Support)) to being authorized under the MCA 2005 is a reference to being authorized (whether in general or specific terms) as a) a donee of a lasting power of attorney granted under that Act or b) a deputy appointed by the Court of Protection under Section 16(2)(b) of that Act.

Protection of Vulnerable Adults

Protection of Vulnerable Adults (POVA) scheme in England and Wales for care homes and domiciliary care agencies: A practical guide (2004)[41] was provided for by Part 7 of the Care Standards Act 2000. At the heart of the POVA scheme is the POVA list. The POVA scheme acts like a workforce ban.

The Safeguarding Vulnerable Groups Act 2006 makes criminal record checks compulsory for staff who:

- Have contact with service users in registered care homes
- Provide personal care services in someone's home
- Are involved in providing adult placement schemes

Potential employers had to carry out a pre-employment criminal record check with the Criminal Records Bureau (CRB) for all potential new healthcare and social care staff. This includes nursing agency staff and home care agency staff.[42]

The Disclosure and Barring Service was formed from the merger of the Independent Safeguarding Authority (ISA) with the Criminal Records Bureau on December 1, 2012)

Sections 42–47 of the Care Act 2014 place a duty on LAs to safeguard adults at risk of abuse or neglect and are listed in Statute Box 11.2.

Statute Box 11.2 Care Act, Sections 42–45: Safeguarding adults at risk.

42 Enquiry by local authority
43 Safeguarding Adults Boards
44 Safeguarding adults reviews
45 Supply of information
46 Abolition of local authority's power to remove persons in need of care
47 Protecting property of adults being cared for away from home

The Act requires a local authority which has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there):

a) has needs for care and support (whether or not the authority is meeting any of those needs),
b) is experiencing, or is at risk of, abuse or neglect, and
c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it

Then the local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.

Abuse includes financial abuse

Each local authority must establish a **Safeguarding Adults Board** (*SAB*) for its area with the objective of helping and protecting adults in its area in cases of need.

An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support if specific conditions exist. Each member of the SAB must cooperate in and contribute to the carrying out of a review under this section with a view to (a) identify the lessons to be learnt from the adult's case and (b) apply those lessons to future cases.

Section 45 sets out the right of the SAB to obtain information from persons providing specified conditions are met.

In 2013 the government issued a policy statement on adult safeguarding. It is available on the government website.[43] It sets out the principles which agencies should be following: empowerment, prevention, proportionality, protection, partnership, and accountability, and stresses the importance of interagency cooperation through local multiagency partnerships. Further guidance is available from SCIE and its website.[44] SCIE reported that in the first 6 months of 2015, over 30 000 allegations of abuse involving people using social care services were reported to CQC. Allegations ranged from physical, emotional, and sexual abuse to financial fraud.

Criminal law and mental capacity

There are many areas of the criminal law where specific account is taken of a person's mental capacity to ensure that an injustice does not occur. These include:

- Having the requisite mental capacity (i.e., mens rea) to commit a specific offence
- Police procedures on arrest
- Making a confession
- Standing for trial
- Being a witness
- Being on a jury

> **Scenario 11.2** Criminal proceedings and a mentally incapacitated offender.
>
> Harry, a community nurse, was asked to attend the police station where one of his clients, Peter, from a community home for those with challenging behavior, was being questioned. It appeared that Peter had been arrested in the street for exposing himself. Harry was asked to act as an appropriate adult while Peter was questioned and to provide information on Peter's background.

Having the requisite mental capacity (i.e., mens rea)

It is a requirement of most criminal offences that a person has the mental capacity to form the intent to commit the offence. Where a person lacks the requisite mental capacity (known in law as the mens rea), then the person cannot be guilty of that offence. As noted previously, the law provides different forms of protection for the person who lacks mental capacity, and Scenario 11.2 illustrates a situation where a person with severe learning disabilities is involved in criminal proceedings.

While it would usually be unwise for a registered nurse to be identified as an independent advocate of a patient, in these circumstances there would be no obvious reason why Harry should not be able to provide the protection which Peter required. Harry should have had some training in what was required as the *appropriate adult*. There would be clear advantages in Harry ensuring that Peter had legal representation. Most trusts, clinical commissioning groups, and social service departments should have established a procedure with the local police and criminal courts so that in the event of a person lacking mental capacity being arrested, identified officers could be made available to attend the police station and the courts.

Police procedures on arrest

The Code of Practice which has been drawn up under the Police and Criminal Evidence Act 1984 Code C Annex 1 Appendix A-105 provides protection for the mentally disordered, mentally vulnerable, and mentally incapable

of understanding the significance of questions. The assessment as to whether a defendant is mentally handicapped should be made on the basis of medical evidence, and police, not having expertise in the matter, should not be allowed to state their opinion with respect thereof.[45] An appropriate adult is required to be brought in to ensure that the accused fully understands his or her rights, that the interview is conducted correctly, and that he or she clearly understands what is being said to him or her.

Making a confession

Under Section 77 of the Police and Criminal Evidence Act 1984, where the case against the accused depends wholly or substantially on a confession by him, and the court is satisfied that he is mentally handicapped and the confession was not made in the presence of an independent person, then the court must warn the jury that there is special need for caution before convicting the accused in reliance on the confession.

An independent person is defined as not including a police officer or a person employed for police purposes,[46] and mentally handicapped is defined as meaning that a person is in a state of arrested or incomplete development of mind, which includes significant impairment of intelligence and social functioning.

There is no rule that a confession obtained from a mentally handicapped person in the absence of a solicitor and an appropriate adult should automatically lead to exclusion under Section 77 of the Police and Criminal Evidence Act 1984.

A defendant's mental condition is one of the factors to be taken into account in deciding if the confession is unreliable, and nothing in the authorities limits or defines the particular form of mental or psychological condition or disorder. The disorder must not only be of a type which might render a confession unreliable, but there must also be a significant deviation from the norm shown; and there must be a history predating making of admissions which is not based solely on a history given by the subject and which points to or explains the abnormality or abnormalities.[47]

Being a witness

No witness is competent to give evidence if he or she is prevented by reason of mental illness or mental handicap from giving rational testimony. Where it is contended that the witness falls in such a category, it is for the judge to ascertain whether the witness is competent to give evidence. Where the judge is satisfied that he or she is, the judge should allow the witness to be examined and leave to the jury the decision on the worth of his or her testimony.[48]

Being on a jury

Under the Juries Act 1974 Schedule 1 Part 1, the following persons are disqualified for jury services:

1 a person who suffers or has suffered from mental illness, psychopathic disorder, mental handicap or severe mental handicap and on account of that condition either:
  a) is resident in a hospital or similar institution or
  b) regularly attends some institution for treatment by a medical practitioner.

2 A person for the time being under guardianship under Section 7 of the Mental Health Act 1983.

3 A person who under Part 7 of that Act has been determined by a judge to be incapable, by reason of mental disorder, of managing and administering his property and affairs.

(The definition of mental handicap is as given in the Mental Health Act 1983, with the qualifications omitted—see Chapter 13.)

In addition the judge has the ability to discharge a person from jury service if he or she believes that they lack the capacity to cope with the information needed for the trial.

Sexual Offences Act 2003

The Sexual Offences Act 2003 creates offences under Sections 30–33, designed to give protection to persons with a mental disorder which impeded choice. The offences are as follows:

- Section 30 Sexual activity with a person with a mental disorder impeding choice.
- Section 31 Causing or inciting a person, with a mental disorder impeding choice, to engage in sexual activity.
- Section 32 Engaging in sexual activity in the presence of a person with a mental disorder impeding choice.
- Section 33 Causing a person, with a mental disorder impeding choice, to watch a sexual act.

In a recent case a defendant appealed against his conviction under Section 30, arguing that the magistrates had been wrongly advised as to the nature of the offence. The victim C suffered from cerebral palsy and had a mental age well below that of her actual age of 27 years. The High Court held that there was evidence on which the magistrates could properly conclude that the victim had been unable to effectively communicate her wishes to the accused by reason of her mental condition.[49]

In addition the Sexual Offences Act 2003 also creates offences in relation to providing inducements etc to persons with a mental disorder to engage in sexual activity. The offences are as follows:

- Section 34 Inducement, threat or deception to procure sexual activity with a person with a mental disorder.
- Section 35 Causing a person with a mental disorder to engage in or agree to engage in sexual activity by inducement, threat or deception.
- Section 36 Engaging in sexual activity in the presence, procured by inducement, threat or deception, of a person with a mental disorder.
- Section 37 Causing a person with a mental disorder to watch a sexual act by inducement, threat or deception.

In addition offences are created in relation to care workers and sexual activity with a person with a mental disorder. They are:

- Section 38 Care workers: sexual activity with a person with a mental disorder.
- Section 39 Care workers: causing or inciting sexual activity.
- Section 40 Care workers: sexual activity in the presence of a person with a mental disorder.
- Section 41 Care workers: causing a person with a mental disorder to watch a sexual act.

Section 42 defines care workers as follows:

a person (A) is involved in the care of another person (B) in a way that falls within section 42 if any of subsections (2) to (4) applies.

(2) This subsection applies if –
  a) B is accommodated and cared for in a care home, community home, voluntary home or children's home, and
  b) A has functions to perform in the home in the course of employment which have brought him or are likely to bring him into regular face to face contact with B.

(3) This subsection applies if B is a patient for whom services are provided –
  a) by a National Health Service body or an independent medical agency, or
  b) in an independent clinic or an independent hospital, and A has functions to perform for the body or agency or in the clinic or hospital in the course of employment which have brought him or are likely to bring him into regular face to face contact with B.

(4) This subsection applies if A –
  a) is, whether or not in the course of employment, a provider of care, assistance or services to B in connection with B's mental disorder, and
  b) as such, has had or is likely to have regular face to face contact with B.

(5) In this section –
'care home' means an establishment which is a care home for the purposes of the Care Standards Act 2000 (c. 14);
'children's home' has the meaning given by section 1 of that Act;
'community home' has the meaning given by Section 53 of the Children Act 1989 (c. 41);
'employment' means any employment, whether paid or unpaid and whether under a contract of service or apprenticeship, under a contract for services, or otherwise than under a contract;
'independent clinic', 'independent hospital' and 'independent medical agency' have the meaning given by Section 2 of the Care Standards Act 2000;
'National Health Service body' means –
  a) a Health Authority,
  b) a National Health Service trust,
  c) a primary care trust, or
  d) a Special Health Authority;
'voluntary home' has the meaning given by Section 60(3) of the Children Act 1989.

Sections 43 and 44 of the Sexual Offences Act 2003 provide exceptions where marriage occurs or where the sexual relationships predated the care relationship.

These provisions are designed to provide more protection for vulnerable persons.

Contractual liability and mental incapacity

Protection in a contractual situation

In law a mentally competent adult has the right to enter into lawful contracts and once an offer has been accepted, then is bound by the terms of the contract. There is a presumption in law that a person over 16 years is mentally competent. However if the adult lacks the mental capacity to make the contract, then, in certain circumstances, the contract is only binding upon him if the contract was for necessaries. *Necessaries* would cover goods and services suitable to his actual requirements. By Section 3 of the Sale of Goods Act 1979, it is provided that where necessaries are sold and delivered to a person who by reason of mental incapacity is incompetent to contract, he must pay a reasonable price for them. *Necessaries* is defined as goods suitable to the position in life of such a person and to his actual requirements at the time of the sale and delivery.[50] Section 7 of the MCA states in relation to the payment for necessary goods and services that:

1. If necessary goods or services are supplied to a person who lacks capacity to contract for the supply, he must pay a reasonable price for them.
2. "Necessary" means suitable to a person's condition in life and to his actual requirements at the time when the goods or services are supplied.

Provisions in the Consumer Credit Act 2006 give powers to the court to alter or even set aside a credit agreement if it determines the relationship between the creditor and the debtor to be unfair.

Even if an adult lacks the requisite mental capacity to make a contract, he or she may be bound by a contract supplying him or her with necessities. The problems which can arise are illustrated by a letter to Margaret Dibben in the *Observer*[51] which is considered in Scenario 11.3.

The following answer was provided by Margaret Dibben:

> Under common law, people cannot be held to a contract if they are unable to understand the consequences, unless they are buying necessities.
>
> But again by law, every one must presume that people they deal with are capable and must not discriminate against anyone with disabilities. It's a fine line.
>
> Initially, Halifax repeated that it had no reason to reject your son's application though it became concerned when it realised that he was unable to repay the debt.
>
> I pointed out his inability to enter into the contract in the first place and, as a gesture of goodwill, Halifax has now agreed to write off the outstanding loan.

Scenario 11.3 Contracts and mental capacity.

The Halifax allowed my 22-year-old son to take out a £3000 personal loan. He has Asperger's syndrome and is identified by the authorities as a vulnerable adult. He receives disability benefits and lives in supported accommodation. He has no concept of the value of money. His carers take his rent and household expenses from his income, giving him the balance.

Within a few days, he spent the entire loan on a number of consumer items. Despite Halifax's claim that it followed proper procedures, there appears to have been little, if any, check on my son's expenses.

Scenario 11.4 Financial abuse.

Martha, aged 74, leads a hermit-like existence and never leaves her home. She has an arrangement with a neighbor for her benefit to be collected on her behalf. A community nurse visits Martha and suspects that she is not receiving all the money she should be getting and that the neighbor is keeping some for herself. What action can she take?

The aforementioned situation is fraught with difficulties as Margaret Dibben points out: to require proof of mental capacity from persons with disabilities may be seen as discriminatory. Yet there needs to be evidence of mental incapacity in order that the presumption of capacity can be rebutted.

See Scenario 11.4 and abuse in relation to social security payments and the role of the Department of Works and Pensions.

Financial abuse (Scenario 11.4)

It is uncertain from the facts of this case as to whether the neighbor has taken on the role of an appointee, that is, a person appointed by the Department for Work and Pensions (DWP) to receive and deal with the benefits

of Martha, who lacks the capacity to do this for herself. It may be just an informal arrangement between the neighbor and Martha. Whatever the arrangement, the receiver of the money has a duty to use it entirely in the best interests of Martha.

The Code of Practice[52] states that the DWP can appoint someone (an appointee) to claim and spend benefits on a person's behalf if that person:

- gets social security benefits or pensions
- lacks the capacity to act for themselves
- has not made a property and affairs legal power of attorney or an enduring power of attorney (EPA) and
- the court has not appointed a property and affairs deputy.

The DWP has a responsibility to check that an appointee is trustworthy and can investigate any allegations that an appointee is not acting appropriately or in the person's interests. The community nurse could take up her query with the relevant DWP agency (i.e., since Martha is over 60, the Pension Service. If Martha were under 60, concerns could be raised with the local job center). The DWP can remove an appointee who abuses their position. If the neighbor is not an appointee, then the DPW can take steps to appoint an approved person. Guidance by the DWP upon the question of appointeeship can be found on the website.[53]

Acts in connection with care or treatment

Section 5 protects a person from civil and criminal action when they act under the provisions of the MCA in providing care and treatment for an adult lacking mental capacity. (This is discussed in Chapter 5 and shown in Statute Box 5.2.) However Section 5(3) states that nothing in Section 5 excludes a person's civil liability for loss or damage or his criminal liability resulting from his negligence in doing the act. This means that a person could still face civil or criminal proceedings because of their actions. This is explained in the following and see also Scenarios 11.5 page 222 and 11.6 page 223.

Section 62 makes it clear that:

> For the avoidance of doubt, it is hereby declared that nothing in this Act is to be taken to affect the law relating to murder or manslaughter or the operation of Section 2 of the Suicide Act 1961 (assisting suicide).

Criminal law on murder, manslaughter, suicide, letting die and pain relief

Murder

In order to secure a conviction of murder, the prosecution has to prove beyond reasonable doubt that the defendant must either have intended to cause death or intended to cause grievous bodily harm. Unless a situation comparable to that of the Dr Shipman case, who was convicted of murdering 15 patients, exists, it would be very unusual to be able to prove the intent necessary to convict of murder in a case involving professional care. Following a conviction for murder, a judge at the present time has no discretion over sentencing but must sentence the convicted person to life imprisonment, that is, a life sentence is mandatory, but a judge can indicate how long should be served before parole.

Involuntary manslaughter

This may arise where death results from the gross negligence of a health professional, where there is no intention to kill or to cause grievous harm. In such cases there may be a prosecution for involuntary manslaughter or there may be no prosecution at all. It depends upon the circumstances. If, for example, there is such gross negligence leading to the death, then there may be a prosecution for manslaughter.

In a manslaughter prosecution, the jury would have to be convinced beyond reasonable doubt both as to the existence of the gross negligence and also that it caused the death of the victim. (The grandmother of a child mauled to death by a pit bull terrier was charged with her manslaughter as a result of gross negligence, faced a Crown Court trial in September 2007[54] but was acquitted after a six day trail.)

An example of a leading case involving gross negligence amounting to manslaughter is given in Case Study 11.6.

The House of Lords clarified the legal situation.

The stages which the House of Lords suggested should be followed were:

- The ordinary principles of the law of negligence should be applied to ascertain whether or not the defendant had been in breach of a duty of care towards the victim who had died.
- If such a breach of duty was established, the next question was whether that breach of duty caused the death of the victim.

Case Study 11.6 Manslaughter.

Dr Adomako,[55] the person charged, was, during the latter part of an operation, the anesthetist in charge of the patient, who was undergoing an eye operation. At approximately 11.05 a.m. a disconnection occurred at the endotracheal tube connection. The supply of oxygen to the patient ceased and led to a cardiac arrest at 11.14 a.m. During that period the defendant failed to notice or remedy the disconnection. He first became aware that something was amiss when an alarm sounded on the Dinamap machine, which monitored the patient's blood pressure. From the evidence it appeared that some 4.5 min would have elapsed between the disconnection and the sounding of the alarm. When the alarm sounded the defendant responded in various ways by checking the equipment and by administering atropine to raise the patient's pulse. But at no stage before the cardiac arrest did he check the integrity of the endotracheal tube connection. The disconnection was not discovered until after resuscitation measures had been commenced.

Dr Adomako accepted at his trial that he had been negligent. The issue was whether his conduct was criminal. He was convicted of involuntary manslaughter but appealed against his conviction. He lost his appeal in the Court of Appeal and then appealed to the House of Lords.[56]

- If so, the jury had to go on to consider whether that breach of duty should be characterised as gross negligence and therefore as a crime. That would depend on the seriousness of the breach of duty committed by the defendant in all the circumstances in which the defendant was placed when it occurred.
- The jury would have to consider whether the extent to which the defendant's conduct departed from the proper standard of care incumbent upon him, involving as it must have done a risk of death to the patient, was such that it should be judged criminal.

The judge was required to give the jury a direction on the meaning of *gross negligence* as had been given in the present case by the Court of Appeal. The jury might properly find gross negligence on proof of:

- indifference to an obvious risk of injury to health, or
- actual foresight of the risk coupled with either
  - a determination nevertheless to run it, or
  - an intention to avoid it but involving such a high degree of negligence in the attempted avoidance as the jury considered justified conviction, or
- inattention or failure to advert to a serious risk going beyond mere inadvertence in respect of an obvious and important matter which the defendant's duty demanded he should address.

The House of Lords held that the Court of Appeal had applied the correct test and his appeal was dismissed.

It follows that if a paid or informal carer of a person who lacked mental capacity acted or omitted to act with such gross negligence that the client/patient died, then proceedings for manslaughter could be brought. Following a conviction, the judge has full discretion over the sentencing, which could range from an absolute discharge to substantial time of imprisonment.

Voluntary manslaughter

This term is used to cover the situation where the defendant has caused the death of a person with intent, but owing to special circumstances, a charge or conviction of murder is not appropriate. As a result of the Coroners and Justice Act 2009, changes have been made to the defenses to a charge of murder. Voluntary manslaughter now covers:

- Death as a result of the loss of control of the accused
- Death as a result of diminished responsibility of the accused
- Killing as a result of a suicide pact

Suicide

As a result of the Suicide Act 1961, to attempt to commit suicide ceased to be a crime. However the aiding and abetting of the suicide of another remained a criminal offence under Section 2(1). This is shown in Box 11.1.

The MCA 2005 has not changed the law on assisted suicide and it is still a criminal offence to assist a person to die. There are specific provisions in the Act covering the power of a person holding a lasting power of attorney or a person acting according to an advance direction to agree to the withholding of lifesaving treatment, and these are discussed in Chapters 6 and 9. The MCA recognizes the right of a person when they have the requisite mental capacity to make their own decisions about treatment and refuse lifesaving treatment if they so wish at a future time when they do not have the requisite mental capacity.

Box 11.1 Section 2 of the Suicide Act 1961 (as amended by the Coroners and Justice Act 2009).

Section 2(1) A person ("D") commits an offence if –

(a) D does an act capable of encouraging or assisting the suicide or attempted suicide of another person, and

(b) D's act was intended to encourage or assist suicide or an attempt at suicide.

2(1)(A) The person referred to in subsection (1)(a) need not be a specific person (or class of persons) known to, or identified by, D.

2(1)(B) D may commit an offence under this section whether or not a suicide, or an attempt at suicide, occurs.

2(1)(C) An offence under this section is triable on indictment and a person convicted of such an offence is liable to imprisonment for a term not exceeding 14 years.

2(2) If on the trial of an indictment for murder or manslaughter of a person it is proved that the deceased person committed suicide, and the accused committed an offence under sub-section (1) in relation to that suicide, the jury may find the accused guilty of the offence under subsection (1).

2A Acts capable of encouraging or assisting

1 If D arranges for a person ("D2") to do an act that is capable of encouraging or assisting the suicide or attempted suicide of another person and D2 does that act, D is also to be treated for the purposes of this Act as having done it.

2 Where the facts are such that an act is not capable of encouraging or assisting suicide or attempted suicide, for the purposes of this Act it is to be treated as so capable if the act would have been so capable had the facts been as D believed them to be at the time of the act or had subsequent events happened in the manner D believed they would happen (or both).

3 A reference in this Act to a person ("P") doing an act that is capable of encouraging the suicide or attempted suicide of another person includes a reference to P doing so by threatening another person or otherwise putting pressure on another person to commit or attempt suicide.

2B Course of conduct

A reference in this Act to an act includes a reference to a course of conduct, and a reference to doing an act is to be read accordingly.

Letting die and killing

The law makes a distinction between letting die and killing, and this distinction is not changed by the MCA 2005. The difference is shown in the Tony Bland case and in the contrasting cases of Re B[57] and Diane Pretty.[58] See Case Studies 11.7, 11.8, 11.9, 11.10, and 11.11, and see Case Study 2.2 for *Re B*.

Case Study 11.7 Tony Bland.

The patient was a victim of the football stadium crush at Hillsborough and it was established that although he could breathe and digest food independently, he could not see, hear, taste, smell, or communicate in any way, and it appeared that there was no hope of recovery or improvement. The House of Lords had to decide if it was lawful to permit artificial feeding to be discontinued in the case of a patient in a persistent vegetative state. The House of Lords decided that it would be in the best interests of the patient to discontinue the nasal gastric feed and he was later reported as having died.

Case Study 11.8 Re C (withdrawal of treatment) [2010].[61]

A 21-year-old man was injured in a road accident when 16 years. The medical view was that he was in a persistent vegetative state and Drs, his family (including twin brother), and the experts all agreed that it was in his best interests for artificial nutrition and hydration to be withheld. The staff at the unit where he was cared for disagreed and felt that he had shown a level of awareness. The Judge held the situation was the same as in the Bland case (see Case Study 11.7), and it was in his best interests for a declaration to be made. The patient would be transferred to a new unit for this to take place because of the opposition of the staff where he was.

Case Study 11.9 *Aintree University Hospitals NHS Foundation Trust* v. *James*.[62]

In 2013 the widow of a man who had died in December 2012 appealed against a decision of the Court of Appeal that it was in his best interests to have life-sustaining treatment withheld. The Supreme Court dismissed her appeal. It ruled that the focus should be on whether it was in the patient's best interests to give the treatment, rather than on whether it was in his best interests to withhold or withdraw it. In determining his best interests, decision makers had to look at his welfare in the widest sense, not just medical, but social and psychological. The guidance in the Mental Capacity Code of Practice and that given by the General Medical Council in its booklet *Treatment and care towards the end of life: good practice in decision making* was applicable.

Lady Hale setting out the unanimous decision stated that the starting point was that there is a strong presumption that it is in a person's best interests to stay alive, although

there would be cases where it was not in the person's best interests to receive life-sustaining treatment. If the court decided it was not in his best interests to receive treatment, then the court could not give its consent on his behalf and it would follow that it would be lawful to withhold or withdraw it.

Case Study 11.10 *United Lincolnshire Hospitals NHS Trust* v. *N*.

In this case the patient had subarachnoid hemorrhage and was then in a minimally conscious state (MCS). It was held to be lawful and in the best interests of P for a treating NHS trust not to make further efforts to establish and maintain a method of treating her with artificial nutrition. Judge Pauffley cited the Aintree case and emphasized that the fundamental question was whether it is lawful to give the treatment, not whether it is lawful to withhold it. The focus is on whether it is in the best interests of the patient to give the treatment rather than on whether it is in the best interest to withhold it or withdraw it. Judge Pauffley followed a balance sheet approach to best interests as in a Hospital National Health Service (NHS) Trust and S 2003.[64] In contrast in the case of *St George's Healthcare NHS Trust* v. *P&Q* [2014],[65] Newton J refused to give the declarations sought by the Trust to discontinue dialysis for a brain-damaged man on the grounds that he when competent had expressed his views on the value of life and his religious beliefs as a Sunni Muslim were that life should not be shortened but could only be taken by God.

Case Study 11.11 *R (David Tracey)* v. *Cambridge University Hospitals NHS Foundation Trust and others*.[66]

Mr Tracey sought judicial review of the DNR notices placed on his wife's notes without consultation. He lost in the High Court, but the Court of Appeal allowed the appeal because his allegations should not be dismissed out of hand. The Drs' failure to consult her before the first DNR notice could be seen as a breach of her Article 8 rights and so it should go to a substantive hearing The substantive hearing held that failure to consult with Mrs Tracey prior to the DNR notice being placed was a breach of her Article 8 rights. There was no breach by the Secretary of State's failure to have a national system in place for DNR notices.

Tony Bland case[59]

The House of Lords in the Tony Bland case made it clear that there was in law a clear distinction between letting nature take its course when, in the light of the prognosis, it was in the best interests not to continue active interventions and killing the patient.

In the words of Lord Goff:

> The law draws a crucial distinction between cases in which a doctor decides not to provide, or to continue to provide, for his patient treatment or care which could or might prolong his life and those in which he decides, for example, by administering a lethal drug, actively to bring his patient's life to an end.

The facts of Tony Bland are shown in Case Study 11.7.

A court in Bristol gave consent in a similar case a few months after the House of Lords decision in Tony Bland's case.[60]

The Aintree case was subsequently followed in the case of *United Lincolnshire Hospitals NHS Trust* v. *N* See case study 11.10.[63]

Withholding life-sustaining treatment case

Case Study 11.12 *An NHS Trust* v. *L and others* [2013].[67]

The family wanted treatment to be given and held that that was what L would have wanted. The Judge held L was in a minimally conscious state; further life-sustaining interventions were unlikely to be effective, no treatment options were available. He carried out a balancing exercise and concluded that it was not in L's best interests for further life-sustaining treatment to be given. L's wishes could not simply be followed—the test the court had to apply was that of best interests, not substituted judgment. This case contrasts with the first reported case on a minimally conscious state, *W* v. *M* [2011][68] EWHC 2443 CoP (see Case Study 11.13 where M's family were unanimous that M would not have wanted to be kept alive in that state, yet the court decided it was in her best interests for artificial nutrition and hydration to continue).

In L's case the family was unanimous that L would have wanted further treatment, yet the court reached opposite conclusion—the issue of how to deal with P's likely wishes in end-of-life scenarios remains a difficult decision.

Case Study 11.13 *W* v. *M* [2011].[69]

In this case much reliance was placed on the previously declared views of P which were spoken in relation to not wanting to be in a care home. M had become ill with viral encephalitis which left her with irreparable brain damage and in a minimally conscious state. The family, with the support of M's doctors, applied for a court order authorizing the withdrawal of artificial nutrition and hydration. Baker J held that in the absence of a valid advance decision, the statements made by M when she had capacity were taken into account but were not binding. The factor which did carry significant weight was the preservation of life. It was not in her best interests to withdraw ANH and the order was refused. The DNR notice was continued.

Case Study 11.14 Case of *Re B*.[70]

Miss B suffered a ruptured blood vessel in her neck which damaged her spinal cord. As a consequence she was paralyzed from the neck down and was on a ventilator. She was of sound mind and knew that there was no cure for her condition. She asked for the ventilator to be switched off. Her doctors wished her to try out some special rehabilitation to improve the standard of her care and felt that an intensive care ward was not a suitable location for such a decision to be made. They were reluctant to perform such an action as switching off the ventilator without the court's approval. Miss B applied to court for a declaration to be made that the ventilator could be switched off.

Assisted suicide

Cases of Re B and Diane Pretty

Two experts examined Miss B and said that she had the mental capacity to make decisions about switching off the ventilator. In the light of that assessment, the judge had no option other than to declare that she was entitled to refuse lifesaving treatment. The case is considered in more detail in Chapter 2. See also Case Study 2.2.

The Council of Europe issued a press release entitled *Chamber judgment in the case of Pretty* v. *the United Kingdom* published on April 29, 2002. It stated that:

> The European Court of Human Rights has refused an application by Diane Pretty, a British national dying of motor neurone disease, for a ruling that would allow her husband to assist her to commit suicide without facing prosecution under the Suicide Act 1961 section 2(1). The applicant is paralysed from the neck downwards and has a poor life expectancy, whilst her intellect and decision making capacity remain unimpaired. She wanted to be given the right to decide when and how she died without undergoing further suffering and indignity. The court unanimously found the application inadmissible with no violations under the European Convention of Human Rights under Art 2 the right to life, Art 3 prohibition of human or degrading treatment or punishment; Art 8 the right to respect for private life; Art 9 freedom of conscience and Art 14 prohibition of discrimination.

Case Study 11.15 Case of Diane Pretty.[71]

In a well-publicized case, Diane Pretty, a sufferer of motor neurone disease, appealed to the House of Lords that her husband should be allowed to end her life and not be prosecuted under the Suicide Act 1961. The House of Lords did not allow her appeal. It held that if there were to be any changes to the Suicide Act to legalize the killing of another person, then these changes should be made by Parliament. As the law stood, the Suicide Act made it a criminal offence to aid and abet the suicide of another person, and the husband could not be granted immunity from prosecution were he to assist his wife to die. The House of Lords held that there was no conflict between the human rights of Mrs Pretty as set out in the European Convention on Human Rights. Mrs Pretty then applied to the European Court of Human Rights in Strasbourg but lost. The court held that there was no conflict between the Suicide Act 1961 and the European Convention of Human Rights.

It was subsequently reported that Diane Pretty had died.

It is clear that Diane Pretty would have had the right to refuse natural or artificial feeding and hydration. However she stated that she did not wish to suffer a slow death by starvation and would prefer to have a pain-free, dignified, and speedy death. In law she could lawfully attempt to commit suicide, but in practice she lacked the physical powers to do so. She therefore needed to have assistance. However to assist anyone to commit suicide is a criminal offence (see Box 11.1).

As a consequence the DPP (after interim guidance and a consultation) issued final guidance in February 2010[73] clarifying the public interest factors which should be taken into account in deciding whether or not there should be a prosecution under the Suicide Act 1961 as amended.

Case Study 11.16 Debbie Purdy.[72]

An MS sufferer, Debbie Purdy brought an action on the law on assisted suicide. She wished her husband to take her to a Belgian clinic or Switzerland to commit suicide if her condition became unbearably painful and wanted to ensure that he would not be prosecuted for aiding and abetting her suicide. The House of Lords unanimously held that the DPP should be required to promulgate a policy identifying the facts and circumstances he would take into account in considering whether to prosecute persons such as the claimant's husband for aiding and abetting an assisted suicide abroad. The lack of clarity on whether there would be a prosecution of relatives who took someone abroad to die was an infringement of Article 8 rights.

Case Study 11.17 Nicklinson.[74]

Tony Nicklinson (suffered from locked-in syndrome following a stroke) sought declarations from the High Court[75] that a. it would not be unlawful on the grounds of necessity for a doctor to terminate his life, b. the current law of murder and assisted suicide was incompatible with Article 8 of the Human Rights Convention, and c. existing domestic law and practice failed adequately to regulate the practice of active euthanasia in breach of Article 2. Although he had died following the failure of his appeal to the Court of Appeal, his widow asked for the case to proceed to the Supreme Court.

The Supreme Court in a majority judgment ruled that it was not yet prepared to grant a declaration that Section 2 of the Suicide Act 1961 (as amended—See Box 11.1) was incompatible with Article 8 of the European Convention on Human Rights and therefore the appeals must fail. It urged Parliament to consider whether Section 2 should be amended. Two judges dissented: Lady Hale and Lord Kerr, while agreeing that Parliament was the appropriate forum in which the issue should be decided, were prepared to issue a declaration of incompatibility that the current law against assisted suicide was contrary to Article 8. The judgment was published a week before the second reading of the Assisted Dying Bill in Parliament, and while this enabled the Bill to procede, Parliament was dissolved before the final stages could take place. A new attempt to introduce an Assisted Dying Bill was made in the Parliament in 2015 but failed.

Pain relief and killing

It does not follow that providing appropriate pain relief which may incidentally shorten life is a crime, as the trial of Dr Bodkin Adams[76] made clear. Case Study 11.18

Case Study 11.18 Dr Bodkin Adams.

Dr Adams was charged with the murder of a resident of a nursing home in Eastbourne. It was alleged that he gave her large quantities of morphia and heroin which caused her death.

illustrates the difference between giving a dose of medication in order to bring about the death of the patient and giving medication to control the patient's pain.

In the case of Dr Bodkin Adams, the trial judge, Patrick Devlin, directed the jury in the following words:

> If the first purpose of medicine—the restoration of health—can no longer be achieved, there is still much for the doctor to do, and he is entitled to do all that is proper and necessary to relieve pain and suffering even if the measures he takes may incidentally shorten life. … It remains a fact, and remains a law, that no doctor has the right to cut off life deliberately … (the defence counsel) was saying that the treatment given by the doctor was designed to promote comfort; and if it was the right and proper treatment of the case, the fact that incidentally it shortened life does not give any grounds for convicting him of murder.[77]

Dr Adams was found not guilty of murder.

Clearly it must be established that the dosages which are given to a patient in the terminal stages of cancer and other illnesses are in accordance with the reasonable practice of a competent practitioner. It frequently happens that the tolerance built up to some pain medication requires higher and higher doses which, given to persons without that tolerance, would be lethal, grossly negligent, and probably amount to a criminal offence. There is considerable benefit when practitioners are treating persons at such high levels for them to discuss recommended practice with colleagues. The importance of following competent medical practice is shown in the Annie Lindsell case (see Case Study 11.19).

After the Annie Lindsell hearing, the British Medical Association (BMA) stated that it was pleased with the outcome:

> it has confirmed that doctors working within the law, can treat the symptoms of terminally ill patients, even if that treatment may have a secondary consequence of shortening the patient's life.

Annie Lindsell died a month later.

Case Study 11.19 Annie Lindsell controlling pain.

On October 28, 1997 Annie Lindsell,[78] who was terminally ill with motor neurone disease, applied to court for a declaration that her GP would not risk prosecution for murder if he gave her potentially lethal painkillers when her condition deteriorated. After hearing that a responsible body of medical opinion supported her GP's plan, she withdrew her application for the court's intervention. In the case a clear distinction was made between pain relief whose principal purpose was to control her pain, even though incidentally it might shorten her life, and medication given to end her life.

Other criminal offences

Any paid or informal carer could also be liable to other criminal offences such as the offence of causing grievous bodily harm or offences of theft.

Civil liability

Section 5 does not exclude liability for a civil wrong as Section 5(3) states that nothing in Section 5 excludes a person's civil liability for loss or damage resulting from his negligence in doing the act. The usual rules of the law of negligence therefore apply to those taking responsibility for the care and treatment of persons lacking mental capacity.

Negligence and other civil wrongs

An action for negligence is the most frequent civil action brought in order to obtain compensation. It is one of a group of civil wrongs known as *torts*. An action would be brought in the county court where less than £50 000 was being claimed. Claims above that amount would be brought in the High Court—the Queen's Bench Division. Other torts or civil wrongs are set out in Box 11.2.

To obtain compensation in an action for negligence, the claimant must establish the elements shown in Box 11.3 (see Scenario 11.5).

The burden is on the claimant to establish on a balance of probabilities that each of the four elements shown in Box 11.3 is present.

Box 11.2 Civil wrongs, that is, torts.

- Action for negligence
- Action for breach of statutory duty
- Action for trespass to the person, goods, or land (this is considered in Chapter 2)
- An action for nuisance
- An action for defamation (which includes libel and slander)

Box 11.3 Elements in an action for negligence.

1. The defendant owed a duty of care to the claimant.
2. The defendant was in breach of that duty of care, and
3. as a reasonably foreseeable result of that breach,
4. harm recognized by the courts as subject to compensation was caused.

Duty of care

Usually it is fairly clear if the law would recognize a duty of care as being owed to an individual in the context of healthcare. The health professional clearly has a duty of care toward all his clients. This may include others for whom he is not directly responsible but is asked to care for. It may also, depending upon the contract of employment, require him or her to return from off duty in a crisis. The duty will certainly involve the need to communicate with the client, relatives, and colleagues. The duty to inform the mentally incapacitated person and the informal carer about significant risks is as much part of the duty of care as treatment and other procedures.

The definition of the duty of care was raised in a House of Lords case in 1932.[79] It was concerned with the question of whether a manufacturer owed a duty of care to the ultimate consumer, regardless of who had paid for the product.

The facts in this case were that the claimant alleged that she had drunk ginger beer which contained the decomposed remains of a snail and held the manufacturers liable for the harm she suffered. The case went to the House of Lords over the issue of whether the manufacturers owed a duty of care to her. In a majority decision, the House of Lords decided in her favor. This may seem very remote from the duty of care owed by the carer of a person with mental capacity problems,

but the statement of Lord Justice Atkins is very important in defining the duty of care. He said:

> You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who then, in law, is my neighbour? The answer seems to be persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question.

No person has a duty to volunteer help if a duty of care does not already exist. Once, however, this duty is assumed, then liability could arise. In Scenario 11.1 a situation where Janice did shopping for a person sharing the same house is discussed. If Janice undertook to help her neighbor on a regular and substantial basis, it may be that the law would consider her to have assumed a duty of care.

Of what does the duty consist?

The duty of care would include not only duties in relation to treatment and care, and in giving information, but also duties relating to the keeping of satisfactory records, duties in relation to management of the situation, of supervision and delegation to other staff, and all actions necessary to ensure that the client will be reasonably safe. A duty would also be held to exist in relation to colleagues to ensure that they are reasonably safe.

Duty to parents

The House of Lords (in a majority verdict) has held that healthcare and other child care professionals did not owe a common law duty of care to parents against whom they had made unfounded allegations of child abuse and who, as a result, suffered psychiatric injury.[80] However this was overruled by the European Court of Human Rights which held that there were breaches of the European Convention on Human Rights.[81] The same principles would apply where abuse of a mentally incapacitated adult was reasonably feared and reported.

The Court of Appeal held that the fact that the person causing harm to the claimant was suffering from paranoid schizophrenia did not mean that his estate was not liable for the harm caused to the claimant. The claimant was severely burnt when attempting to stop V from igniting a lighter to set fire to the petrol which he had poured over himself. The Court of Appeal held that a duty of care was owed to the claimant, and the defendant was expected to meet the standards of the ordinary reasonable person in spite of the fact that he suffered from mental illness and the claimant was able to succeed under the insurance terms.[82]

Standard of care

The claimant (formerly known as the plaintiff, i.e., the person suing for compensation) has to show that the defendant acted in breach of the duty of care. This is the *fault element* which is required under the present laws to obtain compensation. In order to show that there has been a breach, it is first necessary to establish what standard should have been followed and how the defendant's actions differed, if at all, from what it was reasonable to expect.

The courts use a test known as the *Bolam test* to determine the standard expected from professionals. The name derives from a case heard in 1957[83] where a psychiatric patient was given electroconvulsive therapy without any relaxant drugs or restraint. He suffered several fractures and claimed compensation against Friern Hospital Management Committee. Mr Justice McNair, in deciding how to determine the standard which should have been followed, said:

> When you get a situation which involved the use of some special skill or competence, then the test as to whether there has been negligence or not is … the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well-established that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.

He added later:

> He is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.

The Bolam test relates to the standards which were reasonably expected at the time the alleged negligent act took place. It thus enables the standards applied by the courts to change and for professionals to be judged against the standards of the time of the alleged negligence acts, not the standards which existed at the time of the court hearing which may be many years later.

In the actual case of Bolam, the patient lost his claim. However, were the same facts to occur in the 21st century, there would probably be an offer to settle without any attempt to defend the case, since standards are much higher now.

What if there are different opinions over the standard which should be followed?

Mr Justice McNair in the Bolam case referred to the fact that there are sometimes differences of opinion and quoted from an earlier case (*Hunter* v. *Hanley* 1955):[84]

> In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion, and one man clearly is not negligent merely because his conclusion differs from that of other professional men, nor because he has displayed less skill or knowledge than others would have shown. The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of, if acting with ordinary care.

This principle was followed in the case of *Maynard* v. *West Midlands Regional Health Authority*[85] where the House of Lords stated the following:

> It was not sufficient to establish negligence for the plaintiff [i.e., claimant] to show that there was a body of competent professional opinion that considered the decision as wrong, if there was also a body of equally competent professional opinion that supported the decision as having been reasonable in the circumstances.

Standards of care and national guidance

Clearly health and social services professionals would be expected to follow the guidance issued nationally by the DH and other bodies, relating to procedures and practice on the care and treatment of vulnerable adults. The fact that particular advice and guidance was not followed would not in itself constitute evidence of negligent practice, since there may be special circumstances which justified not following that particular guidance. The national guidance would however constitute a presumption that it should be followed.

The MCA Code of Practice

The MCA places the guidance on the MCA provided by the Code of Practice on a different legal basis from that of other national guidance. Section 42 places a duty on specific persons or officers (informal or unpaid carers are not included in the list) to follow the code. The effect of failure to obey the code is that if it appears to a court or tribunal conducting any criminal or civil proceedings that a provision of a code or a failure to comply with a code is relevant to a question arising in the proceedings, the provision or failure must be taken into account in deciding the question (S.42(5)) (see further in Chapter 17). The situation with regard to informal carers is considered in Chapter 16. Scenario 11.5 discusses civil liability in failing to follow the Code of Practice.

In Scenario 11.5, not only has Justin failed to follow the Code of Practice, he has also failed to follow the basic principle of the MCA 2005, namely, that:

> A person must be assumed to have capacity unless it is established that he lacks capacity (Mental Capacity Act S.1(2)).

It is the duty of a person to have regard to any relevant code if he is acting in relation to a person who lacks

Scenario 11.5 Failure to follow Code of Practice.

Justin was a staff nurse working in a community home for those with learning disabilities. One of his residents, Ollie, was complaining of toothache. Justin decided that Ollie was not capable of giving consent to the dental examination and therefore arranged for Ollie to be given an anesthetic for the examination and extraction. Ollie's parents discovered belatedly that Ollie had had the extraction and complained to Justin's manager. They maintained that Ollie's consent should have been obtained. And if it was established that he was not capable of giving consent to dental treatment, then they should have been brought in to give consent. An investigation was carried out. It was discovered that Justin had failed to follow the guidance in the Code of Practice relating to the determination of capacity. He had just assumed that Ollie lacked the requisite capacity and he had not carried out any evaluation of Ollie's mental capacity. He had not attempted to try to minimize anxiety or stress by making Ollie feel at ease. Nor had he chosen the best location where Ollie felt most comfortable and the time of day when Ollie was most alert. Nor did he consider bringing in an expert to advise on Ollie's mental capacity to make the specific decision.

capacity and is doing so in a professional capacity (S.42(4)(e)).

The effect of failure to obey the code is that if it appears to a court or tribunal conducting any criminal or civil proceedings that a provision of a code or a failure to comply with a code is relevant to a question arising in the proceedings, the provision or failure must be taken into account in deciding the question (S.42(5)).

What action could Ollie's parents bring in his name?

Failure to assess Ollie's capacity is a civil wrong, not just by Justin, but also by the dentist who should have carried out his own test to determine whether Ollie could give consent. It could be argued that both have failed to follow the reasonable standard of care required of a professional as set down in the case. In addition, Justin's failure to follow the guidance in the Code of Practice could be used as evidence of a trespass to Ollie's person. In theory the parents could bring a civil action for trespass to the person in the name of Ollie. In practice it is more likely that they would pursue their grievance through the complaints procedure and perhaps seek some disciplinary action against Justin. Justin's employers could be held vicariously liable for Justin's civil wrongs.

Causation

It is not enough for the claimant to show that the duty of care which was owed was broken; the claimant must also show that there was a causal link between that breach of duty and the harm which has occurred. This is known as *causation*. There must be factual causation as well as the link being reasonably foreseeable. In the case shown in Case Study 11.20, the claimants failed to establish causation, and the House of Lords ordered a new hearing on the issue of causation.

Case Study 11.20 *Wilsher* v. *Essex Area Health Authority*.[86]

A premature baby was being treated with oxygen therapy. A junior doctor mistakenly inserted the catheter to monitor the oxygen intake into a vein rather than an artery. A senior registrar, when asked to check what had been done, failed to notice the error. The baby was given excess oxygen. The parents claimed compensation for the retrolental fibroplasia that the baby suffered but failed to prove that it was the excess oxygen which had caused the harm. They therefore failed in their claim. It was agreed that there were several different factors which could have caused the child to become blind, and the negligence was only one of them. It could not been presumed that it was the defendant's negligence which had caused the harm. The House of Lords ordered the case to be reheard on the issue of causation. In the event, the parties settled.

An example of negligence

If a person follows the principles of the MCA, establishes that a client/patient lacks the requisite mental capacity and acts in the best interests of that client according to the criteria set down in Section 4, then that person is protected against an action for trespass to the person. However their actions may still lead to civil and criminal proceedings, as Scenario 11.6 illustrates.

Scenario 11.6 Negligence.

Dawn was a care assistant working in a community home. She was asked to arrange for Kevin, one of the residents, to be taken to the shops. She had been trained in this activity and knew that two care assistants were required. However because her colleagues were busy, she decided to take him on her own. As they were about to cross the road, Kevin let go of her hand, rushed across the road in front of a lorry and was severely injured. Kevin's relatives are prepared to sue on his behalf.

In the situation in Scenario 11.6, Dawn is at fault in failing to follow the risk assessment and management procedures of the home which have been set down to ensure Kevin's protection. She would be held personally accountable for this, but it would be her employers who would have to pay compensation to Kevin. The employers are vicariously liable for the negligence of Dawn, an employee who was acting in the course of employment. Under Section 5(3) of the MCA, there can still be liability for negligence, even though a person was acting under the powers of the MCA in making decisions in P's best interests.

See also Scenario 5.8 on risk taking.

Factual causation

In one decided case[87] three night watchmen drank tea which made them vomit. They went to the casualty department of the local hospital. The casualty officer, on being told of the complaints by a nurse, did not see the men but told them to go home and call in their own

doctors. Some hours later, one of them died from arsenical poisoning. The court held that:

– The casualty department officers owed a duty of care in the circumstances.
– The casualty doctor had been negligent in not seeing them, but
– even if he had, it was improbable that the only effective antidote could have been administered in time to save the deceased, and
– therefore the defendants were not liable. The patient would have died anyway.

The onus is on the claimant to establish that there is this causal link between the breach of the duty of care and the harm which occurred as shown in Case Study 11.20.

An intervening cause, which breaks the chain of causation, may also prevent causation being established and therefore cause the claimant to fail in her claim.

Loss of a chance

The House of Lords (in a majority ruling) ruled in January 2005[88] that where a doctor negligently failed to refer for investigation a patient with possible symptoms of cancer, with the result that there was a 9-month delay in treatment for the condition, the patient whose chances of survival during that delayed period had fallen from 42 to 25% could not recover damages for that loss of chance. The delay had not deprived that patient of the prospect of a cure because, on a balance of probability, he could probably not have been cured anyway, and loss of a chance was not in itself a recoverable head of damage for clinical negligence.

Harm

To obtain compensation for negligence it must be established that harm has resulted from the negligent act. Harm includes personal injury and death, loss, and damage of property. What types of harm do the courts recognize as being subject to compensation? Some of the forms of harm are shown in Box 11.4.

Box 11.4 Harm recognized as subject to compensation in the civil courts.

- Personal injury, pain, and suffering
- Death
- Loss of the ability to have children
- Loss of the opportunity to have an abortion
- Having a child after being sterilized
- Post-traumatic stress syndrome or nervous shock
- Loss or damage of property

Where psychiatric harm has occurred as well as physical injury, then that is compensatable if a breach of the duty of care and causation can be established. However, where post-traumatic stress disorder (once known as nervous shock) has occurred on its own, compensation will only be paid if a duty of care can be established. The principles of liability for nervous shock were outlined by the House of Lords in the case of *McLoughlin* v. *O'Brian*.[89] More recently, the House of Lords has set out the principles in a series of cases, some involving post-traumatic stress disorder suffered by those who witnessed or assisted at the Hillsborough football stadium disaster. In *Alcock* v. *Chief Constable of South Yorkshire Police*,[90] the House of Lords held that a person who suffers reasonably foreseeable psychiatric illness as a result of another person's death cannot recover damages unless he can satisfy three requirements:

– that he had a close tie of love and affection with the person killed, injured or imperilled
– that he was close to the incident in time and space, and
– that he directly perceived the incident rather than, for example, hearing about it from a third person.

In *Page* v. *Smith*[91] the House of Lords made a distinction between primary and secondary victims: a claimant who was within the range of foreseeable injury was a primary victim, all other victims must satisfy the requirements set out previously.

This was applied by the House of Lords in the case of *White* v. *Chief Constable of South Yorkshire Police and Others*[92] where it decided by a majority that police officers who had assisted in the aftermath of the Hillsborough disaster could not obtain compensation because they were not primary victims, since they were not in the zone of danger, nor did they satisfy the requirements set out previously of being secondary victims.

In contrast, a girl who witnessed her mentally ill brother stab their mother to death was given £500 000 compensation by the NHS trust who admitted liability for her severe mental breakdown.[93] An independent inquiry had found that he had been allowed to leave the ward, even though medical staff realized that he posed a danger to himself and others.

In a recent case the Court of Appeal held that compensation was not payable to the husband of a woman who as a result of negligence in an operation had to have emergency surgery. The husband suffered psychological injury as a result of seeing her condition. He was awarded £9 000 but the hospital's appeal to the Court of Appeal was upheld. It held that in order to successfully claim compensation as a secondary victim, the shocking event must be exceptional, sudden, and horrifying as judged by objective standards with reference to persons of ordinary susceptibility.[94]

Harm may also include financial losses such as loss of earnings.

In the case of *Robshaw* v. *United Lincolnshire Hospitals NHS Trust* [2105],[95] a boy who suffered brain damage at birth from oxygen starvation received £14.6 million compensation for medical negligence.

The claimant, that is, the person bringing the action, normally has the burden of proving that there was negligence by the defendant which caused harm to him. The standard of proof in the civil courts where an action for compensation would take place is *on a balance of probabilities*. This contrasts with the standard of proof in a criminal case, which is *beyond reasonable doubt*.

However, where certain circumstances arise it is possible for the claimant to argue that *the thing speaks for itself* and the defendant has the task of showing that he was not negligent. This is known as a *res ipsa loquitur* situation.

Time limits

Where compensation is being claimed as a result of negligence causing harm, the action must be brought within 3 years of the harm occurring or knowledge that actionable harm has occurred. However where the victim is a child, time does not start to run until he or she becomes 18 years. Where the victim is under a disability, the time limit does not start to run until the disability has ended. For some this may mean death. As a consequence of the amendments to Section 38 of the Limitation Act 1980 by the MCA Schedule 6, Para 25, a person shall be treated as under a disability while he is an infant or lacks the capacity (within the meaning of the MCA) to conduct legal proceedings. Since under the MCA capacity is issue specific (see Chapter 4) and has to be assessed at the relevant time, the claimant will have to establish that he or she lacked capacity at the time the cause of action commenced and also continuously thereafter during the time it was claimed that time should not run against him or her.[96]

Burden of proof

Vicarious liability

It would be usual in the case of an employed health or social services professional for his employer to be sued in the event of him or her being negligent. For obvious reasons, the employer is more likely to be able to pay the compensation due as a consequence of any harm caused by his negligence. This applies even though the employer has not been negligent in any way. In order to ensure that an innocent victim obtains compensation for injuries caused by an employee, public policy dictates that the doctrine of vicarious liability applies. Under the doctrine of vicarious liability, the employer is responsible for compensation payable for the harm. The effect of vicarious liability is shown in the discussion of Scenario 11.6.

For vicarious liability to be established, the elements shown in Box 11.5 must be established.

The Supreme Court ruled in October 2013 that a school had a duty of care to a pupil who was severely brain damaged during a swimming lesson run by an independent swimming instructor in a council run pool in Essex.[97] It was alleged that the swimming instructor's negligence had caused the injuries. The Supreme Court ruled that the school had a nondelegable duty of care toward its pupils—not merely to take reasonable care of them but also to provide that reasonable care is taken of them by third parties, even while outside the premises of the school. It stated that "the duty extends beyond

Box 11.5 Elements in vicarious liability.

– There must be negligence, that is, a duty of care which has been breached and, as a reasonably foreseeable consequence, has caused harm, or some other failure by the employee.
– The negligent act or omission or failure must have been by an employee.
– The negligent employee must have been acting in the course of employment.

being careful, to procuring the careful performance of work delegated to others." Five defining features justified departure from the established principle of the delegation of the duty of care:

1 The claimant is a child or vulnerable person.
2 There is a preexisting duty owed by the defendant to the claimant with a positive obligation to protect the claimant from harm.
3 The claimant has no control over the defendant's performance of that obligation.
4 The defendant has delegated some part of its function to a third party.
5 The third party has been negligent.

This ruling has significant implications for both health and local authorities as they delegate services to be performed by outside organizations.

Case Study 11.21 *Dunhill* v. *Burgin 2014*.

The Supreme Court ruled on the definition of mental capacity in March 2014 in a case following a road accident. The defendant motor cyclist had knocked down the claimant who was crossing the road. An initial agreement had been reached whereby the claimant received £12 500 with costs. That was a gross undervaluation of the claim which was assessed as £2 million by the claimant's advisers and about £800 000 by the defendant. The Supreme Court held that the claimant lacked the capacity to commence and conduct proceedings. She should have had a litigation friend from the outset and the settlement should have been approved by the court under rule 21(10)(1) of the civil procedure rules. The consent order was set aside and the case was to go to trial.[101]

Personal accountability of the employee

Even where the employer is held to be vicariously liable, the employee who is responsible for harm, such as the death of a client, could be found guilty of manslaughter for the gross negligence which led to the death, could lose his job following disciplinary action, and, if a registered practitioner, could also be struck off the register following a Nursing and Midwifery Council, Health Professions Council, or other registration body's hearing on fitness to practice. A schoolmaster was sentenced to a year's imprisonment following the death of a boy on a school trip in the Lake District. The judge held that he was unbelievably foolhardy and negligent in allowing the boy to jump into a turbulent mountain pool.[98] Similar principles would apply to the care of vulnerable adults.

Procedural provisions for claims brought in the name of a mentally incapacitated adult

The Civil Procedure Rules cover the situation when children or protected parties are incapable of managing and administering their property and affairs)[99] are involved in civil proceedings. Rule 21.2 requires a protected person to have a litigation friend to conduct proceedings on his or her behalf. The court can either appoint the litigation friend or a person may act as the litigation friend (either as claimant or defendant) if he can fairly and competently conduct proceedings on behalf of the patient. Such a person is required to follow the procedure set out in Rule 21.5. This includes filing with the court the authorization or certificate of suitability. No settlement, compromise, or payment can be made without the approval of the court. Where money is recovered for the patient, it must be held according to the directions given by the court. Any expenses incurred by a litigation friend on behalf of the patient can be recovered from the amount paid into court if it has been reasonably incurred and it is reasonable in amount.

A case concerned with the definition of legal capacity for the purposes of being able to participate in legal proceedings heard before the MCA came into force held that vulnerability to exploitation was an aspect of personality and behavior to be taken into account when assessing whether an individual had capacity.[100] The judge held that, since the claimant was unlikely to be able to deal with the advice he was likely to have to give or receive in legal proceedings, he was declared a patient within the meaning of Part VII of the 1983 Mental Health Act and therefore came within Part 21 of the Civil Procedure Rules (See also Case Study 11.2).

Disciplinary action

All employees also face the possibility of disciplinary action if they fail to provide a reasonable standard of care for those vulnerable adults in their care. Under the contract of employment, the employee has an implied duty to act with reasonable care and to obey reasonable instructions. Being negligent in the care of

vulnerable adults, whether or not harm was caused, could be seen as being a breach of this contractual term. As a consequence, the employer could hold disciplinary proceedings and, if the conduct was held to justify dismissal, terminate the contract of employment. The employee may then, if he has the requisite length of continuous service, apply to the employment tribunal, alleging that the employer has unfairly dismissed him or her.

Professional conduct proceedings

Any registered practitioner could be reported to his registration body in the event of an untoward event occurring, where there is evidence of negligence or professional misconduct. Recent changes to the fitness to practice proceedings of the Nursing and Midwifery Council, the General Medical Council, and Health and Care Professions Council means that these bodies are operating upon similar lines, with comparable committees and procedures for determining if a registered practitioner should remain on the register, be cautioned or face interim suspension. In addition the establishment of the Council for the Regulation of Healthcare Professions (subsequently known as the Council for Healthcare Regulatory Excellence and now known as the Professional Standards Authority for Health and Social Care) is likely to lead to even greater similarities between the workings of the different health registration bodies.

Confidentiality

The fact that an individual lacks mental capacity does not mean that their rights of confidentiality are not protected. Those who are capable of giving consent to the disclosure of information are permitted in law to do so. If they lack that capacity, then the provisions of the Data Protection Act and the regulations made under that Act provide them with the same protection. There are specific and limited occasions where disclosure of personal information is permissible in law without the consent of the individual. These exceptions to the duty of confidentiality are set out in Chapter 16 on informal carers, but the same principles apply to health and social services professionals.

Section 60 of the Health and Social Care Act 2001 (now Section 251 of the NHS Act 2006) enabled regulations[102] to be made to enable people to use confidential patient information without breaking the law of confidentiality. Applications must be made to the Confidentiality Advisory Group within the Health Research Authority for approval on behalf of the Secretary of State.[103] For further information on the HRA, see its website[104] and Chapter 10. The duty of confidentiality on informal carers is considered in Chapter 16. Guidance on the duty of confidentiality has been issued by the Department of Health.[105]

Complaints

The use of complaints procedures to challenge decisions made under the Act or challenge omissions in implementing the Act is considered in Chapter 17.

Conclusions

This chapter has considered the protection of the vulnerable adult and the different forms of accountability which apply to the work of health and social services professionals. They apply as much to the care of vulnerable adults as they do to the care of those without disabilities. The operation of the new criminal offence of ill-treating or wilfully neglecting a person who lacks capacity has been a challenge in its interpretation and implementation but it does provide protection for the vulnerable adult. At the time of writing, the Government response to the House of Lords Scrutiny Report on the Section 44 offence has not yet been implemented.

Quick fire quiz, QFQ11

1. Which persons can be prosecuted under Section 44(2) of the MCA which makes it an offence to ill-treat or wilfully neglect a person who lacks capacity?
2. In what circumstances could a neighbor be prosecuted under Section 44(2)?
3. How does the Disclosure and Barring Service provide protection for vulnerable adults?
4. In which circumstances does the criminal justice system provide protection for a vulnerable adult caught up in criminal proceedings?
5. What elements are required for an employer to be held responsible for the actions of an employee?
6. How can a legal action be brought on behalf of a person who lacks the requisite mental capacity to act on his own behalf?

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CHAPTER 12

Children and young persons

THIS CHAPTER CONSIDERS THE FOLLOWING TOPICS

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Introduction

Those under 16 years are in general excluded from the provisions of the Mental Capacity Act (MCA), since under Section 2(5) no power is exercisable in relation to a person under 16 years. However there is an exception to this principle in relation to property matters. In addition there are several provisions where a person must be at least 18 years to utilize some of the tools given in the Act. There are a few sections of the MCA relating to children, and for convenience these are brought together in this chapter and the general rules relating to decision making by and on behalf of children considered.

European Convention on Human Rights and the United Nations Convention on the Rights of the Child (1989)

The European Convention on Human Rights is directly enforceable in the United Kingdom through the Human Rights Act 1998. It is considered in Chapter 3. In contrast the United Nations Convention on the Rights of the Child (1989)[1] is not directly enforceable in the United Kingdom. The extent to which the United Kingdom complies with the Convention is monitored on a biannual basis by the Human Rights Joint Committee of the House of Lords and Commons. In its

Legal Aspects of Mental Capacity: A Practical Guide for Health and Social Care Professionals, Second Edition. Bridgit Dimond.
© 2016 John Wiley & Sons, Ltd. Published 2016 by John Wiley & Sons, Ltd.

Eighth Report on the UK's compliance with the UN Convention (available on the Parliamentary website[2]), it recommended that the Children's Commissioner in England should have the power to take up individual child cases, like her fellow Commissioners in the rest of the United Kingdom and that a future government should review the legal aid changes which have impeded access to the courts. Both conventions are significant in protecting the rights of the child.

Children Act 1989

The Children Act 1989 makes provision for the care of children and young persons under 18 years, and this Act will continue to be the main source of law for those individuals. In addition children and young persons come under the inherent jurisdiction of the High Court (the inherent jurisdiction of the court is considered in Chapter 2) and if they suffer from mental disorder may come under the Mental Health Act 1983 (see Chapter 13). The Deprivation of Liberty Safeguards (DOLs) which were added to the MCA do not apply to those under 18 years (see Chapter 14).

Family Law Reform Act 1969 and children of 16 and 17

Young persons of 16 and 17 years have a statutory right to give consent to surgical, medical, and dental treatment under Section 8 of the Family Law Reform Act 1969.

Like adults (those over 18 years), there is a presumption that they have the capacity to give consent. The presumption of capacity can be rebutted, that is, removed, if there is evidence that the person lacks capacity to make a specific decision and the standard of proof is on a balance of probabilities. Even where the young person is considered to have the necessary capacity, a refusal to consent to lifesaving treatment can be overruled by the court if it is considered to be in the best interests of the young person to have the treatment[3] (see Scenario 12.1). For this reason a person must be over 18 years to be eligible to draw up an advance decision which would cover the situation if they subsequently lack capacity (See advance decision on page 236). A case involving the refusal of a young person of 16 and 17 to consent to treatment considered to be in his or her best interests where the young person had the requisite mental capacity would be heard in the High Court, not the Court of Protection. However where capacity was lacking or disputed, the Court of Protection could have jurisdiction. (An example can be seen in Scenario 12.2.) As will be seen in pages 234–5, there is maximum flexibility to enable a case to be transferred from the High Court to the Court of Protection and vice versa, wherever that would be in the interests of justice.

This is a situation where in theory the parents are able to make the decision for Ben and overrule his wish to stay in the family home. However since Ben has been assessed as having the requisite mental capacity, it would be preferable if that decision were to be made in court so that he would have an opportunity to be represented. Since it has been decided that he does have the requisite mental capacity, it would be likely that the issues would be heard in the Family Division of the High Court. It could not be considered by the Court of Protection, since its jurisdiction is confined to the determination of capacity and decision making once incapacity has been determined to exist. If however there were a dispute over Ben's capacity to make or communicate the decision, then an application could be made to the Court of Protection for a declaration on the

Scenario 12.1 Overruling a young person.

Ben had cerebral palsy and had communication difficulties. When he was 17 years, he was offered the chance of transferring from the family home to a community-based home for young people with physical disabilities. He was assessed under the Mental Capacity Act 2005, and it was determined that he was capable of deciding on his accommodation and with assistance from a therapist of communicating his decision. He was taken on a visit to the new accommodation and shown the room which he would be given and told that it was his choice of furniture and furnishings.

He decided however that he preferred to stay in the family home, where his room had been adapted to meet his disabilities, and he disliked change. His family was considering selling the home and buying a smaller property, and the social workers considered that it was in Ben's best interests for the long term to move to the community home in preparation for a time when his parents could no longer provide accommodation for him. Ben disagreed with that decision.

capacity of Ben, and if it were decided that he lacked the requisite capacity, then a determination of what was in his best interests could be made. See Case Study 12.3 of *LB* v. *Haringey* and the transfer of cases between the High Court and Court of Protection.

Changes to the Mental Health law on overruling the refusal of a young person of 16 or 17 years

Lord Howe introduced an amendment to the Mental Health Bill, amending Section 131 of the Mental Health Act 1983 for a 16- and 17-year-old patient's refusal to consent or resistance to admission/treatment for mental disorder not to be overridden by the giving of consent by a person who has parental responsibility. An amendment was made by Section 43 of the Mental Health Act 2007. Lord Hunt (for the Government) said that:

> There is clearly support for 16- and 17-year-olds capable of expressing their own wishes to have their consent or refusal to consent to treatment and admittance to hospital for mental disorder protected in the Bill. Where they consent to admission and treatment in hospital for mental disorder, their consent should not be overridden by a person with parental responsibility for them. Where they do not consent to admission and treatment in hospital for mental disorder, their lack of consent should not be overridden by a person with parental responsibilities for them.[4]

Such a change may have a significant effect in the recognition of the human rights of the 16- and 17-year-old.

Young persons and children under 16 years

As a consequence of the House of Lords ruling in the Gillick[5] case, those under 16 years are able to give a valid consent to treatment and examination if they have the requisite capacity to make the specific decision. However in these circumstances there is no presumption of capacity: capacity has to be established in respect of each decision which is to be made.

The House of Lords in a majority ruling held that if a child has the maturity to understand the nature, purpose, and likely effects of any proposed treatment, then he or she could give a valid consent without the involvement of the parents. This has given rise to the expression *Gillick competent* which is also known as the test of competence according to Lord Fraser's guidelines. (Lord Fraser was one of the judges in the House of Lords which decided the Gillick case.) Lord Fraser stated that:

> Provided the patient, whether a boy or a girl, is capable of understanding what is proposed, and of expressing his or her own wishes, I see no good reason for holding that he or she lacks the capacity to express them validly and effectively and to authorise the medical man to make the examination or give the treatment which he advises.

Case Study 12.1 An *NHS Foundation Trust* v. *A, M, P, and A local authority* [2014][6]

A 15-year-old girl, weighed only 5 ½ stones and had a life expectancy of 8–12 weeks. She vomited up to 30 times a day. Both she and her mother opposed treatment. The trust sought declaration that it was lawful and in her best interests to have a nasojejunal tube inserted and reinserted if it was removed, and lawful and in her best interests to have fluids, nutrition, and medication through the tube and for her to receive treatment and assessment. The judge applied a balance sheet approach, that is, benefits/disadvantages table to determine what was in her best interests and made the declarations sought by the Trust, determining the case under the Children Act rather than the MCA.

While the Gillick case itself was concerned with family planning and treatment, the principle applies to other forms of treatment, including abortion, and can apply to boys as well as girls. The principle that the ascertainable wishes and feelings of the child concerned (considered in the light of his age and understanding) should also be taken into account is also stated in the Children Act 1989 Section 1(3)(a) as one of the factors to which the court must have regard in determining what if any orders should be made or varied.

In Case Study 12.1 the Court applied the same balance sheet approach in determining the best interests of the child, as they would do, had they been making the determination under the MCA.

Parental rights and consent on behalf of young persons and children

Section 8(3) of the Family Law Reform Act 1969 preserves the right of a parent to give consent to treatment and examination on behalf of a young person of 16 or

17 years. If a young person of 17 came unconscious into a hospital's Accident and Emergency department after a road accident, the parent(s) could give consent to treatment on his or her behalf. Where however there is a dispute between the young person and the parent, as for example, where a young person of 16 has become a Jehovah's Witness and has refused to give consent to a lifesaving blood transfusion, and the parent is not of the same faith and wants blood to be given, then it would be preferable, in order to protect the rights of the child and parents, for an application to be made to court for a declaration on what is in the best interest of the young person.

Where the young person or child is under 16 years, the parent has the right and duty to act in the child's best interests and could be prosecuted for failure to act appropriately if harm is caused to the child as a consequence. Where there is a major decision to be made, it is preferable for a declaration of the court to be obtained. See Case Study 12.2 on the sterilization of a young person less than 18 years and Case Study 12.5 on page 23 on the court overruling the refusal of a 15-year-old to have a heart transplant. The distinction should be noted that the parent can give consent on behalf his or her child up to 18 years, but if at 18 years or older the young person lacks the requisite mental capacity, the parent would then act in the best interests of that person, not give consent on his or her behalf. The parent would be expected to apply the principles under the MCA and determine the best interests in accordance with section 4. (See Chapter 5 on best interests and also Chapter 16 on the informal carer.)

In the case of *D (A Child) (Deprivation of Liberty)* [2015],[7] a boy of 15, with ADHD, Asperger's, and Tourette's, was sent to a psychiatric hospital for a multidisciplinary assessment and treatment. He did not have the capacity to give consent to admission. While he satisfied the acid test of deprivation of liberty being under constant supervision and control, it was held that the parents did have the power to give consent to his admission and detention and therefore there was not a deprivation of liberty. The decision has been criticized by 39 Essex Chambers on the grounds that he was compared not to ordinary boys but to ones with significant disabilities. Since he was detained on the word of the parents, there was a lack of protections for him such as a review, independent scrutiny, a lack of formalized admission procedures, and time limits.

Case Study 12.2 *Re B (a minor)(wardship: sterilisation)*[8]

Jeanette was 17 years old but was described as having a mental age of 5 or 6. Her mother and the local authority, which held a care order on her, advised by the social worker, the gynecologist, and a pediatrician, considered it vital that she should not become pregnant. She had been found in a compromising situation in her residential home. She could not be relied upon to take or accept oral contraceptives. Jeanette was likely to move to an adult training center at the age of 19, and it would not be possible to provide her with the degree of supervision she had at present.

Sterilization in the best interests of a young person (Case Study 12.2)

The House of Lords decided that the paramount consideration was the interests of the girl and, taking account of all the medical evidence, decided that it was in her interests to be sterilized. They made no distinction between nontherapeutic and therapeutic care of the child and recommended that in future all such cases should come before the courts.

As a result of the MCA 2005, a nontherapeutic (i.e., one for social reasons as opposed to one caused by a physical condition such as cancer) sterilization would come under the definition of serious medical treatment. Since Jeanette is over 16 years and lacking the requisite mental capacity, any decision about whether she should be sterilized could come under the MCA provisions and be heard in the Court of Protection. Alternatively, if there were advantages in the case being heard before the family courts under the provisions of the Children Act 1989, then it could be referred there. The MCA and the Court of Protection rules enable maximum flexibility in hearing cases concerning young people (see also Scenario 12.2 on property matters and Case Study 12.3.)

Court of protection: Property and financial decisions

With the exception of the execution of a will, the powers of the Court of Protection under Section 16 can be exercised even though P has not reached 16, if the court considers that it is likely that P will still lack

Scenario 12.2 Management of property.

James was severely injured in a road traffic accident when he was 12 years old. He was on a pedestrian crossing and the motorist was held entirely to blame. James was awarded a compensation package of over £2 million. His parents were separated and disagreed how the funds should be spent on his behalf. James was then 15 years old and it was agreed that an application should be made to the Court of Protection since it seemed unlikely that he would have the necessary mental capacity at 18 years.

capacity to make decisions in respect of that matter when he reaches 18 (MCA S.18(3)). Thus in the case of a young person with severe learning disabilities, a decision about his property and affairs can be made even though he is under 16 years if it seems unlikely that he will have the necessary mental capacity at 18 years (see Scenario 12.2).

The power under the MCA Section 18(3) for the Court of Protection to exercise the powers given under Section 16 in respect of a child who has not reached 16 years avoids the need for new proceedings to be commenced once the child reaches adulthood and continues the jurisdiction of the previous Court of Protection in relation to children under 16. It enables a deputy to be appointed who can take a long term view where the child has received substantial compensation and is unlikely to have the mental capacity to manage it.[9]

The Code of Practice notes that the Court of Protection can[10]:

- make an order (e.g., concerning the investment of an award of compensation for the child), and/or
- appoint a deputy to manage the child's property and affairs and to make ongoing financial decisions on the child's behalf.

In making a decision, the court must follow the Act's principles and decide in the child's best interests as set out in Chapter 5 of the Code.

The Court of Protection in Scenario 12.2 would be able to decide whether a deputy should be appointed to manage James' property or whether a single declaration by the Court of Protection was appropriate.

Under the Court of Protection rules, the applicant must serve a copy of the application form on a specified list of persons. This includes, where the person who is alleged to be mentally incapacitated is under 18, (i) his or her parent or guardian or, (ii) if he has no parent or guardian, the person with parental responsibility within the meaning of the Children Act 1989.

Jurisdiction over the 16- and 17-year-old

Link between Court of Protection and family courts

A case relating to a 16- or 17-year-old who lacks capacity could be heard either in a court dealing with family proceedings or in the Court of Protection. Under Section 21, the new Court of Protection has the power in certain circumstances to transfer cases concerning children to a court that has jurisdiction under the Children Act 1989. Moreover, a case started in a court having jurisdiction under the Children Act 1989, in which the main relief claim relates to a time after adulthood, can be transferred to the Court of Protection. The intention behind this is to ensure that cases involving vulnerable 16- and 17-year-olds are approached in the most appropriate way possible. Regulations have been issued on the transfer of proceedings from the Court of Protection to a court having jurisdiction under the Children Act and vice versa and came into force on October 1, 2007.[11] In the case of *B Local Authority* v. *RM* [2010],[12] Hedley J considered the matters which the court should take into account in determining whether proceedings should be transferred. The Act allows the Lord Chancellor to make an order allowing for transfer of proceedings from the Court of Protection to the family courts and vice versa (Section 21). The choice of court will depend on what is appropriate in the particular circumstances of the case. Scenario 12.3 on page 235 illustrates the situation.

The Explanatory Memorandum gives the example of a case of a dispute over the property of a person lacking mental capacity under the age of 18 years.

> For example, if the parents of a 17-year-old with profound learning difficulties are in dispute about residence or contact then it may be more appropriate for the Court of Protection to deal with the case, since an order more under the Children Act 1989 would expire on the child's 18th birthday at the latest.[13]

Where the 16- or 17-year-old lacks mental capacity as defined in Sections 2 and 3 of the MCA, then proceedings could either be brought in the High Court or the

Court of Protection, depending on which court appears to be the more appropriate.

The Code of Practice puts forward the following example of the considerations which should be taken into account in determining whether to use the powers set out under the MCA:[14]

- In unusual circumstances it might be in a young person's best interests for the Court of Protection to make an order and/or appoint a property and affairs deputy. For example, this might occur when a young person receives financial compensation and the court appoints a parent or a solicitor as a property and affairs deputy.
- It may be appropriate for the Court of Protection to make a welfare decision concerning a young person who lacks capacity to decide for themselves (e.g., about where the young person should live) if the court decides that the parents are not acting in the young person's best interests.
- It might be appropriate to refer a case to the Court of Protection where there is disagreement between a person interested in the care and welfare of a young person and the young person's medical team about the young person's best interests or capacity.

The transfer of cases between the High Court and the Court of Protection is relatively simple and illustrated by Case Study 12.3.

Case Study 12.3 *LB* v. *Haringey* v. *FG and others (No 2)* [2011][15]

In a previous hearing[16] the judge found that HG, aged 18, lacked the capacity to litigate and take relevant decisions. In this case he made decisions as to what was in her best interests, in particular whether she should continue to be accommodated by the local authority or to return home to live with her mother. Proceedings started under the Children Act 1989 but were then transferred to continue under MCA 2005 given HG's age. A notable feature of the case was that Hedley J met HG before evidence was given, in the company of the solicitor instructed by the official solicitor, and he reported in open court the conversations he had with her.

Case Study 12.4 *Liverpool City Council* v. *SG & Ors* [2014][17]

The court decided that it had power to make an order which authorizes that a person who is not a child (i.e., who has attained the age of 18) may be deprived of his liberty in premises which are a children's home as defined in section 1(2) of the Care Standards Act 2000 and are subject to the Children's Homes Regulations 2001 (as amended). Declarations as to the lack of capacity and best interests of the patient and authorizing the deprivation of her liberty were made and the matter was transferred back to the Court of Protection sitting in Liverpool where future decision making was to be resumed after an appropriate interval by the local district judge there.

Dispute in relation to care and treatment

The Code of Practice discusses the most appropriate court for determining care and treatment decisions in relation to a 16- or 17-year-old and states:[18]

> A case involving a young person who lacks mental capacity to make a specific decision could be heard in the family courts (probably in the Family Division of the High Court) or in the Court of Protection.
>
> If a case might require an ongoing order (because the young person is likely to still lack capacity when they are 18), it may be more appropriate for the Court of Protection to hear the case. For one-off cases not involving property or finances, the Family Division may be more appropriate.

The most appropriate court

There is a principle that cases relating to young persons who lack mental capacity as defined in the MCA should be *heard in the most appropriate court*.

The Code of Practice[19] gives an example of this principle see Scenario 12.3.

Scenario 12.3 Hearing cases in the appropriate court.

Shola is 17. She has serious learning disabilities and lacks the capacity to decide where she should live. Her parents are involved in a bitter divorce. They cannot agree on several issues concerning Shola's care—including where she should live. Her mother wants to continue to look after Shola at home. But her father wants Shola to move into a care home.

In this case, it may be more appropriate for the Court of Protection to deal with the case. This is because an order made in the Court of Protection could continue into Shola's adulthood. However an order made by the family courts under the Children Act 1989 would end on Shola's 18th birthday.

Offence of ill-treatment and neglect

Section 44 covers the offence of ill-treatment or wilful neglect of a person who lacks capacity to make relevant decisions. This section also applies to children under 16 and young people aged 16 or 17. But it only applies if the child's lack of capacity to make a decision for himself or herself is caused by an impairment of or disturbance that affects how his or her mind or brain works. If the lack of capacity is solely the result of the child's youth or immaturity, then the ill-treatment or wilful neglect would be dealt with under the separate offences of child cruelty or neglect.[20]

Provisions of the MCA which are not available for use in respect of a 16- and 17-year-old

Lasting power of attorney

A person creating the power of attorney, that is, the donor, must have reached the age of 18 years in order to execute the instrument (S.9(2)(c)).

A donee or attorney of the lasting power of attorney must have reached 18 years (S.10(1)(a)).

The implications of these two sections are that a young person under 18 years cannot delegate powers of decision making on property and finance or personal welfare until he or she has reached 18 years. It would be possible for the appropriate document to be drafted in advance and then await the 18th birthday for it to be signed, that is, executed by the donor. Even though the unsigned document would not be effective in law as a lasting power of attorney, it would provide a statement of the young person's wishes and feelings, and if for some reason it was never appropriately executed and the young person came under the provisions of the MCA, it could provide evidence for determining what was in his or her best interests by using the criteria set out in Section 4(6) and considering what his or her views and beliefs would have been.

Similarly the young person could not take on the role of donee under a lasting power of attorney until he or she became 18 years. Once again it would be possible to prepare documents in advance to be executed on the 18th birthday of the donee.

Deputy

A person under 18 years cannot be appointed as a deputy of the Court of Protection under section 19(1).

Advance decision

A person making an advance decision to refuse treatment must have reached 18 years (S.24(1)). As explained previously, this is because of the thinking underpinning common law rulings in which refusals by those under 18 years have been overruled, because the refusal of lifesaving treatment was not considered to be in the best interests of the young person. However any views they have previously expressed, either orally or in writing, about treatment preferences or dislikes should be fully taken into account in deciding what may be in their best interests at a time when they may lack capacity to express those views (see Scenario 12.4). The use of a written statement in determining best interests in situations where an advance decision is invalid or irrelevant is considered in Chapter 9.

Several issues arise in Scenario 12.4, assuming that it is correct that Ahmed is not able to make a decision at the present time. The first is the validity of the written document and, if it is not effective as an advance decision, the weight which should be attached to it in the decision-making process. The second issue is the rights of Ahmed's parents, and the third the procedural measures which are required.

Scenario 12.4 Too young to refuse?

Ahmed was 16 years old and had been converted to being a Jehovah's Witness. He was diagnosed with leukemia and told his parents that he would not wish to receive blood. They did not share his religious views. Ahmed drew up an advance statement concerning his refusal, and he signed it and it was witnessed by a member of his church. Following treatment in hospital, the consultants told his parents that he needed blood and they were prepared to give their consent. Ahmed was too ill to be able to make any decisions about his future treatment. The health professionals were aware of his advance decision, but the patients' services manager advised them that since Ahmed was younger than 18 years, it was not binding on them and they should act in Ahmed's best interests.

Validity of the advance decision

In Scenario 12.4 the patient services manager is correct in stating that under the MCA a person must be over 18 years to create a valid advance decision. The document does not therefore properly constitute an advance decision. However it could be seen as incorporating the wishes and beliefs of Ahmed and should therefore be taken into account in determining what are his best interests under Section 4(6).

This requires the decision maker, in determining what are the best interests of a person lacking the requisite mental capacity, to:

> consider, so far as is reasonably ascertainable—
> (a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity).

Rights of Ahmed's parents

Ahmed's parents have the right to make decisions on his behalf until he is 18 years old. Under Section 8(3) of the Family Law Reform Act 1968, any consent which would have been valid prior to the passing of the Act continues to be valid, and this would include parental consent on behalf of a child or young person less than 18 years old.

However Ahmed comes under the provisions of the MCA and although his advance decision is not valid, since he was under 18 years when he drew it up, decisions must still be made in his best interests according to the criteria set out in Section 4, and the principles set out in Section 1 followed. Ahmed's views and beliefs should therefore be taken into account. They are not necessarily decisive in making the decision as to what was in his best interests but would be part of the balancing exercise.

Procedural measures

It would be unwise for Ahmed's parents to overrule his advance statement and his expressed wishes without seeking a declaration from the court. A court hearing could be speedily arranged and Ahmed should be represented. It is likely that the case would go to the Family Division of the High Court for a declaration as to what was in the best interests of Ahmed. See the Practice note discussed on page 238 Urgent cases[21].

Case Study 12.5 Child refusing a transplant.[22]

A girl of 15 years old refused to consent to a transplant that was needed to save her life. She stated that she did not wish to have anyone else's heart, and she did not wish to take medication for the rest of her life. The hospital, which had obtained her mother's consent to the transplant, sought leave from the court to carry out the transplant.

The court held that the hospital could give treatment according to the doctor's clinical judgment, including a heart transplant. The girl was an intelligent person whose wishes carried considerable weight, but she had been overwhelmed by her circumstances and the decision she was being asked to make. Her severe condition had developed only recently and she had only a few days to consider her situation. While recognizing the risk that for the rest of her life she would carry resentment about what had been done to her, the court weighed that risk against the certainty of death if the order were not made.

Case Study 12.5 illustrates a similar situation which took place before the implementation of the MCA, and even though the girl was only 15 years old, similar issues arose.

Making a will

In keeping with the Wills Act, which requires a person to be over 18 years to make a will (apart from specific exclusions), the MCA Section 18(2) confirms that the Court of Protection has no power to make a statutory will on behalf of young people aged less than 18 years.

DOLs

The DOLs set out in schedule A1 MCA 2005 does not apply to those under 18 years. (Paragraph 13, schedule A1). For a deprivation of liberty to be authorized under the MCA, the relevant person must meet the age requirement and have reached 18 years. If a child or young person under 18 has to be deprived of their liberty in his or her best interests, then to prevent a breach of Article 5 of the European Convention on Human Rights, there must be statutory authorization such as the Children Act 1989 or Mental Health Act 1983 whichever is appropriate in the circumstances. DOLs do not apply to a children's home, but Holman J said that the Court of Protection did have the power to deprive a young woman of 19 years of her liberty by placing her in a children's home. As she was 19 she came under the MCA, but DOLs did not apply because it was a children's home.[23]

Court of protection

No permission is required for an application to the court for the exercise of any of its powers under the MCA by anyone with parental responsibility for a person who has not reached 18.

Parental responsibility has the same meaning as in the Children Act 1989 and includes the mother, the married father (it is irrelevant whether or not they are now divorced or separated), and the unmarried father if he has taken the necessary steps to be recognized as the father who has parental responsibilities for the child. If the child is adopted, parental rights move from the natural parents to the adopted parents by operation of law.

Urgent cases

A Practice Note was issued by the Official Solicitor[24] giving guidance on the procedures to be followed in respect of urgent and out of hours cases in which a decision was sought by a judge of the Family Division. The correct procedure was to make contact with the security officer in the Royal Court of Justice who would then refer the matter to the urgent business officer who, in turn, would contact the duty judge. The judge could agree to convene a hearing in court, elsewhere, or by telephone, via a tape-recorded conference call. Guidance was also given for medical treatment and welfare cases involving adults who lacked capacity to make their own decisions and children. In adult cases, urgent applications had to be made to the Official Solicitor at the earliest possible opportunity. Out of hours cases would be dealt with initially by the urgent business officer who would then contact the Official Solicitor. The application could be made by a National Health Service (NHS) Trust, a local authority, a relative, carer, or the patient. A direction could be sought for anonymity in suitable cases.

Conclusion

The MCA 2005 has attempted to ensure that there is maximum continuity in court proceedings for those aged 16 and 17 by giving jurisdiction to both the family courts and the Court of Protection and also in ensuring that decisions can be made about property and affairs for a person lacking mental capacity who is under 16 years and whose incapacity is likely to continue beyond 18 years. An application should be made to the court which is most appropriate to deal with the needs of that young person. Monitoring of the situation should demonstrate the extent to which these aims have succeeded. The change to the legal situation of not overruling the refusal of a 16- and 17-year-old to admission to a psychiatric hospital may have significant implications for their human rights and may in time be extended to all areas of health and social care.

Quick fire quiz, QFQ12

1 To what age does the MCA in the main apply?
2 What are the provisions of the Family Law Reform Act?
3 Can a parent give consent on behalf of a child of 16 or 17?
4 What provisions of the MCA only apply to a young person of 18 or over?
5 Could the Court of Protection make decisions relating to a child below 16 years?
6 You are concerned that a girl with severe mental impairment who is 17 years is to be sterilized for nontherapeutic reasons with the consent of her father and mother. What action if any would you take?

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CHAPTER 13

Mental capacity and mental disorder

THIS CHAPTER COVERS THE FOLLOWING TOPICS

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Mental incapacity contrasted with mental disorder

"A person is held to lack capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain" (S.2(1)). The inability to make decisions is further explained in Section 3 (see Chapter 4). This contrasts with the remit of the mental health legislation which deals with mental disorder.

Mental disorder is defined in Section 1 of the Mental Health Act (MHA) 1983 (as amended by Section 1 of the MHA 2007) as "any disorder or disability of the mind." The previous classifications of mental illness, mental impairment, and psychopathic disorder are no longer used in mental health law.

Under a new Section 2A of the 1983 Act, learning disability (which is defined as "a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning") is not considered to be mental disorder unless the disability is associated with abnormally aggressive or seriously irresponsible conduct. However for the purpose of the Deprivation of Liberty Safeguards, this qualification is omitted (see Chapter 14).

Dependence on alcohol or drugs is not considered to be a disorder or disability of the mind for the purposes of the definition of mental disorder. "Promiscuity or other immoral conduct, or sexual deviancy" are deleted from the MHA 1983 by the 2007 Act and are not a disorder or disability of the mind.

What are the main differences between the Mental Capacity Act (MCA) 2005 and the MHA 1983 as amended by the 2007 Act?

- The MHA, as amended, does take into account advance decisions. Clinical decisions are the responsibility of the responsible clinician (the 2007 Act substitutes

Legal Aspects of Mental Capacity: A Practical Guide for Health and Social Care Professionals, Second Edition. Bridgit Dimond.
© 2016 John Wiley & Sons, Ltd. Published 2016 by John Wiley & Sons, Ltd.

"responsible clinician" for "responsible medical officer" (RMO)) and in certain circumstances where the patient is unable or unwilling to give consent to treatment for mental disorder, a second medical opinion must be sought before the treatment can be given. However an RMO cannot override an advance decision or decision by a deputy or court of protection where a valid refusal of ECT exists (see S.58A).

- *Mental capacity*: the MCA 2005 applies only to those who are unable to make specific decisions;
  the MHA 1983 does not require a lack of capacity.
- *Mental disorder*: the MCA does not apply to those who are mentally disordered unless they lack mental capacity.
  The MHA 1983 only applies if the patient is suffering from mental disorder as defined in the Act.
- *Best interests*: the MCA requires that all decisions are taken in the best interests of the patient as defined in the Act.
  The MHA does not statutorily require decisions to be made in the best interests of the patient, and detention may be required for the protection of others.
- *Range of treatment and care*: the MCA enables whatever care and treatment is considered to be in the best interests of the patient to be given.
  The MHA only authorizes the administration of treatment for a mental disorder. However this has been defined widely and includes feeding and basic care.
- *Protections available*: the MHA has a wide range of protections for those persons who lose their liberty by being detained under the Act. These include the Care Quality Commission (which took over the responsibilities of the MHA Commission), which has a duty to visit detained patients and respond to their complaints; Mental Health Review Tribunals (MHRTs) to review the justification for their detention or continued detention; managers with responsibilities for making applications to the MHRTs if the patients have not done so themselves within a specified time limit; the rights for patients to be given specified information when detained or when their section is changed.
  The MCA provides protection through the Court of Protection, but an application has to be made to trigger its jurisdiction. The Office of the Public Guardian registers and supervises the exercise of lasting powers of attorney and deputies appointed to make decisions on behalf of those lacking the requisite mental capacity.
- *Restraint*: the MCA enables only limited restraint to be used in narrowly specified circumstances (see Chapter 5 on best interests). It originally did not permit a loss of liberty within the definition of Article 5 of the European Convention on Human Rights. However this provision was repealed in the MHA 2007 in order to fill the Bournewood gap (see Chapter 14). As a consequence of the introduction of the Deprivation of Liberty Safeguards (DOLs), it is possible for loss of liberty to result from the provisions of the MCA. DOLs are discussed in Chapter 14.
  The MHA provides the legal framework within which a patient can lose his or her liberty and be restrained lawfully without any contravention of Article 5.
- *Decision making when capacity is lost*: the MCA recognizes several devices for ensuring that decisions are made in accordance with the wishes of a person made when he or she had the requisite mental capacity, to cover situations when this capacity is lost. These include advance decisions and lasting powers of attorney.

MCA and exclusion of mental disorder

There are specific statutory provisions in the MCA 2005 which exclude mental health matters from the Act. Section 28(1) provides a general exclusion of detained patients and is shown in Statute Box 13.1.

(See definition of **Mental disorder** on page 240.)

The MHA 2007 sets up a new treatment order for mental health patients in the community, and an amendment to the MCA by Section 35(5) of the MHA 2007 makes it clear that such patients are excluded from the MCA. See Subsection 1B to Section 28 of the MCA which is shown in Statute Box 13.1.

Treatment provisions of the MHA 1983

Part 4 of the MHA 1983 covers the treatment for mental disorder of those detained under the Act. Treatments are divided into three categories: Brain surgery, hormonal implants, and other specified treatments (S.57); medication after three months; and ECTs (S.58). All other treatments for mental disorder which are not covered by Sections 57 and 58 come under S.63 (see Statute Box 13.2). Emergency treatments are covered by S.62 as amended (see Statute Box 13.3).

Statute Box 13.1 Section 28 Mental Capacity Act 2005

1 Nothing in [the MCA 2005] authorises anyone
   a) to give a patient medical treatment for mental disorder, or
   b) to consent to a patient's being given medical treatment for mental disorder,
   if, at the time when it is proposed to treat the patient, his treatment is regulated by Part 4 of the Mental Health Act 1983.

(1A) Subsection (1) does not apply in relation to any form of treatment to which section 58A of that Act (electro-convulsive therapy, etc.) (see Statute Box 13.4) applies if the patient comes within subsection (7) of that section (informal patient under 18 who cannot give consent).

(1B) Section 5 does not apply to an act to which section 64B of the Mental Health Act applies (treatment of community patients not recalled to hospital).

2 Medical treatment and mental disorder and patient have the same meaning as in that Act.

Statute Box 13.2 Sections 57, 58, and 63 of the Mental Health Act 1983

1 Treatments involving brain surgery or hormonal implants can only be given with the patient's consent, which must be certified and only after independent certification of the consent and of the fact that the treatment should proceed (Section 57).

2 Treatments involving electroconvulsive therapy or medication where 3 months or more have elapsed since medication was first given during that period of detention can only be given either (a) with the consent of the patient and it is certified by the patient's own approved clinician in charge of the treatment or another registered medical practitioner appointed specifically for that purpose that he is capable of understanding its nature, purpose and likely effects, or (b) the registered medical practitioner appointed (not being the responsible clinician or the approved clinician in charge of the treatment in question) has certified in writing that the patient is not capable of understanding the nature, purpose, and likely effects of that treatment or has not consented to it, but that … the treatment should be given (Section 58) (as amended by the 2007 Act, see Statute Box 13.4 on page 248).

3 All other treatments: these can be given without the consent of the patient provided they are for mental disorder and are given by or under the direction of the approved clinician in charge of the treatment (Section 63).

Statute Box 13.3 Consent to treatment: Urgent treatments

These can be given according to the degree of urgency and whether they are irreversible or hazardous.

Any treatment	which is immediately necessary	to save the patient's life
Treatment which is not irreversible	If it is immediately necessary	to prevent serious deterioration
Treatment which is not irreversible or hazardous	If it is immediately necessary	to alleviate serious suffering
Treatment which is not irreversible or hazardous	If it is immediately necessary and represents the minimum interference necessary	to prevent the patient from behaving violently or being a danger to himself or others

Irreversible is defined as "if it has unfavourable irreversible physical or psychological consequences," and hazardous is defined as "if it entails significant physical hazard."

In the case of *Das, R (On the application of)* v. *Secretary of State for Home Office* [2014][1], the Court of Appeal had to determine the definition of serious mental illness for the purpose of determining the legitimacy of the detention and mental health care of an immigrant and came to the conclusion that the trial judge had set too high a threshold for an illness to qualify as serious mental illness.

Exclusion of short-term detained patients

The following detained patients are excluded from the provisions of Part 4:

a) Patients detained under Section 4 (emergency application: only one medical recommendation)

b) Section 5(2) (patient held under the doctor holding power for up to 72 h) or 5(4) (nurses holding power for up to 6 h) or 35 (remanded to hospital for a court report) or 135 (removal to a place of safety) or 136 (removed from a public place by a police constable) of a direction under Section 37(4) (directions to place of safety) pending a place in hospital under Section 37

c) Patients who have been conditionally discharged under Section 42(2) or Section 73 or 74 and not recalled to hospital

> **Scenario 13.1** Which jurisdiction: MCA or MHA?
>
> Huw was arrested by a police constable in the town center after a crowd had gathered around him as he shouted verbal abuse. He was taken to the police station where the duty officer decided that he had been arrested under Section 136 of the MHA. He was placed in a cell and the police doctor summoned. The doctor decided that Huw needed immediate medication since he appeared to be in a diabetic coma resulting from alcohol consumption. Huw appeared unable to make any decisions for himself. What is the legal situation?

The consequences are that these patients could come within the provisions of the MCA, unless they have been examined by two doctors with a view to detention under Section 2 or 3, and they therefore come under Case E of Schedule 1A of the MCA. Scenario 13.1 considers a possible situation.

If it is clear that Huw is unable to make his own decisions the question arises as to whether action could be taken in his best interests under the MCA 2005 or whether he comes under the MHA 1983. The MCA 2005 excludes from its provisions those patients who are detained under the MHA 1983 and who come under the provisions of Part 4 of the Act. Accepting (though on the facts this is by no means certain) that Huw has been detained by the police using their powers under Section 136 of the MHA 1983, this does not mean that he comes under Part 4 of that Act. Part 4 enables treatment to be given for mental disorder to those who are detained under specified sections of the MHA 1983. Section 136 is excluded from those provisions. It therefore follows that Huw cannot be treated under Part 4 of the MHA, so he is not excluded from the provisions of the MCA 2005. If however two doctors have examined him with a view to his being detained under Section 2 or 3, he may then come under Case E of Schedule 1A of the MCA and be ineligible for loss of liberty under the MCA DOLs provisions (see Chapter 14).

In the absence of medical recommendations for Section 2 or 3 admission, it follows that if Huw lacked the requisite mental capacity to make his own decisions, then the police doctor must act in Huw's best interests. He must follow the principles laid down in Section 1 of the Act and the criteria for determining best interests which are set down in Section 4 of the MCA. If the situation comes within the definition of serious medical treatment, then an independent mental capacity advocate (IMCA) would have to be appointed if there were no other appropriate person who could be consulted about Huw's best interests.

Treatment for physical disorders

Section 28 only excludes treatment for mental disorder, since that is the remit of Part 4 of the MHA 1983. It would be possible for treatments for physical disorder to be covered by the MCA 2005, even though the patient is a detained patient. The definition of treatment under the MHA 1983 has been widely interpreted, and basic care, including nutrition, has been given under the authority of Part 4 of the MHA 1983. There are even judgments where a caesarean section has been regarded as treatment for mental disorder under the MHA 1983, but these are now considered to be too widely defined. Scenario 13.2 describes such a situation. There is a new definition of treatment provided by the MHA 2007 as follows:

> "Medical treatment" includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care. (S.145(1) of the MHA 1983 as amended by Section 7 of the Mental Health Act 2007.)

A case where a patient detained under Section 3 of the MHA 1983 was given treatment for an ovarian cyst against her will, on the grounds that she was incapable of making a decision and that the treatment was in her best interests, is considered in Case Study 5.5.[2]

A further example of the dilemma over which jurisdiction (MCA or MHA) applies can be seen in Scenarios 13.2 and 13.3.

> **Scenario 13.2** MCA 2005 or MHA 1983?
>
> Chris is pregnant and as a result of a serious bout of bipolar disorder has been detained under Section 3 of the Mental Health Act 1983 for treatment for mental disorder. At times she appears to have the mental capacity to make her decisions, but there are other times when she is either so severely depressed that she is unable to communicate or so elated that she is unable to speak rationally. Her obstetrician has examined her and is of the view that it would be in her best interests to have a caesarean section, since she had one for her child who is now 2 years old. The obstetrician is not clear as to whether she has the capacity to give consent to a caesarean. What is the law if she is assessed as being incapable of giving consent?

Scenario 13.3 Detained patient and physical illness.

Bob was a chronic schizophrenic who was periodically detained in hospital under Section 3 of the Mental Health Act 1983, often as a result of his failing to attend the health center for his regular injections. During one admission he complained of severe stomach pain and was diagnosed as having an inflamed appendix. Immediate surgery was arranged, but Bob refused surgery on the grounds that he did not trust the doctors to do him no harm. Can he be compelled to have the surgery?

In this situation of Scenario 13.2, Section 28 of the MCA which excludes the operation of the MCA would not apply since, although Chris is detained under Section 3 of the MHA 1983, the proposed treatment is not for mental disorder but for a caesarean section. (There have been cases in the past when a detained pregnant woman has been given a caesarean under the powers of Part 4 of the MHA, on the grounds that this was treatment for mental disorder.[3] However it is not thought that these decisions would survive the rulings made by the Court of Appeal in the cases of *Re MB*[4] and of *St George's NHS Trust*.)[5]

If the view is taken that an operation to perform a caesarean section is not treatment for mental disorder regulated by the MHA 1983, then although Chris is detained in a psychiatric hospital under Section 3 of the Act and comes under the provisions of Part 4 for treatment for her mental disorder, the decision on whether she should be given a compulsory caesarean does not come under the MHA 1983 but under the MCA 2005 if she lacks the capacity to make the decision (see the discussion of Case Study 5.5[6] on best interests where a patient detained in hospital was compelled to have an operation for removal of an ovarian cyst in her best interests).

If the MCA applies to Chris's situation, then the following questions must be answered:

- Does Chris have the requisite mental capacity to make her own decision on the caesarean section? The fact that she is under Section 3 of the MHA does not automatically mean that she lacks the capacity to give consent or refuse according to the definition of capacity in Sections 2 and 3 of the MCA. It would be preferable for this assessment to be carried out by a person qualified in determining mental capacity who is not a member of the multidisciplinary team caring for Chris, so he or she can act independently of the team.
- If the assessment concludes that Chris lacks the mental capacity to make a decision about a caesarean section, then the question of what is in Chris's best interests has to be answered. MCA provisions on best interests set out in Section 4 and the principles set out in Section 1 would apply.
- Is a caesarean section "serious medical treatment?" Since a caesarean section would appear to come within the definition of serious medical treatment as defined in Section 37(6) and in the regulations,[7] the National Health Service body, that is, the NHS trust who is providing her care and treatment, is required to instruct an IMCA to represent Chris, in the absence of an appropriate person.
- Should an IMCA be appointed? Unless there is an appropriate person (who is neither paid nor working in a professional capacity) who can be consulted on what Chris's best interests are, the NHS trust must ensure that an IMCA is appointed (see Chapter 8).
- What is the consequence of the IMCA appointment? Once the IMCA had been instructed and met with Chris and considered all her views and discussed the situation and Chris's best interests with family, friends, and paid carers and others, she or he would report back to the NHS trust, which has an obligation under Section 37(5) to take into account any information given or submissions made by the IMCA.
- Does urgent action need to be taken? If the obstetrician caring for Chris considers that there is urgent necessity for the caesarean section to be carried out and there is not time for the appointment of an IMCA, the NHS trust has the power under Section 37(4) to provide the treatment, even though it has not been able to appoint an IMCA. There may be time for an application to be made to the Court of Protection for an emergency declaration to be made as to what is in Chris's best interests. The provision of IMCAs is considered in Chapter 8.
- If Chris has to be deprived of his liberty, then the DOLs provisions apply (see Chapter 14).

In Scenario 13.3 Bob comes under Part 4 of the MHA 1983, and therefore his treatment for mental disorder is regulated under that Act and is excluded from the MCA 2005. This does not apply to treatment for a physical

Scenario 13.4 Prophylactic care and a detained patient.

James and John were twins aged 35 years. James suffered from bipolar disorder which occasionally required inpatient admission. John had recently had a genetic test which showed that he had a probability of contracting stomach cancer in the future. He decided that on medical advice that he would have a prophylactic removal of his stomach. He recommended that James should have the same treatment to prevent the cancer occurring. James was detained under Section 3 of the MHA, and it appeared that he was incapable of giving consent to the surgery.

disorder. Since doctors are proposing surgery for a physical condition, the MCA would apply. The following questions therefore arise:

- Does Bob have the capacity to give or refuse consent to the appendectomy?
- If the answer is *yes*, then his decision will prevail.
- If the answer is *no*, then action must be taken in his best interests.

Since the appendectomy would probably come within the definition of serious medical treatment, an IMCA should be appointed if there is no appropriate person who could be consulted about Bob's best interests.

Paragraph 13.39 of the 2015 Code of Practice of the MHA states that:

> If the individual is deprived of their liberty and the need for physical treatment is the only reason why the person needs to be detained in hospital, then the patient is not within the scope of the Mental Health Act (as the purpose of the deprivation of liberty is not to treat mental disorder) and a DOLs authorisation or a Court of Protection order should be sought.

In Scenario 13.4 the proposed surgery for James would not be considered as treatment for mental disorder, so it would not come under Part 4 of the MHA and would not therefore be excluded from the provisions of the MCA. James's competence to make the decision about surgery would have to be assessed. If the conclusion was that James had the requisite capacity, then the decision could be left to him. If the conclusion was that he lacked the requisite capacity, it would have to be decided if he would be likely to have the necessary capacity in the future. If that was a possibility, then the decision could be left until then, since there seems to be no immediate danger of stomach cancer occurring. If however it is doubtful that James will recover the

Case Study 13.1 *A local authority* v. *E and others* [2012].[8]

At the time of the hearing, E was not subject to compulsory detention, though she had been in the past. Mr Justice Peter Jackson decided that it was in E's best interests to be fed, by force if necessary, and that the resulting interference with her Articles 8 and 3 rights was proportionate and necessary to protect her right to life under Article 2. The judge found that while she had the mental capacity to make an earlier advance decision refusing treatment, she did not have the requisite capacity when a later advance decision was drawn up and there was evidence that she did not wish to be bound by this.

(See also Chapter 5 on best interests and feeding an anorexia and Chapter 9 on advance decisions.)

appropriate capacity, then a decision would have to be made in his best interests. The proposed surgery would probably come within the definition of serious medical treatment, and if John is not seen as an appropriate person to consult, an IMCA would have to be appointed by the NHS trust before the treatment proceeded, unless there were an appropriate person among his family or friends who could be consulted on his behalf and act for him.

In Case Study 13.1 the court decided that treatment for anorexia could be regarded as treatment for a mental disorder and forced feeding could therefore be ordered.

IMCAs and Sections 37, 38, and 39

Section 37 (the provision of serious medical treatment by an NHS body and appointment of an IMCA)

Section 37 does not apply if P's treatment is regulated by Part 4 of the MHA 1983 (S.37(2)) (see Chapter 8).

Section 38 (the provision of accommodation by an NHS body and the appointment of an IMCA)

This statutory requirement for the NHS body to instruct an IMCA does not apply if P is accommodated as a result of an obligation imposed on the NHS body under the MHA (S.38(2)) (see Chapter 8).

A new Subsection 2A to Section 38 has been added to the MCA by the MHA 2007 (Paragraph 4(1) of Schedule 9) as follows:

This section (i.e., Section 38) does not apply if:

a) an independent mental capacity advocate must be appointed under Section 39A or 39C (whether or not by the NHS body) to represent P, and

b) the hospital or care home in which P is to be accommodated under the arrangements referred to in this section is the relevant hospital or care home under the authorisation referred to in that section.

Section 39 (the provision of accommodation by a local authority and the appointment of an IMCA)

This statutory requirement for the local authority to instruct an IMCA does not apply if P is accommodated as a result of an obligation imposed on him under the MHA (S.39(3)).

Section 39 only applies if the accommodation is to be provided in accordance with:

a) Section 21 or 29 of the National Assistance Act 1948, or
b) Section 117 of the MHA

as the result of a decision taken by the local authority under Section 47 of the NHS and Community Care Act 1990 (S.39(2)).

It is clear from this section that S.117 accommodation is not regarded as accommodation provided under an obligation set by the MHA 1983. This is discussed in Chapter 8 and is in accordance with the interpretation of the Code of Practice on the MCA.

The Code of Practice on the MCA[9] states that the duty to consult an IMCA in relation to serious medical treatment or accommodation does not arise if the treatment is to be provided under the MHA 1983.

> Nor is there a duty to do so in respect of a move into accommodation, or a change of accommodation, if the person in question is to be required to live in it because of an obligation under the MHA. That obligation might be a condition of leave of absence or conditional discharge from hospital or a requirement imposed by a guardian or a supervisor.
>
> The duty to instruct an IMCA would apply as normal if accommodation is being planned as part of the after-care under section 117 of the MHA following the person's discharge from detention (and the person is not going to be required to live in it as a condition of after-care under supervision). This is because the person does not have to accept that accommodation.

The duty to appoint an IMCA only arises if the person has no close relatives, friends, or any other person to protect their interests. An amendment added by the MHA 2007 makes it clear that a person appointed under Part 10 of Schedule A1 of the MCA (as amended by the MHA) to be P's representative (for the purpose of Deprivation of Liberty Safeguards) is not, by virtue of that appointment, engaged in providing care or treatment for P in a professional capacity or for remuneration.

Amendments to the MCA are made in the MHA 2007, which added new sections to Section 39, that is, Ss.39A, 39B, 39C, 39D, and 39E (see Chapter 14). In addition a new Subsection 3A states that Section 39 does not apply if:

a) an independent mental capacity advocate must be appointed under section 39A or 39C (whether or not by the local authority) to represent P, and
b) the place in which P is to be accommodated under the arrangements referred to in this section is the relevant hospital or care home under the authorisation referred to in that section.

In Scenarios 13.5 and 13.6.

The following questions would have to be asked:

- Is this person (formerly detained under the MHA) under a duty to live in the accommodation provided under Section 117?
- If the answer to that is *no*, then the provisions relating to IMCAs apply.
- If the answer is *yes*, then the person comes under the MHA and the IMCA provisions do not apply.

Section 117 accommodation

Scenario 13.5 Patient detained under the MHA and due to be discharged with Section 117 aftercare.

Sahra had been detained under Section 3 of the Mental Health Act 1983 and was due to be discharged. It was decided that there was no need for her to be placed under a community treatment order. The multidisciplinary team met to consider provision for her aftercare and decided that it was preferable if she stayed in a hostel, especially provided for those with mental health needs. This accommodation was offered to her. The approved social worker suggested that an independent mental capacity advocate should be appointed for her, since she had no immediate family or friends. The psychiatrist said that that was not a requirement of the legislation.

Scenario 13.6 Patient detained under the MHA.

Jessica was detained under Section 3 of the Mental Health Act 1983, and it was agreed in the multidisciplinary team that she should be given leave to stay at a home where there were fewer restrictions, as part of her rehabilitation progress. It was decided not to transfer her to the unit but that she should be given leave under Section 17, which would enable her to be returned to the psychiatric hospital and leave to be cancelled if the leave did not work well. Her approved social worker questioned whether an independent mental capacity advocate should be appointed for her, since she appeared to lack close family and friends.

In Scenario 13.5 the local authority approved social worker (ASW) is part of the multidisciplinary team deciding upon Sahra's aftercare. The accommodation is being discussed as part of the duty of the NHS trust and the local authority and voluntary groups under Section 117 of the MHA 1983. Section 39 applies where the local authority is providing accommodation under Section 117 of the MHA, as a result of its community care assessment under Section 47 of the NHS and Community Care Act 1990. Under Section 39 the local authority has a responsibility to ensure that an IMCA is appointed to support and represent Sahra if she has no appropriate person who could be consulted as to what was in her best interests. Section 39 will only apply if Sahra lacks the requisite mental capacity to make her own decisions on accommodation. Since Sahra is not under an obligation under the MHA to stay at the hospital, the provisions of Section 39 are not excluded.

The consultant is therefore wrong in assuming that the obligation to consider the appointment of an IMCA under Section 39 does not apply. It would have been a different situation had she been transferred to accommodation under Section 17 of the MHA 1983, where she had an obligation to remain (see Scenario 13.9). The situation in Scenario 13.5 contrasts with that in Scenario 13.6.

In contrast with Scenario 13.5 Jessica in Scenario 13.6 is being placed in accommodation by the NHS trust as part of its functions and duty under the MHA. Where an NHS organization is providing accommodation, Section 38(2) excludes the requirement to appoint an IMCA if the accommodation is being provided as the result of an obligation imposed under the MHA. There is therefore no requirement to appoint an IMCA under the MCA for Jessica. The fact that the statutory duty under Section 38 of the MCA does not apply to the situation does not, of course, mean that an advocate cannot be provided under any of the local advocacy schemes. However the fact that this advocate does not have the statutory powers and rights as an IMCA under the MCA could affect his or her effectiveness. (This is discussed in Chapter 8.)

New sections 39A, 39 B, 39C, 39D, and 39E have been added to the MCA by the MHA 2007 to cover the appointment of IMCAs when a person comes under the Deprivation of Liberty Safeguards. These are considered in Chapter 14.

Refusal of treatment by an advance decision

Scenario 13.7 Advance decision refusing ECT.

Jamie's mother was a chronic schizophrenic, and disturbed by the treatment she received when detained under the Mental Health Act, Jamie drew up an advance decision. In this he stated that if he were ever to be detained under the MHA, he would not wish to be given electroconvulsive therapy (ECT). He later showed signs of severe depression and had to be detained under Section 3 of the MHA. Doctors recommended that he should receive ECT. He refused to give consent to this, and a second opinion doctor was appointed under the provisions of Part 4 of the MHA. The Second Opinion Appointed Doctor (SOAD) recommended that Jamie should receive compulsory ECT. The nurses were concerned because of Jamie's advance decision.

Jamie is detained under the MHA 1983, and his treatment for mental disorder is regulated by Part 4 of that Act. Although he has drawn up an advance direction, Section 28(1) excludes treatment being given under the Act when the person's treatment is regulated by Part 4 of the MHA 1983. Under Part 4, Section 58 of the MHA applies to the administration of ECT. Section 58 enabled (prior to the amendments of the 2007 Act; see S.58A and Statute Box 13.4) ECT to be given without the consent of the patient if a second opinion was obtained from an independent medical practitioner that the ECT should be given. Jamie's advance direction would therefore have been overruled under the law which preceded the 2007 Act. This would clearly appear to be contrary to Jamie's rights. If he, when mentally capacitated, stated that he would never wish to receive certain forms of treatment for his mental disorder, surely there should be some recognition from his health professionals over his specified wishes. Amendments were made to the MHA 1983 by the MHA 2007 which prevents the previously declared wishes (in relation to ECT) of a patient when mentally competent being overruled by clinicians at a later date. S.58A was added to the 1983 Act by the 2007 Act and prevents a responsible medical practitioner giving a patient ECT if the treatment would conflict with an advance decision which the registered medical practitioner concerned is satisfied is valid and applicable nor can ECT be given if it would conflict with a decision made by a donee or

Statute Box 13.4 58A Electro-convulsive therapy, etc

1 This section applies to the following forms of medical treatment for mental disorder—
  a) electro-convulsive therapy; and
  b) such other forms of treatment as may be specified for the purposes of this section by regulations made by the appropriate national authority.

2 Subject to section 62 …, a patient shall not be given any form of treatment to which this section applies unless he falls within subsection (3) or (4) below.

3 A patient falls within this subsection if—
  a) he has consented to the treatment in question; and
  b) either the approved clinician in charge of it or a registered medical practitioner appointed as mentioned in section 58(3) … has certified in writing that the patient is capable of understanding the nature, purpose and likely effects of the treatment and has consented to it.

4 A patient falls within this subsection if a registered medical practitioner appointed as aforesaid (not being the approved clinician in charge of the treatment in question) has certified in writing—
  a) that the patient is not capable of understanding the nature, purpose and likely effects of the treatment; but
  b) that it is appropriate for the treatment to be given; and
  c) that giving him the treatment would not conflict with—
    i) an advance decision which the registered medical practitioner concerned is satisfied is valid and applicable;
    ii) a decision made by a donee or deputy or by the Court of Protection; or
    iii) an order of a court.

5 Before giving a certificate under subsection (4) above the registered medical practitioner concerned shall consult two other persons who have been professionally concerned with the patient's medical treatment (neither of whom shall be the responsible clinician or the approved clinician in charge of the treatment in question), and of those persons one shall be a nurse and the other shall be neither a nurse nor a registered medical practitioner.

6 Before making any regulations for the purposes of this section, the appropriate national authority shall consult such bodies as appear to it to be concerned.

7 In this section—
  a) a reference to an advance decision is to an advance decision (within the meaning of the Mental Capacity Act 2005) made by the patient;
  b) "valid and applicable," in relation to such a decision, means valid and applicable to the treatment in question in accordance with section 25 of that Act;
  c) a reference to a donee is to a donee of a lasting power of attorney (within the meaning of section 9 of that Act) created by the patient, where the donee is acting within the scope of his authority and in accordance with that Act; and
  d) a reference to a deputy is to a deputy appointed for the patient by the Court of Protection under section 16 of that Act, where the deputy is acting within the scope of his authority and in accordance with that Act.

8 In this section, "the appropriate national authority" means—
  a) in a case where the treatment in question would, if given, be given in England, the Secretary of State;
  b) in a case where the treatment in question would, if given, be given in Wales, the Welsh Ministers.

The effect of S.58A is that if Jamie, when mentally capacitated, had stated in a valid advance decision that he would never wish to receive ECT or another treatment specified under Section 58A, then he cannot be given it. There is an exception in relation to urgent treatments required to save the patient's life or to prevent a serious deterioration of the patient's condition, and the treatment does not have unfavorable physical or psychological consequences which cannot be reversed. In this latter situation ECT could be given in spite of the advance decision (S.62(1A) MHA and Paragraph 13.13 of the MHA Code of Practice).

Advance decisions are considered in Chapter 9.

deputy or by the Court of Protection. Section 58A is shown in Statute Box 13.4. The advance decision can be overruled in relation to other kinds of treatment under Sections 58 and 83.

Nearest relative and the European Convention on Human Rights

See Chapter 3 for the relationship between the MHA and the European Human Rights Convention and in particular the series of case brought by MH[11] against the Secretary of State in relation to the law relating to the rights of the nearest relative and the discharge of the patient shown in Case Study 3.2.

In the case of the *Mental Health NHS Foundation Trust and Others* [2015] UKUT 36 (AAC), Charles J held that a welfare deputy could not withdraw an application to challenge her son's detention under the MHA Section 2. The First-tier Tribunal should not have acceded to her request but should have addressed the issues of the patient's capacity to consent to withdraw the application, to remain in hospital, and to consent to a deprivation of his liberty.

Case Study 13.2 Nottinghamshire Healthcare NHS Trust and RC.[10]

RC (known as J in the earlier case) was 23, in prison, and detained under the MHA in hospital following serious self-harming with profuse bleeding. He suffered a serious personality disorder. As a Jehovah's Witness he refused blood transfusions. He drew up a valid advance decision to refuse specified medical treatments, namely, blood transfusions. The trust sought declaration that a written advance decision was valid and applicable to the treatment described, and it was lawful to withhold treatment, even though it could be authorized under S.63. Mostyn J held that the fact that he had refused blood and was a Jehovah's Witness and did not weigh the information (just as a Muslim would not weigh information relating to eating pork) did not mean he lacked capacity. He stated:

> But it would be an extreme example of the application of the law of unintended consequences were an iron tenet of an accepted religion to give rise to questions of capacity under the MCA.

He held that RC had full capacity and was able to refuse the blood transfusion. He also held that giving blood following self-harm which resulted from personality disorder was treatment for mental disorder and came under S.63. The decision of Dr S not to use S.63 to override RC's capacitous wishes was entirely completely correct. He stated that:

> In my judgment it would be an abuse of power in such circumstances even to think about imposing a blood transfusion on RC having regard to my findings that he presently has capacity to refuse blood products and were such capacity to disappear for any reason, the advance decision would be operative. To impose a blood transfusion would be a denial of a most basic freedom.

In the case of *Bostridge* v. *Oxleas NHS Foundation Trust* [2015][12], there was held to be a breach of the European Convention on Human Rights when the patient was recalled from a nonexistent Community Treatment Order (the patient had been discharged from section and the CTO could only be applied to a detained patient) and held unlawfully. However because no loss had been shown, only nominal damages were awarded, and this decision was upheld by the Court of Appeal.

Guardianship or community treatment order

Similar problems arise over whether the provisions of the MCA relating to the appointment of deputies should be used or the guardianship provisions of the MHA. This is discussed in the Code of Practice on the MCA (Paras 13.16–13.21).

A guardian can only be appointed under the MHA 1983 if it can be shown that the person is suffering from a mental disorder. The previous requirement that a person must be suffering from a specified form of mental disorder has been amended by the MHA 2007.

The aftercare under supervision arrangements introduced in 1996 have been repealed by the MHA 2007 and a compulsory treatment in the community order introduced.

Court of Protection

Court of Protection visitors (S.61)

The Lord Chancellor can appoint a Court of Protection visitor to a panel of Special Visitors or a panel of General Visitors. (These Court of Protection visitors replace the current "Lord Chancellors Visitors.") (See Section 102 of the MHA 1983.)

This is further considered in Chapter 7.

Lasting powers of attorney and deputies of the Court of Protection

These powers can still be exercised even though the patient is detained under the MHA, and provided that the patient has the requisite mental capacity, he or she could create a lasting power of attorney (LPA), even though detained under the MHA. The Code of Practice[13] states that:

> Being subject to the MHA does not stop patients creating new Lasting Powers of Attorney (if they have the capacity to do so). Nor does it stop the Court of Protection from appointing a deputy for them.
>
> However the powers of both the LPA and a court appointed deputy are limited by the MHA and they would not be able to give consent to treatment on behalf of the patient, if the treatment is being given under the MHA. Nor, unless they happened to be the nearest relative,

would they be able to exercise the powers which the MHA gives to the nearest relative in relation to the discharge of the patient.

In certain cases, people subject to the MHA may be required to meet specific conditions relating to:

- leave of absence from hospital
- after-care under supervision (now repealed by Mental Health Act 2007) and replaced by a community treatment order or
- conditional discharge.

Conditions vary from case to case but could include a requirement to:

- live in a particular place
- maintain contact with health services, or
- avoid a particular area.

If an attorney or deputy takes a decision that goes against one of these conditions, the patient will be taken to have gone against the condition. The MHA sets out the actions that could be taken in such circumstances. In the case of leave of absence or conditional discharge, this might involve the patient being recalled to hospital.[14]

Attorneys and deputies may also be able to apply to the MHRT on behalf of the detained patient.

Since the hospital authorities might not be aware of the appointment of an LPA or deputy, it would be good practice for the LPA or deputy to notify the hospital of their appointment and discuss with the health professionals both the implications and the limitations of their appointments.

Where the patient is not detained under the MHA, then the MHA provisions do not apply and the LPA and the deputy may have powers to give consent to the treatment for mental disorder.

Scenario 13.8 Role of LPA when patient detained under the MHA.

Beryl suffered from bipolar disorder and was frequently admitted to psychiatric hospital. She asked her mother if she would act as her attorney to make decisions on her care and treatment. Her mother accepted and the appropriate papers were completed and signed. Beryl was then admitted to the ward under Section 3, and her mother told the charge nurse that she had been appointed under a lasting power of attorney (LPA). The charge nurse said that since Beryl was under section, the LPA was irrelevant, and all decisions should be made by the multidisciplinary team. Beryl's mother wished to challenge that statement.

In Scenario 13.8 the charge nurse is correct to a limited extent: if the treatment of a patient is regulated under Part 4 of the MHA 1983, then the provisions of the MCA do not apply to that treatment. However Part 4 only applies to treatment for mental disorder. There may be other treatments for a physical condition on which Beryl's mother could be consulted. The charge nurse should welcome Beryl's mother to the multidisciplinary team meetings when Beryl's care and treatment is being discussed and her future accommodation and care being planned. Although the mother would have no legal right to make those decisions which come under Part 4, as the nominated representative of the patient, her contribution to the planning of Beryl's care and treatment should be welcomed, and if Beryl lacks the requisite mental capacity to make her own decisions, Beryl's mother should be invited to give her views on the best interests of Beryl according to the criteria in Section 4.

In the case of *YA* v. *CWL NHS Trust* [2015] UKUT 37 (AAC), Charles J had to determine the capacity of a patient to appoint a representative for the MHRT and held that the capacity needed was not just understanding that they can make an application to the MHRT but also the capacity to decide whether or not to appoint a representative in the first place. There is a substantial overlap between the capacity to appoint a representative and to conduct proceedings himself.

Role of deputy when patient detained under the MHA

Scenario 13.9 Role of deputy when patient detained under the MHA.

Ivor was severely injured in a road accident and received over £3 million in compensation. The Court of Protection appointed his cousin Jane as a deputy for decisions relating both to welfare and also to property and finance. The latter included powers to authorize expenditure from his account. One of the effects of the road traffic accident was serious brain damage which led him to be aggressive and dangerous without any warning. After attacking a stranger who was walking past his house, he was placed under Section 37 of the Mental Health Act 1983 with a restriction order and sent to a regional secure unit. Jane was uncertain of her role as deputy following Ivor's detention.

In Scenario 13.9 on her appointment Jane would have been given specific instructions as to the action she would be able to take on Ivor's behalf. If it was not a reasonably foreseeable event that Ivor should be placed under section, then it is clear that Jane's instructions need to be updated. She should consult with the Office of the Public Guardian as to whether there should be a further hearing by the Court of Protection to determine whether her appointment should continue and what new instructions she should be working under. Even though Ivor's treatment for mental disorder now comes under the MHA 1983, there are still other decisions which need to be made on his behalf, particularly in relation to his finances.

Reform of the MHA 1983

The MHA 2007 made significant changes to the MHA 1983. These are less radical proposals than had originally been proposed when a new MHA was envisaged but even so have encountered opposition in the House of Lords in relation to the proposal that patients could be detained in a psychiatric hospital even though the *treatability test* was not satisfied. The changes to the MHA 1983 include:

- Amending the definition of mental disorder by replacing it with a new simplified definition, that is, "any disorder or disability of the mind" and by abolishing the four separate categories of mental disorder. This is discussed earlier (see **Mental capacity** and **mental disorder** on page 240). This will mean that some categories not covered by the MHA 1983 will be included under the definition of mental disorder, for example, mental disorders arising out of injury or damage to the brain in adulthood. Learning disability will only be treated as a mental disorder for the purposes of the MHA if it is associated with abnormally aggressive or seriously irresponsible conduct on the part of the patient concerned. However for the purposes of the Deprivation of Liberty Safeguards, these qualifications on the definition of learning disabilities are omitted (see Chapter 14). The definition of mental disorder no longer cites promiscuity, other immoral conducts, and sexual deviancy as conditions excluded from its definition.
- The former treatability test used as the basis of detention for psychopathic disorder and mental impairment is replaced by a test of the availability of appropriate treatment, which must be satisfied before a patient can be detained.
- A new community treatment order is introduced for patients following a period of detention in hospital. It replaces the aftercare under supervision provisions which were introduced by the Mental Health (Patients in the Community) Act 1995.
- The group of practitioners who can take on functions previously performed by the ASW and responsible medical officers is broadened:
- The new role replacing the ASW is now known as the approved mental health professional (AMHP), and he or she has the same functions as the ASW as well as additional functions in relation to supervised community treatments. The AMHP may include suitably trained nurses, occupational therapists, and chartered psychologists and, unlike the ASW, do not have to be employed by the local authorities.
- The new role replacing the responsible medical officer is now known as the responsible clinician and is open to other suitably trained professionals such as chartered psychologists, nurses, social workers, and occupational therapists, as well as registered medical practitioners. The responsible clinician has overall responsibility for a patient.
- Enabling a patient to apply to the county court for the nearest relative to be displaced and amending the definition of nearest relative to include a civil partner.
- Increasing the frequency with which the MHRT considers the cases of civil (i.e., those not subject to court orders) patients treated under the MHA.
- Ending finite restriction orders so that the restrictions will remain in force for as long as the offender's mental disorder poses a risk of harm to others.

On September 10, 2007, the Department of Health and the Ministry of Justice published two Consultation Papers: the MCA 2005 Deprivation of Liberty Safeguards and a draft addendum to the MCA Code of Practice. Consultation ended on December 2, 2007. The documents can be accessed on the Ministry of Justice website: www.justice.gov.uk/publications. They are considered in Chapter 14.

The amendments made by the MHA 2007 to the MHA 1983 came into force in October 2008. A new Code of Practice for the MHA was published in 2015 (Wales has its own Code of Practice). It includes the fundamental principles set out in Section 8 of the MHA 2007. It can be downloaded from the government

website.[15] Other changes from the previous edition of the MHA Code of Practice include:

- Additional chapters on equality and health inequalities, care planning, and human rights.
- Guidance on when to use the MHA and when to use the MCA and the Deprivation of Liberty Safeguards.
- New guidance on restrictive interventions including seclusion and long-term segregation.
- Guidance on blanket restrictions, immigration detainees, and supporting patients with different conditions including autism and learning disabilities and dementia.
- Provisions to address some of the concerns raised by the Winterbourne View scandal and by the CQC. These include ensuring patients are discharged as soon as possible, ensuring people have a say in their care and treatment and are able to complain, ensuring that commissioners, local authorities, and other health professionals are clear in their role.
- The interface between the MCA and MHA including the DOLs.

Interface between MHA and MCA

The previous discussion on the differences between the MCA and the MHA shows the difficulties in determining which is the appropriate Act to use. Chapter 13 of the MCA Code of Practice provides some pointers as to which Act would be relevant.

Restraint

If there is a need to use restraint which would deprive a person of liberty, then the MHA or other legislations might be considered appropriate. The MCA would not be appropriate unless it was the limited loss of liberty envisaged under the Deprivation of Liberty Safeguards (see Chapter 14). The Code of Practice[16] states that:

It might be necessary to consider using the MHA rather than the MCA if:

- it is not possible to give the person the care or treatment they need without carrying out an action that might deprive them of their liberty
- the person needs treatment that cannot be given under the MCA (for example, because the person has made a valid and applicable advance decision to refuse all or part of that treatment). (Authors note: this may now have to be amended since the new provisions of the Mental Health Act 2007 enable a person to draw up an advance decision which refuses ECT or other treatments set out in Regulations—see Scenario 13.7.)
- the person may need to be restrained in a way that is not allowed under the MCA
- it is not possible to assess or treat the person safely or effectively without treatment being compulsory (perhaps because the person is expected to regain capacity to consent, but might then refuse to give consent)
- the person lacks capacity to decide on some elements of the treatment but has capacity to refuse a vital part of it—and they have done so, or
- there is some other reason why the person might not get the treatment they need, and they or somebody else might suffer harm as a result.

Following the implementation of the Deprivation of Liberty Safeguards, there is scope for using the MCA in some of the earlier situations, rather than the MHA (see Chapter 14).

It was once stated by Charles J that in any conflict between the MHA and the MCA, the former has primacy. He modified his views in a later case (see Chapter 14) and emphasized that each case must be considered on its particular facts and a decision made as to the relevance and appropriateness of the one statutory framework compared with the other.

Chapter 13 of the MHA Code of Practice covers the interface of the MHA and the MCA. It sets out the differences between the two acts and states the following (in summary form):

1. Treatment for physical conditions (where the individual is liable to be detained under the Act)
   - **a)** Physical conditions which are linked to the mental disorder can be treated under the MHA.
   - **b)** Where the physical condition is unrelated to the mental condition and P lacks capacity, then P can be treated in his best interests under the MCA.
   - **c)** If P needs to be deprived of his liberty for the purpose of treatment of a physical condition, then a DOLs authorization or Court of Protection Order must be sought.
2. Authorizing deprivations of liberty under DOLs and the MCA (see Chapter 14 of this book)

Further cases which discuss which statutory regime is the relevant one are considered in Chapter 14.

Inherent jurisdiction

In some cases the judges have resorted to the use of the inherent jurisdiction of the court where they considered the powers within the MCA or MHA were not available. This is further considered in Chapter 2 and is illustrated by the cases of *Great Western Hospitals NHS Foundation Trust* v. *AA, BB, CC, DD* [2014],[17] *NHS Trust* v. *Dr A*[18], and a *Local Health Board* v. *AB*[19] in Case Studies 2.8, 2.9, and 2.10, respectively. In the case of the *NHS Trust* v. *Dr A*, the patient was detained under MHA and could not be deprived of liberty under MCA for any purpose. It was held that force feeding was not treatment for mental disorder and could not therefore be ordered under MHA, so the inherent jurisdiction of the court was used to authorize force feeding.

Conclusions

The interface between mental health and mental capacity is extremely complex, and there has been considerable confusion over the scope of the different Acts of Parliament as the cases reveal. The revised Code of Practice on the MHA has attempted to provide some clarity. The topic is further considered in Chapter 14. In addition the measures taken to fill the Bournewood gap, the Deprivation of Liberty Safeguards (see Chapter 14), have been criticized as being inadequate, too slow, or bureaucratic to provide adequate protection to those lacking mental capacity and who risk losing their liberty. The Law Commission is undertaking a review of Deprivation of Liberty Safeguards and is due to report at the end of 2016 with a draft Bill. New legislation is unlikely to be implemented before the end of 2017.

Quick fire quiz, QFQ13

1 What is the definition of mental disorder?
2 What is the definition of mental capacity?
3 Can treatment for a physical condition be carried out under the authorization of the Mental Health Act 1983 (as amended)?
4 Can treatment for a physical condition be carried out under the authorization of the Mental Capacity Act 2005?
5 What is the difference between an Independent Mental Capacity Advocate and an Independent Mental Health advocate?
6 Is there a requirement to consider the appointment of an IMCA when a detained patient is provided with accommodation under Section 117 of the Mental Health Act 1983?

References

1 *Das, R (On the application of)* v. *Secretary of State for Home Office* [2014] EWCA Civ 45.
2 *Trust A & Trust B* v. *H (An adult patient)* [2006] EWHC 1230.
3 *Tameside and Glossop Acute Services Trust* v. *CH* [1996] 1 FLR 762; *Norfolk and Norwich (NHS) Trust* v. *W* [1996] 2 FLR 613; *Rochdale NHS Trust* v. *C* [1997] 1 FCR 274.
4 *MB(re) (Adult Medical Treatment)* [1997] 2 FLR 426.
5 *St George's NHS Trust* v. *S* [1998] 3 All ER 673.
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17 *Great western Hospitals NHS Foundation Trust* v. *AA, BB, CC, DD* [2014] EWHC 132 Fam.
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19 *A Local Health Board* v. *AB* [2015] EWCOP 31.

CHAPTER 14

Deprivation of liberty safeguards

THIS CHAPTER COVERS THE FOLLOWING TOPICS

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Reform of the Mental Capacity Act 2005 to fill the Bournewood gap: Background to deprivation of liberty safeguards

One of the most difficult areas both for the understanding and interpretation of the mental capacity legislation has been the Deprivation of Liberty Safeguards (described by Charles J as labyrinthine provisions[1]). These were enacted as a result of the decision of the European Court of Human Rights (ECHR) which held, in the Bournewood case, that the liberty of those lacking the requisite mental capacity who were admitted to hospital under the common law doctrine of necessity was not protected as required by Article 5 of the European Convention on Human Rights. As a consequence in November 2006, the Government introduced into the draft Mental Health Bill (which amended the Mental Health Act 1983) provisions to amend the Mental Capacity Act 2005 in order to provide protection for those persons caught in the Bournewood situation. The Bournewood case is set out in Case Study 14.1 (see also Chapter 3 and the discussion on human rights).

Legal Aspects of Mental Capacity: A Practical Guide for Health and Social Care Professionals, Second Edition. Bridgit Dimond.

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Case Study 14.1 Bournewood case.

L was born in 1949 and lived in Surrey. He was autistic and unable to speak and his level of understanding was limited. He was frequently agitated and had a history of self-harming behavior. He lacked the capacity to consent to or object to medical treatment. For over 30 years he was cared for in a National Health Service trust hospital, Bournewood Hospital. He was an inpatient at the hospital's intensive behavioral unit from around 1987 to 1994, when he was discharged on a trial basis to paid carers, with whom he successfully stayed until July 1997. In 1995 he started attending a day-care center on a weekly basis. On July 22, 1997, while at the day center, he became particularly agitated, hitting himself on the head with his fists and banging his head against the wall. Staff could not contact his carers, so called a local doctor, who gave him a sedative. L remained agitated and, on the recommendation of a social worker, was taken to hospital. A consultant psychiatrist diagnosed him as requiring inpatient treatment. With the help of two nurses, he was transferred to the hospital's intensive care unit as an informal patient. The consultant considered detaining him compulsorily under the MHA but concluded that it was not necessary, as he was compliant and had not resisted admission or tried to run away. His carers asked for his discharge, but his psychiatrist considered that it was not in his best interests to be discharged and that he should remain in hospital. The carers on his behalf challenged the legality of this decision, by seeking judicial review of the hospital's decision to admit him. They lost in the High Court, which held that L had not been detained but had been informally admitted in accordance with the common law doctrine of necessity. L appealed to the Court of Appeal which held that Section 131 of the MHA required a person to have the mental capacity to agree to admission; a person lacking the requisite capacity should be examined for compulsory admission under the Act. L had been detained in July 1997 and had therefore been unlawfully detained. The healthcare authorities appealed to the House of Lords. They succeeded in their appeal to the House of Lords, which held that an adult lacking mental capacity could be cared for and detained in a psychiatric hospital, using common law powers. L therefore had not been detained but had been lawfully admitted as an informal patient on the basis of the common law doctrine of necessity.

The claimants subsequently took the case to the ECHR.[2] The ECHR held that the absence of procedural safeguards to protect an applicant against arbitrary deprivation of liberty on the ground of necessity after he had been compulsorily detained breached his right to liberty guaranteed by Article 5.1 of the European Convention on Human Rights. It also held unanimously that Article 5.4 had been breached, in that the applicant's right to have the legality of his detention reviewed by a court had not been ensured. (Article 5.4 of Schedule 1 of the Human Rights Act 1998 is shown in Statute Box 14.1 and considered in Chapter 3.) The court considered that the violation of Articles 5.1 and 5.4 constituted sufficient just satisfaction for any nonpecuniary damage sustained. It awarded 29 500 euros for costs and expenses, less 2 677 euros received in legal aid from the Council of Europe.

As a result of these amendments, a person can only be deprived of liberty by the MCA

if:

a) the deprivation is authorised by an order of the Court of Protection under section 16(2)(a) of the MCA (and P is not ineligible because he comes under the MHA as set out in Schedule 1A to the MCA); or

b) the deprivation is authorised in accordance with the deprivation of liberty procedures (DOLs) set out in Schedule A1 (and P is not ineligible because he comes under the MHA as set out in Schedule 1A to the MCA); or

c) the deprivation is carried out because it is necessary in order to give life sustaining treatment, or to carry out a vital act to prevent serious deterioration in the person's condition, while a decision as respects any relevant issue is sought from the court.

Statute Box 14.1 Article 5.4 of the European Convention on human rights.

Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful. See Chapter 3 for discussion on the full Article 5 right to liberty and security.

The DOLs regime set out in the following only applies in hospitals or care homes, but protection of Article 5 rights must be ensured in all other locations where liberty of movement is prevented.

As a consequence of this decision, Parliament had to consider filling what has become known as the Bournewood gap (or even chasm). The United Kingdom

was obliged to provide protection for those adults who were incapable of giving a valid consent to admission but were being detained without being placed under the Mental Health Act. The Department of Health (DH) issued a Consultation Paper asking respondents to choose from various options put forward.

Options to fill the gap identified in the Bournewood case[3]

The dilemma facing the Government over filling the Bournewood gap was clearly stated by Lord Carter in moving Amendment No. 23 to the Mental Capacity Bill. He analyzed the problems presented by the Bournewood decision and summed up the options available to the Government to fill the Bournewood gap.[4] The option to amend the Mental Capacity Bill was not taken at that time, since fuller discussion was required. The DH published a Consultation Paper in March 2005 seeking views raised by and consequent options for public policy arising from the judgment of the ECHR, published on October 5, 2004, in the case of *HL* v. *the United Kingdom*.[5] As a result of the judgment, it was clear that additional procedural safeguards were required for those incapacitated patients who are not subject to mental health legislation, but whose treatment nonetheless involves a deprivation of liberty. Four options put forward by the DH for consultation (Option 1: Do nothing; Option 2: Protective care; Option 3: Extend the use of the Mental Health Act 1983; and Option 4: Extend the use of existing 1983 Act powers to place people under guardianship). In June 29, 2006, the DH published its report on the consultation and the Government's proposals.[6] It put forward the following key proposals:

- All involved will have to act in the best interests of the person in care and in the least restrictive manner.
- The criteria under which someone can be detained will be strengthened.
- An individual's rights will have to be respected and it will be easier to challenge the decision once someone has been detained.
- Every person will have someone independent to represent their interests.
- The proposals will cover both care homes and those being treated in hospitals.

It was the intention of the Government to amend the MCA to ensure that the European Court ruling was included in mental health legislation.

The outcome of the consultation suggested that minimum requirements in any legislation relating to the protective custody of the mentally incapacitated person were identified as:

- A clear and unambiguous definition of "deprivation of liberty" (see section "Deprivation of Liberty")
- A clear definition of those liable to be made subject to these powers
- Processes and timescales for tests of capacity
- Admission procedures
- Assessment, care planning, and reviews
- The respective responsibilities of the various agencies involved
- The role of advocacy
- The rights of carers, relatives, and friends, including a statutory requirement for "appropriate persons to be consulted"
- The appeals process

Deprivation of liberty

The Government decided not to give a statutory definition to the deprivation of liberty since "what constitutes deprivation of liberty will depend on the specific circumstances of each individual case." It would however include in the revised Code of Practice detailed guidance setting out the factors that would need to be taken into account when considering whether a person is, or needs to be, deprived of liberty. Guidance has been given by the Supreme Court in the case of Chester[7] which is considered in Case Study 14.2 on page 270.

Section 4A and 4B was added to the Mental Capacity Act by Section 50 of the Mental Health Act 2007 to define those situations in which a person could be deprived of his or her liberty under the MCA. They are shown in Statute Boxes 14.2 and 14.3.

Deprivation of Liberty Safeguards

The Mental Health Act 2007 contains amendments to the MCA to introduce the safeguards necessary to justify loss of liberty of residents in hospitals and care homes. These are known as the "Deprivation of Liberty Safeguards" or DOLs. They are set out in the new

Statute Box 14.2 Section 4A: Restriction of deprivation of liberty.

1 The Act does not authorise any person (D) to deprive any other person (P) of his liberty.
2 But that is subject to:
  a) the following provisions of this Section, and
  b) Section 4B.
3 D may deprive P of his liberty if, by doing so, D is giving effect to a relevant decision of the court.
4 A relevant decision of the court is a decision made by an order under Section 16(2)(a) in relation to a matter concerning P's personal welfare (Power of Court of Protection to make decisions and appoint deputies on P's behalf—see Chapter 7 and Statute Box 7.1).
5 D may deprive P of his liberty if the deprivation is authorised by Schedule A1 (hospital and care home residents: deprivation of liberty).

Statute Box 14.3 Section 4B: Deprivation of liberty necessary for life-sustaining treatment, etc.

1 If the following conditions are met, D is authorised to deprive P of his liberty while a decision as respects any relevant issue is sought from the court.
2 The first condition is that there is a question about whether D is authorised to deprive P of his liberty under Section 4A.
3 The second condition is that the deprivation of liberty:
  a) is wholly or partly for the purpose of
    i) giving P life-sustaining treatment, or
    ii) doing any vital act, or
  b) consists wholly or partly of
    i) giving P life-sustaining treatment, or
    ii) doing any vital act.
4 The third condition is that the deprivation of liberty is necessary in order to:
  a) give the life-sustaining treatment, or
  b) do the vital act.
5 A vital act is any act which the person doing it reasonably believes to be necessary to prevent a serious deterioration in P's condition.

Schedule A1 to the MCA as introduced by Schedule 7 of the Mental Health Act 2007 and can be found in a Briefing Paper available from the DH[8] and the guidance covered in the supplementary Code of Practice. The new Schedule A1 to the MCA details these safeguards (which are considered on pages 258–262). In addition a new Schedule 1A (introduced by Schedule 8 of the Mental

Statute Box 14.4 16A Section 16 powers: Mental Health Act patients, etc.

Subsection 50(3) of the Mental Health Act 2007 adds in a new Section 16A to the Mental Capacity Act
1 If a person is ineligible to be deprived of liberty by this Act, the court may not include in a welfare order provision which authorises the person to be deprived of his liberty.
2 If—
  a) welfare order includes provision which authorises a person to be deprived of his liberty, and
  b) that person becomes ineligible to be deprived of liberty by this Act,
  the provision ceases to have effect for as long as the person remains ineligible.
3 Nothing in subsection (2) affects the power of the court under section 16(7) to vary or discharge the welfare order.
4 For the purposes of this section—
  a) Schedule 1A applies for determining whether or not P is ineligible to be deprived of liberty by this Act;
  b) "welfare order" means an order under section 16(2)(a).
  S(50)(4) Omit the following provisions (which make specific provision about deprivation of liberty)—
  a) section 6(5);
  b) section 11(6);
  c) section 20(13).
5 Schedule 7 (which inserts the new Schedule A1 into the Mental Capacity Act 2005 (c. 9)) has effect.
6 Schedule 8 (which inserts the new Schedule 1A into the Mental Capacity Act 2005) has effect.
7 Schedule 9 (which makes other amendments to the Mental Capacity Act 2005 and to other Acts) has effect.

Health Act 2007) lists the persons who come under the MHA and are therefore ineligible to be deprived of liberty by the MCA. For example, if P is subject to a hospital treatment regime and detained in a hospital under that regime, then he is ineligible to lose his liberty under the MCA. Schedule 9 introduces other amendments to the MCA including the appointment of IMCAs which is considered in the following and in Statute Box 14.6.

Section 16A was added by Section 50(3) of the Mental Health Act 2007 and qualifies the powers of the Court of Protection which are set out in Section 16 and discussed in Chapter 7. It brings into the statutory framework Schedules A1 and 1A. Section 16A is shown in Statute Box 14.4.

As can be seen from Statute Box 14.4, the Mental Health Act 2007 repeals Section 6(5) which stated that

D does more than merely restrain P if he deprives him of his liberty within the meaning of Article 5(1) of the European Convention of Human Rights. Other consequential amendments are noted throughout this book and include the provision for an Independent Mental Capacity Advocate to be appointed under new Sections 39A and 39C (see Statute Box 14.6). See also Chapters 3 and 8 (on IMCAs) and 13 (on the relationship between the Mental Capacity Act 2005 and the Mental Health Act 1983 (as amended)). Further details about DOLs can be found in Schedule 7 of the Mental Health Act 2007.

Who are covered by the DOLs provisions?

- Those over 18 years
- Who suffer from a disorder or disability of mind (this includes learning disabilities)
- Who lack the capacity to give consent to the arrangements made for their care
- For whom such care (in circumstances that amount to a deprivation of liberty within the meaning of Article 5 of the European Convention on Human Rights) is considered after an independent assessment to be a necessary and proportionate response in their best interests to protect them from harm.

(The Government view was that in the main those protected by the Bournewood provisions would be mainly those with significant learning disabilities or elderly people suffering from dementia but would include a minority of others who have suffered physical injury.)

The Court of Protection could order the deprivation of liberty of a person under 18 years and for a person in accommodation other than a hospital or care home, since those persons are not covered by DOLs. This power does not apply if the person is ineligible under Schedule 1A (see Eligibility assessment page 259).

A. Authorization of deprivation of liberty by a supervisory body

Where a hospital or care home (known as the managing authority) identifies that a person who lacks capacity is, or risks, being deprived of their liberty, they must apply to the supervisory body for authorization of deprivation of liberty. The supervisory authority will be the relevant local authority for those in England or in Wales the local health board for those in hospital or the National Assembly for Wales where it has commissioned their care and/or treatment. (The relevant primary care trust was removed as supervisory authority with the result that as from April 1, 2013, in England the supervisory body is now the local authority (see Schedule AI paragraphs 21 and 180(2)).)

The Supplementary Code of Practice (see following text) includes three checklists: (1) for care homes and hospitals (managing authorities), (2) for local authorities and NHS bodies (supervisory bodies), and (3) for managing authorities and supervisory bodies to assist in the assessment of whether a person is at risk of deprivation of liberty. DH guidance builds on that issued by the DH and Welsh Assembly Government (WAG) in December 2004 following the ECHR decision. The decision by the Supreme Court in the Cheshire case has led to further guidance from the DH on the implications of that ruling (see Case Study 14.2 and pages 270–3).

Regulations set out the information to be provided with a request for authorization.

Normally authorization will be sought in advance. However in urgent circumstances it will be possible for the hospital or care home to issue an urgent authorization, giving their reasons in writing, and a standard authorization must be obtained within seven days of the start of the deprivation of liberty.

B. Assessment required preauthorization

The supervisory body must obtain the following assessments before granting an authorization of deprivation of liberty (set out in Schedule 7 of the 2007 which introduces a new schedule A1 into the MCA 2005). The assessments are listed and then considered in detail:

1. Age assessment
2. Mental health assessment
3. Mental capacity assessment
4. Eligibility assessment
5. Best interests assessment
6. No refusals assessment

1. *Age assessment*—the person being assessment must be aged 18 years or over.
2. *Mental health assessment*—the person must be suffering a mental disorder.

   Para 14 of Schedule A1 (1) The relevant person meets the mental health requirement if he is suffering from mental disorder (within the meaning of the Mental Health Act, but disregarding any exclusion for persons with learning disability).

   (2) An exclusion for persons with learning disability is any provision of the Mental Health Act

which provides for a person with learning disability not to be regarded as suffering from mental disorder for one or more purposes of that Act. (Under the 1983 Mental Health Act as amended, learning disabilities are only classified as a mental disorder if it is associated with abnormally aggressive or seriously irresponsible conduct. This is not a requirement for the purposes of a deprivation of liberty authorization.)

3 *Mental capacity assessment*—P lacks the capacity to decide whether to be admitted to or remain in the hospital or care home.

Under Para 15 of Schedule A1, the relevant person meets the mental capacity requirement if he lacks capacity in relation to the question whether or not he should be accommodated in the relevant hospital or care home for the purpose of being given the relevant care or treatment.

An example of a case where the capacity of a person who had an alcohol problem was disputed is *RB* v. *Brighton and Hove Council* [2014] EWCA[9] (see Chapter 4 and Case Study 14.1 on page 255). See also *X* v. *A local Authority and an NHS Trust* [2014] EWCOP 29[10] which is also considered in Chapter 4 (Case Study 14.2 on page 270).

4 *Eligibility assessment*—a person is eligible unless they are:

a) detained under the MHA

b) subject to a requirement under the MHA which conflicts with the authorisation sought, e.g. a guardianship order requiring them to live somewhere else.

c) subject to powers of recall under the MHA, or

d) unless the application is to enable mental health treatment in hospital and they object to being in hospital or to the treatment in question.

1 The relevant person meets the eligibility requirement unless he is ineligible to be deprived of liberty by this Act.

2 Schedule 1A applies for the purpose of determining whether or not P is ineligible to be deprived of liberty by this Act. Schedule 1A sets out in Part I those who are ineligible and includes a table of five cases setting out the status of P and whether or not they are ineligible to come under DOLs. Part 2 of Schedule 1A gives interpretations of all the terms used.

In the case of *Westminster City Council* v. *Sykes* [2014][11] (Case Study 14.10 on page 276), Judge Eldergill considered the eligibility requirement in a standard authorization and stated that the eligibility requirement "is concerned with the inter-relationship between the Mental Health Act 1983 and the Mental Capacity Act 2005. In certain situations where the Mental Health Act 1983 is 'in play' detention or compulsory treatment or care takes place under that Act, not the Mental Capacity Act. The eligibility requirement prohibits an incapacitated person from being deprived of their liberty under a standard authorization if he or she comes within any of the following groups:

1 People who are currently detained in a hospital under one of the following sections of the Mental Health Act 1983: sections 2, 3, 4, 35–38, 44, 45A, 47, 48, 51.

2 People who, though not currently detained, are subject to one of these sections or to a community treatment order, if the care or treatment in question consists wholly or partly of medical treatment for mental disorder in a hospital.

3 People who, though not currently detained, are subject to one of these sections, or to a community treatment order or guardianship, if accommodating them in the hospital or care home under the Mental Capacity Act would conflict with a requirement imposed on them under their Mental Health Act section.

4 People who are subject to guardianship under the Mental Health Act, if they object to being accommodated in the particular hospital for the purpose of being given some or all of the proposed medical treatment for their mental disorder (unless they have a donee or deputy who consents to each matter to which they object).

5 People who meet the criteria for being sectioned under section 2 or 3 of the Mental Health Act 1983, if they object to being accommodated in the particular hospital for the purpose of being given some or all of the proposed medical treatment for their mental disorder (unless they have a donee or deputy who consents to each matter to which they object).

He concluded that Ms Sykes was eligible to come under DOLs and only the best interests requirement was in doubt. This is considered in Chapter 5."

5 *Best interests assessment*

Under Para 16 of Schedule A1

1 the relevant person meets the best interests requirement if all of the following conditions are met.

2 The first condition is that the relevant person is, or is to be, a detained resident.

3 The second condition is that it is in the best interests of the relevant person for him to be a detained resident.

4 The third condition is that, in order to prevent harm to the relevant person, it is necessary for him to be a detained resident.

5 The fourth condition is that it is a proportionate response to—

a) the likelihood of the relevant person suffering harm, and

b) the seriousness of that harm, for him to be a detained resident

If the best interests assessor concludes that deprivation of liberty is necessary in a person's best interests to protect them from harm, he will be required to recommend who would be the best person to be appointed to represent the person's interests (see pages 264–5 the relevant person's representative).

6 *No refusals requirement*—the authorization sought does not conflict with a valid decision by a donee of a lasting power of attorney or a deputy appointed for the person by the Court of Protection and is not for the purpose of giving treatment which would conflict with a valid and applicable advance decision made by the person.

Under Para 18 of Schedule A1, the relevant person meets the no refusals requirement unless there is a refusal within the meaning of paragraph 19 or 20.

19 (1) There is a refusal if these conditions are met—

a) the relevant person has made an advance decision;

b) the advance decision is valid;

c) the advance decision is applicable to some or all of the relevant treatment.

(2) Expressions used in this paragraph and any of sections 24, 25, or 26 have the same meaning in this paragraph as in that section.

20 (1) There is a refusal if it would be in conflict with a valid decision of a donee or deputy for the relevant person to be accommodated in the relevant hospital or care home for the purpose of receiving some or all of the relevant care or treatment—

a) in circumstances which amount to deprivation of the person's liberty, or

b) at all.

(2) A donee is a donee of a lasting power of attorney granted by the relevant person.

(3) A decision of a donee or deputy is valid if it is made—

a) within the scope of his authority as donee or deputy, and

b) in accordance with Part 1 of this Act.

C. Effect of the six assessments

If any of the assessments conclude that the person does not meet the criteria for an authorization to be issued, the supervisory body must turn down the request for authorization. It must also notify the hospital or care home, the person concerned, any IMCA, and all interested persons consulted by the best interests assessor of the decision and the reasons.

A person could be detained while a decision is sought from the Court of Protection about the lawfulness of authorizing detention to enable life-sustaining treatment or treatment believed necessary to prevent a serious deterioration in the person's condition to be given (see Statute Box 14.3).

D. Duration of authorization for deprivation of liberty

This is assessed on a case-by-case basis. The maximum period for authorization would be 12 months, but it is expected that authorizations should be for shorter periods in many cases and must be the shortest time necessary to protect them from harm and not exceed the time recommended by the best interests assessor.

E. Action to be taken by supervisory body after receiving assessments which show the criteria are met

- It must grant the authorization of deprivation of liberty.
- It cannot be longer than the time period recommended by the best interests assessor nor longer than 12 months.
- The authorization must be in writing and include the purpose of the deprivation of liberty, the time period, any conditions attached, and the reasons that each of the qualifying criteria is met.
- A copy must be given to the hospital or care home, the person concerned, any IMCA appointed, and all

interested persons consulted by the best interests assessor.

- The relevant person's representative must keep in touch with the person, support them in all matters concerning the authorization, and request a review or make an application to the Court of Protection on their behalf where necessary.
- If there is no one available among friends or family, then the supervisory body will appoint a person, who may be paid, to act as the representative for the duration of the authorization.

F. Duties of hospital and care home managers

- To take all practical steps to ensure that the person concerned and their representative understand what the authorization means for them and how they may appeal or request a review
- To ensure that any conditions attached to the authorization are met
- To monitor the individual's circumstances as any change may require them to request that the authorization is reviewed

Hospitals and care homes may apply for further authorization when the authorization expires.

G. Review of authorization

An authorization may be reviewed for the following reasons:

- The hospital or care home requests a review because the individual's circumstances have changed.
- The person or their representative requests a review.

The supervisory body must review an authorization following such a request and obtain a new assessment where any of the criteria for authorization are affected by the changed circumstances. Outcomes from the review include:

- Termination of authorization
- Varying of the conditions attached to the authorization
- Changing the reason recorded that the person meets the criteria for authorization

H. Powers of court

Section 21A of the MCA (added by the MHA 2007) is shown in Statute Box 14.5. It sets out the specific powers of the court in relation to Schedule A1. In

Statute Box 14.5 New section 21A added to the MCA by para 2 of schedule 9 of the Mental Health Act 2007.

1 This section applies if either of the following has been given under Schedule A1:
  a) a standard authorisation
  b) an urgent authorisation.

2 Where a standard authorisation has been given, the court may determine any question relating to any of the following matters:
  a) whether any relevant person meets one of more of the qualifying requirements;
  b) the period during which the standard authorisation is to be in force
  c) the purpose for which the standard authorisation is given
  d) the conditions subject to which the standard authorisation is given.

3 If the court determines any question under subsection (2), the court may make an order:
  a) varying or terminating the standard authorisation, or
  b) directing the supervisory body to vary or terminate the standard authorisation.

4 Where an urgent authorisation has been given, the court may determine any question relating to any of the following matters:
  a) whether the urgent authorisation should have been given;
  b) the period during which the urgent authorisation is to be in force;.
  c) the purpose for which the urgent authorisation is given

5 Where the court determines any question under subsection (4), the court may make an order:
  a) varying or terminating the urgent authorisation, or
  b) directing the managing authority of the relevant hospital or care home to vary or terminate the urgent authorisation.

6 Where the court makes an order under subsection (3) or (5), the court may make an order about a person's liability for any act done in connection with the standard or urgent authorisation before its variation or termination.

7 An order under subsection (6) may, in particular, exclude a person from liability.

Re HA [2012][15] provides an example of S 21A proceedings. In an interim hearing Charles J held that the court could as an interim measure make declarations under its general welfare jurisdiction. The LA was made an interim deputy in relation to health and welfare and property and affairs.

addition the Court of Protection also has its powers under Section 15 to make a declaration on the mental capacity of P and the lawfulness of any act done or to be done in relation to P and powers under Section 16 to make decisions and appoint deputies. These are discussed in Chapter 7 of this book. The scope of Section 21A powers is considered in the cases of *CC* v. *KK* [2012][12] and in *Re UF* [2013][13]. The latter case is discussed in (Case Study 14.5 on page 275). See also the Court of Appeal decision *TA* v. *AA Knowsley* [2013] (Case Study 14.6 on page 275).[14]

I. DOLs Code of Practice

Lord Chancellor issued a Mental Capacity Act 2005: Deprivation of liberty safeguards Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice on August 26, 2008, in accordance with Sections 42 and 43 of the Act.[16] Both the DOLs Code and the main Code have statutory force, which means that certain people are under a legal duty to have regard to them (see Chapter 17).

The areas it covers are shown in Box 14.1.

Checklists cover:

Key points for care homes and hospitals (managing authorities)

Key points for local authorities and NHS bodies (supervisory bodies)

Box 14.1 Areas covered by the DOLs Code of Practice.

1. What are the deprivation of liberty safeguards and why were they introduced?
2. What is deprivation of liberty?
3. How and when can deprivation of liberty be applied for and authorized?
4. What is the assessment process for a standard authorization of deprivation of liberty?
5. What should happen once the assessments are complete?
6. When can urgent authorizations of deprivation of liberty be given?
7. What is the role of the relevant person's representative?
8. When should an authorization be reviewed and what happens when it ends?
9. What happens if someone thinks a person is being deprived of their liberty without authorization?
10. What is the Court of Protection and when can people apply to it?
11. How will the safeguards be monitored?

Key points for managing authorities and supervisory bodies

Annexes cover:

Annex 1—Overview of the deprivation of liberty safeguards process

Annex 2—What should a managing authority consider before applying for authorization of deprivation of liberty?

Annex 3—Supervisory body action on receipt of a request for a standard deprivation of liberty authorization or to determine whether there is an unauthorized deprivation of liberty

Annex 4—Standard authorization review process

Key words and phrases used in the Code of Practice.

Key words can also be found in the glossary to this book.

Court of Protection Practice Direction on Deprivation of Liberty

The Court of Protection has, in the light of increases in applications following the Supreme Court decision in the Cheshire case, issued a new standard application form (COPDOL10) to support a streamlined procedure. It is explained in a Practice Direction (10AA) supplementing Part 10A of the CP Rules 2007 and covers the procedure to be followed in making an application under 21A and under 16(2)(a). DOL court forms can be downloaded from the Court of Protection website.

Deprivation of liberty situation: Scenario 14.1

Following the implementation of the DOLs provisions contained within the Mental Health Act 2007, the care home must follow the procedure set out on page 261.

1 *Application for authorization*

The care home, that is, the managing authority, must identify Maud as being a person who lacks capacity and who risks being deprived of her liberty.

It must apply to the supervisory body, that is, the local authority in which Maud was ordinarily resident, for authorization of deprivation of liberty.

2 *Assessments required*

i) Age assessment—Maud is over 18 years.

ii) Mental health assessment—Maud is suffering a mental disorder.

Scenario 14.1 Patient held at common law in a deprivation of liberty situation.

Maud had been living in a care home for several years. She suffered from Alzheimer's disease, and this had been accompanied by growing violence in recent months. Her mental capacity had greatly diminished and the home believed that she needed to be detained to prevent her leaving the home and possibly being a danger to other people. The relatives were opposed to her being detained under the MHA, and her psychiatrist believed that her detention need be for only a short time. The care home was registered to take mentally disturbed patients and was prepared to keep her there as long as it could exercise greater control over her movements. It therefore wished to apply for the power to restrict her movements.

iii) Mental capacity assessment—Maud lacks the capacity to decide whether to be admitted to or remain in the hospital or care home.

iv) Eligibility assessment—Maud is:

a) Not detained under the MHA

b) Not subject to a conflicting requirement under the MHA

c) Not subject to powers of recall under the MHA, nor

d) A treatment order in hospital to which Maud objects

However she may come under Case E of Schedule 1A if she is within the scope of the Mental Health Act, but not subject to any of the mental health regimes. This would be so if doctors had made the necessary recommendations for a section 2 or 3 admission. In their absence, she would not be ineligible and could come under the MCA and DOLs (see the discussion of whether the MHA or the MCA is appropriate in the case of *GJ* v. *The Foundation Trust & Anor* [2009][17] (Case Study 14.11 on page 276).

v) Best interests assessment—the authorization would be in Maud's best interests and is a proportionate response to the likelihood of suffering harm and the seriousness of that harm.

vi) No refusals requirement—There is no conflict between the authorization sought and a valid decision by a donee of a lasting power of attorney or a deputy, and it does not conflict with a valid and applicable advance decision made by Maud.

3 *Appointment of representative for Maud*

If the best interests assessor concludes that Maud has the capacity to appoint her own representative, then she can do this. Otherwise the best interests assessor can appoint a representative. If the assessor notifies the supervisory body that a representative has not been appointed for her, then it can appoint a representative who can be paid to act as Maud's representative.

4 *Authorization granted*

If all the assessments are satisfactory, then authorization by the supervisory body can be granted for the deprivation of Maud's liberty for up to 12 months or up to any lesser period recommended by the best interests assessor.

5 *Review and monitoring*

The supervisory authority should keep under review Maud's deprivation of liberty, and the whole process of the assessments and authorization will be monitored to ensure that all the required procedures were followed.

Deprivation of liberty in other circumstances

The Court of Protection may make an order on a personal welfare matter which may lead to a deprivation of liberty (see Chapter 7 and the new powers of the Court of Protection under Section 21A set out in the following). However under Section 16A(1) if a person is ineligible to be deprived of liberty by the MCA (i.e., comes within the list set out in Schedule 1A), the court may not include in a welfare order provision which authorizes the person to be deprived of his liberty (see Statute Box 14.4 on page 265).

The Mental Capacity Act 2005 as amended has made deprivation of liberty unlawful in cases where there is neither a DOLs authorization nor a relevant decision by the Court of Protection. The High Court may use the powers of its inherent jurisdiction to deprive a person of their liberty but must ensure that their article 3, 5, and 8 rights are protected. See the discussion in Chapter 2 and in particular the case of *Re PS (an Adult) and the City of Sunderland* [2007].[18]

Transporting of P

The Deprivation of Liberty Safeguards do not specifically give the right to convey P to the hospital or care home where he or she is to be deprived of liberty. This gap was considered in the case of *GJ* v. *Foundation Trust* 2009[19] (Case Study 14.11 on page 276) where Charles J considered that the Court of Protection could fill the gap. The Joint Committee recommended statutory powers of take and convey being added to the authorization, but this recommendation was not accepted by the Government and for those exceptional cases where authorization was required, the Court of Protection could make an order. Paragraphs 2.14 and 2.15 of the Deprivation of Liberty Safeguards' Code of Practice cover the issue.

The relevant person's representative (RPR)

Regulations cover the appointment of a representative and who is eligible to be appointed.[20] The eligibility criteria are shown in Box 14.2 and the definition of a relative shown in Box 14.3.

The definition of "relative" is shown in Box 14.3.

The regulations also cover the process of selection (Part 2). The best interests assessor must determine whether the person has the capacity to select their own representative. If so the relevant person may select a family member, friend, or carer. If the relevant person does not wish to appoint a representative, then the best interests assessor does so under regulation 8. Under regulation 8 the best interests assessor may select a family member, friend, or carer as a representative if the relevant person has the capacity but does not wish to make the selection and a donee or deputy does not wish to make the selection. Where the relevant person lacks the requisite capacity and does not have a donee or deputy (or there is a donee or deputy but the scope of authority does not permit the selection of a representative), then the best interests assessor makes the selection. If the best interests assessor does not select a person who is eligible to be a representative, he must notify the supervisory body (8(5)). Regulation 9 then applies and the supervisory body makes the appointment.

Box 14.2 Eligibility criteria for a representative.

a) 18 years of age
b) Able to keep in contact with relevant person
c) Willing to be the relevant person's representative
d) Not financially interested in the relevant person's managing authority
e) Not a relative (see Box 14.3) of a person who is financially interested in the managing authority
f) Not employed by, or providing services to, the relevant person's managing authority where the relevant person's managing authority is a care home
g) Not employed to work in the relevant person's managing authority in a role that is, or could be, related to the relevant person's case, where the relevant person's managing authority is a hospital
h) Not employed to work in the supervisory body that is appointing the representative in a role that is, or could be, related to the relevant person's case

Box 14.3 Relative for the purpose of the regulations on representatives.

a) Spouse, ex-spouse, civil partner, or an ex-civil partner
b) A person living with the relevant person as if they were a spouse or a civil partner
c) A parent or child
d) A brother or sister
e) A child of a person falling within a, b, or c
f) A grandparent or grandchild
g) A grandparent-in-law or grandchild-in-law
h) An uncle or aunt
i) A brother-in-law or sister-in-law
j) A son-in-law or daughter-in-law
k) A first cousin
l) A half-brother or half-sister

Relationships c to k include step relationships.

Part 2 of the regulations covers the commencement of the appointment procedure, the appointment of the representative, the formalities of appointing a representative, the termination of the representative's appointment, and its formalities and payment to a representative.

The representative can be paid where the best interests assessor has notified the supervisory body that they have not selected a nominated person to be a representative. In this situation (under regulation 9) the

supervisory body may select a person to be a representative, who:

a) Would be performing the role in a professional capacity
b) Has satisfactory skills and experience to perform the role
c) Is not a family member, friend, or carer of the relevant person
d) Is not employed by, or providing services to, the relevant person's managing authority, where the relevant person's managing authority is a care home
e) Is not employed to work in the relevant person's managing authority in a role that is, or could be, related to the relevant person's case
f) Is not employed by the supervisory body (as amended)[21]

The supervisory body must also check that there is a criminal record certificate.

Any appointment is in addition to and does not affect any appointment of a donee or deputy.

The role of the RPR under Part 10 Schedule A1

In the case of *AB* v. *LCC (A local authority)* [2011][22] Mostyn J considered the role of the RPR and a litigation friend and concluded that there is no impediment to the RPR acting as litigation friend in a 21A application provided that (1) the RPR is not already a party to the proceedings, (2) the RPR fulfils the CoP rule 140 conditions, (3) the RPR can and is willing to act as litigation friend in P's best interests, and (4) the procedure as set out in CoP rule 143 is complied with. Mostyn J also discussed the advantages and disadvantages in appointing the Official Solicitor as litigation friend, noting that the OS had a policy that the OS should be appointed when there is no one else willing and able to act.

Baker J considered the role of the LA when an inappropriate person is chosen as the RPR in the case of *AJ* v. *A Local Authority* [2015] EWCOP 5 (see Case Study 14.14 on page 277). Even though the Best Interest Assessor had suggested Mr C as the RPR, the LA should have been aware that MC was not intending to initiate proceedings on behalf of AJ to ensure compliance with Article 5(4) and should have taken steps to replace the RPR.

Chapter 7 of the DOLs Code of Practice covers the appointment and duties of the RPR. See pages 268–9 the relationship between the RPR and the IMCA.

Assessments, assessors, eligibility requirements, and monitoring

Assessments

Part 5 of the regulations[23] also makes provisions relating to the assessments. All assessments required for a standard authorization must be completed within 21 days from the date the supervisory body receives a request for such an authorization from a managing authority. Where the best interests assessor and the eligibility assessor are not the same person, then the former must provide the latter with any information he has. Where the managing authority and the supervisory body are the same, an employee of that body cannot be appointed as the best interests assessor.

Assessors

Regulations on the eligibility and selection of assessors[24] set out the eligibility criteria for mental health assessments, best interests assessments, mental capacity assessments, eligibility assessments, age assessments, and no refusals assessments (see following text).

General eligibility criteria

In addition general eligibility criteria require all assessors (other than the age assessor) to be insured in respect of any liabilities that might arise in connection with carrying out the assessment. The supervisory body must be satisfied that the assessors have the requisite insurance and also that they have the skills and experience appropriate to the assessment they are to carry out. This must include (but is not limited to) an applied knowledge of the Mental Capacity Act and related Code of Practice and an ability to keep appropriate records and to provide clear and reasoned reports in accordance with legal requirements and good practice. The supervisory body must be satisfied that there is an enhanced criminal record certificate issued in respect of the person.

Mental health assessors must be approved doctors under Section 12 of the Mental Health Act 1983 or a registered medical practitioner who the supervisory body is satisfied has special experience in the diagnosis and treatment of mental disorder. Eligibility criteria for mental capacity assessors are shown in Box 14.4 and for best interests assessors in Box 14.5.

Box 14.4 Eligibility criteria for mental capacity assessors.

a) Approved under S.12 of the Mental Health Act 1983.
b) A registered medical practitioner who the supervisory body is satisfied has special experience in the diagnosis and treatment of mental disorder.
c) An approved mental health professional.
d) A social worker registered with the General Social Care Council or Care Council for Wales (since 2012 registered with the Health and Care Professions Council).
e) A first level nurse registered with the Nursing and Midwifery Council (NMC) with a recordable qualification in mental health nursing.
f) A first level nurse registered with the NMC with a recordable qualification in learning disabilities nursing.
g) A registered occupational therapist.
h) A chartered psychologist registered with the British Psychological Society and who holds a practicing certificate issued by that Society.

Box 14.5 Eligibility criteria for best interests assessors.

a) An approved mental health professional.
b) A social worker registered with the General Social Care Council or the Care Council of Wales (since 2012 registered with the Health and Care Professions Council).
c) A first level nurse registered with the NMC with a recordable qualification in mental health nursing.
d) A first level nurse registered with the NMC with a recordable qualification in learning disabilities nursing.
e) A registered occupational therapist.
f) A chartered psychologist registered with the British Psychological Society and who holds a practicing certificate issued by that Society.

Selection of assessors

A supervisory body may only select a person to carry out an assessment in any individual case where the person is not financially interested in the care of the relevant person, not a relative of the relevant person, and not a relative of a person who is financially interested in the care of the relevant person. “Relative” has the same meaning as shown in Box 14.3. There are also regulations to ensure the independence of the best interests assessor, so that he or she cannot be involved in the care, or making decisions about the care, of the relevant person, and is not employed by the care home or hospital where the relevant person is to be detained.

Monitoring of assessors

The DH published a statement of intent stating that regulations were to be published on the monitoring arrangements. The monitoring function was initially given to the three existing inspectorates—the Healthcare Commission, the Commission for Social Care Inspection, and the MHA Commission—but these three bodies were merged into the Care Quality Commission.

The monitoring role would include the following:

- Monitor and report on the operation of the Deprivation of Liberty Safeguards.
- Visit hospitals and care homes.
- Visit and interview people in hospitals and care homes.
- Require the production of and inspect reports.

The monitoring process would consider:

- Whether the provisions have been applied correctly and in line with guidance in the Code of Practice in cases where authorization has been requested.
- Whether the guidance in the Code of Practice on identifying those at risk of deprivation of liberty and on avoiding deprivation of liberty is being complied with.
- Whether conditions attached to authorization and requirements to request review if circumstances change are complied with.
- Whether appropriate steps are being taken in cases where authorization has been refused.

Monitoring would not cover treatment and care (other than as it relates to the deprivation of liberty) nor would it cover the revisiting of individual assessments. Monitoring would not constitute an alternative review or appeals process.

The CQC must have regard to the need to protect and promote the rights of people who use health and social care services (including in particular persons who are deprived of their liberty in accordance with the Mental Capacity Act 2005 and of other vulnerable adults).[25] Regulations on monitoring place a duty on the CQC to monitor the operation of Schedule A1 in relation to England; to report to the Secretary of State on the operation of Schedule A1 when requested; to

visit hospitals and care homes; to visit and interview persons accommodated therein; and to require the production of and inspect records relating to the care and treatment of persons who are the subject of an authorization under Schedule A1 or whom the Commission has reason to consider ought to have been or should be the subject of an assessment under Schedule A1. The CQC may at any time give advice and information on the operation of Schedule A1 to the Secretary of State.[26] The CQC has published an infographic explaining the use of DOLs which is available on its website.[27] Its fifth annual report on the use of DOLs 2013/4 is also available online. It notes a rapid and unprecedented increase in the number of applications since March 2014.

Information to be provided with an application for authorization

The information to be included is shown in Box 14.6.

If there is an existing authorization, the information set out in Box 14.6 from * to * need not be included if there has been no change.

Time frame for assessments

The Regulations[28] require a standard authorization to be completed within the period of 21 days beginning with the date that the supervisory body receives a request for such an authorization. However where an urgent authorization has been given, the assessments required for the standard authorization must be completed within the period during which the urgent authorization is in force. The time limit for carrying out an assessment to decide whether or not there is an unauthorized deprivation of liberty must be completed within the period of 7 days beginning with the date that the supervisory body receives the request from an eligible person.

Ordinary residence

Particulars relating to ordinary residence were included in the Regulations relating to eligibility and assessments[29] following a statement of intent published by the DH in 2007. These regulations authorize or require an LA in which the person is ordinarily resident to:

Box 14.6 Information to be provided in application for a standard authorization.

- The name and gender of the relevant person, their age (if not known the managing authority believe him/her to be 18 years or older), address and telephone number, The name, address and telephone number of the managing authority and the name of the person dealing with the request.
- Purpose for which the authorization is requested
- Date from which the standard authorization is sought and
- Whether an urgent authorisation has been issued and, if so, the date it expires.
- *Any medical information relating to the relevant person's health that the managing authority considers to be relevant to the proposed restrictions on the person's liberty,
- the diagnosis of the mental disorder (within the meaning of the Mental Health Act but disregarding any exclusion for persons with learning disability that the relevant person is suffering from
- any relevant care plans and relevant needs assessment
- the racial, ethnic or national origins of the relevant person
- whether the relevant person has any special communication needs
- details of the proposed restrictions on the relevant person's liberty
- whether section 39A of the Act (person becomes subject to Schedule A1) applies
- where the purpose of the proposed restrictions to the relevant person's liberty is to give treatment, whether the relevant person made an advance decision that may be valid and applicable to some or all of that treatment
- whether the relevant person is subject to i. the hospital treatment regime; ii the community treatment regime; or iii the guardianship regime
- *the name and address and telephone number of: i. anyone named by the relevant person as someone to be consulted about his welfare; ii anyone engaged in caring for the person or interested in his welfare; iii any donee of a lasting power of attorney by the person iv. Any deputy appointed for the person by the court and v. any independent mental capacity advocate appointed under the Act.
- Whether there is an existing authorization in relation to the detention of the relevant person and if so the date of the expiry to that authorisation

- Act as the Supervisory Body to deal with the application, even though it may wish to dispute being the Supervisory Body
- Become the Supervisory Body in place of another local authority
- Recover from another local authority expenditure incurred in exercising functions as a Supervisory Body

The purpose of the regulations is to prevent any dispute about which LA is the Supervisory Body delaying decisions about whether the deprivation of liberty is authorized. Directions which came into force in 2010 lay down rules relating to disputes over ordinary residence[30] and guidance was issued by the DH in March 2013.

Role of the Court of Protection

Many respondents to the consultation which preceded the decision to introduce Deprivation of Liberty Safeguards considered that an appeal against detention should be to the Mental Health Review Tribunals. However the Government stated that it considered the appropriate appeals process to be through the Court of Protection since that court, as the Court established by the Mental Capacity Act, is best placed to take on this role as part of its overall responsibility for the personal welfare of those who lack capacity. A relative, friend, or carer has the right to bring proceedings before the Court of Protection, and if there is not such a suitable person, an independent person (possibly an independent mental capacity advocate) is appointed by the relevant local authority. The Court of Protection Rules came into force in October 2007.[31]

In July 2015 amendment rules[32] relating to the Court of Protection came into force placing the focus firmly on P. They are considered in Chapter 7. The changes were introduced partly as a result of the Supreme Court judgment in the Chester case (see Case Study 14.2 on page 270) which led to an increase in the applications for DOLs Orders. Appeals can be made to a higher judge within the CoP. Judges within the CoP are divided into three tiers, with appeals being able to lie from a judge in a lower tire to a judge in a higher tier.

Independent Mental Capacity Advocate

When a deprivation of liberty is being contemplated, action must be taken by the managing authority of the hospital or care home or by the local authority to ensure that in certain circumstances an independent mental capacity advocate is appointed. These circumstances are set out in Sections 39A to 39E of the MCA added by Schedule 9 of the Mental Health Act 2007 and are shown in Statute Box 14.6. They supplement the provisions for IMCAs which are considered in Chapter 8.

Section 40 qualifies the duty to appoint an IMCA and is shown in Statute Box 14.7.

Statute Box 14.6 Sections 39A, 39B, 39C, 39D, and 39E.

Section 39A

1. This section applies if:
   - **a)** a person P becomes subject to Schedule A1, and
   - **b)** the managing authority of the relevant hospital or care home are satisfied that there is no person, other than one engaged in providing care or treatment for P in a professional capacity or for remuneration, whom it would be appropriate to consult in determining what would be in P's best interests.
2. The managing authority must notify the supervisory body that this section applies.
3. The supervisory body must instruct an independent mental capacity advocate to represent P.
4. Schedule A1 makes provision about the role of an independent mental capacity advocate appointed under this section.
5. This section is subject to paragraph of 152 of Schedule A1.
6. For the purposes of subsection (1), a person appointed under Part 10 of Schedule A1 to be P's representative is not, by virtue of that appointment engaged in providing care or treatment for P in a professional capacity or for remuneration.

Section 39B

1. This section applies for the purposes of section 39A.
2. P becomes subject to Schedule A1 in either of the following cases.
3. The first case is where an urgent authorisation is given in relation to P under paragraph 69(2) of Schedule A1 (urgent authorisation given before request made for standard authorisation).
4. The second case is where the following conditions are met:
5. The first condition is that a request is made under Schedule A1 for a standard authorisation to be given in relation to P (the requested authorisation).

6 The second condition is that no urgent authorisation was given under paragraph 69(2) before that request was made.
7 The third condition is that the requested authorisation will not be in force on or before, or immediately after, the expiry of an existing standard authorisation.
8 The expiry of a standard authorisation is the date when the authorisation is expected to cease to be in force.
9 The third case is where, under paragraph 69 of Schedule A1, the supervisory body select a person to carry out an assessment of whether or not the relevant person is a detained resident.

39C Person unrepresented while subject to Schedule A1

1 This section applies if—
   a) an authorisation under Schedule A1 is in force in relation to a person (“P”),
   b) the appointment of a person as P’s representative ends in accordance with regulations made under Part 10 of Schedule A1, and
   c) the managing authority of the relevant hospital or care home are satisfied that there is no person, other than one engaged in providing care or treatment for P in a professional capacity or for remuneration, whom it would be appropriate to consult in determining what would be in P’s best interests.
2 The managing authority must notify the supervisory body that this section applies.
3 The supervisory body must instruct an independent mental capacity advocate to represent P.
4 Paragraph 159 of Schedule A1 makes provision about the role of an independent mental capacity advocate appointed under this section.
5 The appointment of an independent mental capacity advocate under this section ends when a new appointment of a person as P’s representative is made in accordance with Part 10 of Schedule A1.
6 For the purposes of subsection (1), a person appointed under Part 10 of Schedule A1 to be P’s representative is not, by virtue of that appointment, engaged in providing care or treatment for P in a professional capacity or for remuneration.

39D Person subject to Schedule A1 without paid representative

1 This section applies if—
   a) an authorisation under Schedule A1 is in force in relation to a person (“P”),
   b) P has a representative (“R”) appointed under Part 10 of Schedule A1, and
   c) R is not being paid under regulations under Part 10 of Schedule A1 for acting as P’s representative.
2 The supervisory body must instruct an independent mental capacity advocate to represent P in any of the following cases.
3 The first case is where P makes a request to the supervisory body to instruct an advocate.
4 The second case is where R makes a request to the supervisory body to instruct an advocate.
5 The third case is where the supervisory body have reason to believe one or more of the following—
   a) that, without the help of an advocate, P and R would be unable to exercise one or both of the relevant rights;
   b) that P and R have each failed to exercise a relevant right when it would have been reasonable to exercise it;
   c) that P and R are each unlikely to exercise a relevant right when it would be reasonable to exercise it.
6 The duty in subsection (2) is subject to section 39E.
7 If an advocate is appointed under this section, the advocate is, in particular, to take such steps as are practicable to help P and R to understand the following matters—
   a) the effect of the authorisation;
   b) the purpose of the authorisation;
   c) the duration of the authorisation;
   d) any conditions to which the authorisation is subject;
   e) the reasons why each assessor who carried out an assessment in connection with the request for the authorisation, or in connection with a review of the authorisation, decided that P met the qualifying requirement in question;
   f) the relevant rights;
   g) how to exercise the relevant rights.
8 The advocate is, in particular, to take such steps as are practicable to help P or R—
   a) to exercise the right to apply to court, if it appears to the advocate that P or R wishes to exercise that right, or
   b) to exercise the right of review, if it appears to the advocate that P or R wishes to exercise that right.
9 If the advocate helps P or R to exercise the right of review—
   a) the advocate may make submissions to the supervisory body on the question of whether a qualifying requirement is reviewable;
   b) the advocate may give information, or make submissions, to any assessor carrying out a review assessment.
10 In this section—

“relevant rights” means—

a) the right to apply to court, and
b) the right of review;

“right to apply to court” means the right to make an application to the court to exercise its jurisdiction under section 21A;

“right of review” means the right under Part 8 of Schedule A1 to request a review.

39E Limitation on duty to instruct advocate under section 39D

1 This section applies if an advocate is already representing P in accordance with an instruction under section 39D.
2 Section 39D(2) does not require another advocate to be instructed, unless the following conditions are met.
3 The first condition is that the existing advocate was instructed—
   a) because of a request by R, or
   b) because the supervisory body had reason to believe one or more of the things in section 39D(5).
4 The second condition is that the other advocate would be instructed because of a request by P.

Statute Box 14.7 Section 40: MCA.

Section 40 (1) (as replaced by MHA 2007 S 49) the duty to appoint an IMCA (under Sections 37(3), 38(3), 39(4), or (5), *39A(3), 39C(3), or 39D(2))* does not apply where there is:

a) a person nominated by P (in whatever manner) as a person to be consulted in matters to which that duty relates
b) a donee of a lasting power of attorney created by P who is authorized to make decisions in relation to those matters
c) a deputy appointed by the court for P with power to make decisions in relation to those matters

Section 40(2) A person appointed under Part 10 of Schedule A1 to be P's representative is not, by virtue of that appointment, a person nominated by P as a person to be consulted in matters to which a duty under subsection (1) relates.

Paragraphs 3.22–3.28 of the DOLs Code of Practice give guidance on the circumstances when an IMCA must be appointed. If there is no person to consult in relation to a DOLs application, then the managing authority must notify the supervisory body when it submits the application and the latter must appoint an IMCA immediately. The appointment will end when an RPR is appointed, but the IMCA could still represent P in court. In addition P or an RPR can request the appointment of an IMCA.

Supreme Court Cases of Chester and Surrey

Definition of deprivation of liberty

Case Study 14.2 Deprivation of liberty: The Surrey and Chester cases[33]

The Supreme Court heard two cases concerned with the definition of a deprivation of liberty and the statutory requirement to implement the Deprivation of Liberty Safeguards.

Surrey case

The facts of the first case brought against Surrey County Council were that MIG and MEG were sisters who first became the subject of care proceedings under the Children Act 1989 in 2007, when they were aged respectively 16 and 15. MIG had a learning disability at the lower end of the moderate range or the upper end of the severe range. She also had problems with her sight and her hearing. She communicated with difficulty and had limited understanding, spending much of her time listening to music on her iPod. She needed help crossing the road because she was unaware of danger. MEG had a learning disability at the upper end of the moderate range, bordering on the mild. Her communication skills were better than her sister's and her emotional understanding was quite sophisticated. Nevertheless, she could have had autistic traits and she exhibited challenging behavior.

At the time of the hearing by the Court of Protection, the sisters had been moved from the family home following allegations of sexual abuse by the step father. MIG (then aged 18) was living with a foster mother to whom she was devoted. She had never attempted to leave the home by herself and showed no wish to do so, but if she did, the foster mother would restrain her. She attended a further education unit daily during term time and was taken on trips and holidays by her foster mother. She was not on any medication.

MEG (then aged 17) had originally been placed with a foster carer, who was unable to manage her severe aggressive outbursts, and so she was moved to a residential home. She mourned the loss of that relationship and wished she was still living with her foster carer. The home was an NHS facility, not a care home, for learning disabled adolescents with complex needs. She had occasional outbursts of challenging behavior toward the other three residents and sometimes required

physical restraint. She was also receiving tranquillizing medication. Her care needs were met only as a result of continuous supervision and control. She showed no wish to go out on her own and so did not need to be prevented from doing so. She was accompanied by staff whenever she left. She attended the same further education unit as MIG and had a much fuller social life than her sister.

The Court of Protection decided that the sisters' living arrangements were in their best interests and concluded that they did not amount to a deprivation of liberty.

The Court of Appeal agreed[34]: Wilson LJ, who gave the leading judgment, laid stress on the "relative normality" of the sisters' lives, compared with the lives they might have at home with their family, together with the absence of any objection to their present accommodation. Mummery LJ was also impressed with the "greater fulfilment in an environment more free than they had previously had." Smith LJ, on the other hand, thought their previous arrangements were not relevant, but stressed that "what may be a deprivation of liberty for one person may not be for another."

The Facts of *Cheshire West and Chester Council* v. *P*

P was aged 38 at the time of the Court of Protection hearing. He was born with cerebral palsy and Down's syndrome and required 24 h care to meet his personal care needs. Until he was 37 he lived with his mother, who was his principal carer, but her health began to deteriorate and the local social services authority concluded that she was no longer able to look after P. In 2009 they obtained orders from the Court of Protection that it was in P's best interests to live in accommodation arranged by the local authority. Since November 2009, he had been living in Z house. This was not a care home. It was a spacious bungalow, described by an independent social worker as cozy and with a pleasant atmosphere, and close to P's family home. At the time of the final hearing, he shared it with two other residents. There were normally two staff on duty during the day and one "waking" member of staff overnight. P received 98 h additional one-to-one support each week, to help him to leave the house whenever he chose. He went to a day center four days a week and a hydrotherapy pool on the fifth. He also went out to a club, the pub, and the shops and saw his mother regularly at the house, the day center, and her home. He could walk short distances but needed a wheel chair to go further. He also required prompting and help with all the activities of daily living, getting about, eating, personal hygiene, and continence. He wore continence pads. Because of his history of pulling at these and putting pieces in his mouth, he wore a "body suit" of all-in-one underwear which prevented him getting at the pads. Intervention was also needed to cope with other challenging behaviors which he could exhibit. But he was not on any tranquillizing medication.

By the time of the final hearing before Baker J in April 2011,[35] the principal issue was whether these arrangements amounted to a deprivation of liberty. Baker J held that P was completely under the control of the staff at Z House, that he could not "go anywhere, or do anything, without their support and assistance." Further, "the steps required to deal with his challenging behaviour lead to a clear conclusion that, looked at overall, P is being deprived of his liberty." Nevertheless it was in his best interests for those arrangements to continue:

The Court of Appeal[36] substituted a declaration that the arrangements did not involve a deprivation of liberty: Munby LJ, who delivered the leading judgment with which Lloyd and Pill LJJ agreed, developed the concept of "relative normality" adopted in P and Q, and considered it appropriate to compare P's life, not with that which he had enjoyed before when living with his mother, but with that which other people like him, with his disabilities and difficulties, might normally expect to lead. As Lloyd LJ put it, "It is meaningless to look at the circumstances of P in the present case and to compare them with those of a man of the same age but of unimpaired health and capacity…the right comparison is with another person of the same age and characteristics as P."

Both cases were considered at the same time by the Supreme Court.

Baroness Hale who gave the leading judgment held that:

> In my view, it is axiomatic that people with disabilities, both mental and physical, have the same human rights as the rest of the human race. It may be that those rights have sometimes to be limited or restricted because of their disabilities, but the starting point should be the same as that for everyone else.
>
> The fact that my living arrangements are comfortable, and indeed make my life as enjoyable as it could possibly be, should make no difference. A gilded cage is still a cage.

She rejected relative normality as an approach to determining whether there was a deprivation of liberty.

She then asked if there were an acid test for the deprivation of liberty in these cases and concluded:

> The answer, as it seems to me, lies in those features which have consistently been regarded as "key" in the jurisprudence which started with *HL* v. *United Kingdom*[37] (The Bournewood case): that the person concerned "was under continuous supervision and control and was not free to leave"

There are huge implications of this majority decision. Some were pointed out by 39 Essex Street Chambers[38] and include:

1. The decision extends the need for protection beyond those in care homes and hospitals to include those in foster homes, supported living arrangements, and other settings which provide them with as normal a life as possible.

2 DOLs will be put under strain because of the increase in numbers and will need reform. (Need for reform was pointed out by the House of Lords Select Committee report (see page 273).)
3 Hale's acid test begs many questions: what is meant by supervision and control and freedom to leave ("the way in which the Supreme Court applied its test to the facts of the cases before it should serve as a model for future decision-making, without much need for further elaboration of the test"). Different terminology: Hale used complete supervision and control and not free to leave; Neuberger used continuous supervision and control and lack of freedom to leave and the area and period of confinement. Kerr used the duration of restriction.
4 Hale argued that the case was not about the distinction between a restriction on freedom of movement and the deprivation of liberty. However it has been said that this was at the heart of the appeals. The distinction is shown in the difference between section 6 of the MCA (restriction on movement) and S4A (deprivation of liberty). The threshold at which the constraints upon such liberty are so intense as to constitute a deprivation of it is the same throughout the justificatory grounds in Article 5 and throughout the Council of Europe. The threshold cannot alter depending upon whether the deprivation is potentially justifiable.
5 Strasbourg decisions: MCA S 64(5) expressly gives deprivation of liberty the same meaning as Article 5(1). The UK threshold for Article 5 thereby rises and falls with every Strasbourg decision—potential to create legal uncertainty.
6 Unclear now what role a comparator plays in determining whether there is a deprivation of liberty (i.e., do you compare the situation of a severely physically disabled person with that of a normal person of the same age?).
7 Objection or lack of objection is now irrelevant to the decision as to whether there is a deprivation of liberty.
8 Benevolence or purpose (of the deprivation) is irrelevant.
9 Implications of decision: 200 000 people with dementia in care homes + 28 000 aged 18–64 with learning disabilities in care and nursing homes. All of these lacking the capacity to consent are now likely to be deprived necessitating a DOLs authorization in addition to all those in hospitals, ITUs, etc. receiving life-sustaining treatment. Because of the lowering of the Article 5 threshold, those in supported living and shared lives schemes will also be caught—"all disabled and vulnerable adults lacking the relevant capacity who receive care or support funded by or arranged by a public body may now need to be reviewed to see if the acid test is satisfied. This has huge implications for children and gives rise to the possibility of a new Bournewood gap opening up for children."
10 Implications for Mental Health are:
   a) Incapacitated informal patients are not free to leave if others are deciding on their best interests.
   b) Guardianship patients who have no choice over their place of residence and the intensity of their package of care may tip their regime into Article 5.
   c) What about those under a community treatment order and
   d) Restricted patients conditionally discharged?
11 Will the extension of the groups covered by DOLs provide protection? "Let it not be forgotten that those at Winterbourne View were tortured by 'carers' despite having the benefit of their procedural and substantive safeguards of Article 5."

39 Essex Street Chambers has issued mental capacity law guidance, available on its website on Deprivation of Liberty Safeguards after the Cheshire West decision, setting out key questions for social workers and medical practitioners.[39]

Events following the Chester Supreme Court decision:

Department of Health Memorandum 2014[40]

Key points from the Supreme Court judgment

1 *Revised test for deprivation of liberty*

The Supreme Court has clarified that there is a deprivation of liberty for the purposes of Article 5 of the European Convention on Human Rights in the following circumstances:

The person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements.

The Supreme Court held that factors which are NOT relevant to determining whether there is a deprivation of liberty include the person's compliance or lack of objection and the reason or purpose behind a particular placement. (These factors (compliance/objection and the reason or purpose for the placement) are of course still relevant to assessment of best interests and consideration of Article 8 rights.) It was also held that the relative normality of the placement, given the person's needs, was not relevant. This means that the person should not be compared with anyone else in determining whether there is a deprivation of liberty. However, young persons

aged 16 or 17 should be compared to persons of a similar age and maturity without disabilities.

2 *Deprivation of liberty in "domestic" settings*

The Supreme Court has held that a deprivation of liberty can occur in domestic settings where the State is responsible for imposing such arrangements. This will include a placement in a supported living arrangement in the community. Hence, where there is, or is likely to be, a deprivation of liberty in such placements that must be authorized by the Court of Protection.

Actions suggested by the Department of Health

Relevant staff should:

- Familiarise themselves with the provisions of the Mental Capacity Act, in particular the five principles and specifically the "least restrictive" principle.
- When designing and implementing new care and treatment plans for individuals lacking capacity, be alert to any restrictions and restraint which may be of a degree or intensity that mean an individual is being, or is likely to be, deprived of their liberty (following the revised test supplied by the Supreme Court)
- Take steps to review existing care and treatment plans for individuals lacking capacity to determine if there is a deprivation of liberty (following the revised test supplied by the Supreme Court)
- Where a potential deprivation of liberty is identified, a full exploration of the alternative ways of providing the care and/ or treatment should be undertaken, in order to identify any less restrictive ways of providing that care which will avoid a deprivation of liberty
- Where the care/ treatment plan for an individual lacking capacity will unavoidably result in a deprivation of liberty judged to be in that person's best interests, this MUST be authorised.

Local authorities should in addition:

- Review their allocation of resources in light of the revised test given by the Supreme Court to ensure they meet their legal responsibilities.

Although local authorities are the supervisory body for DOLs for both care home and hospital settings, the NHS (commissioners and providers) have a vital role to play in correctly implementing DOLs (and the wider MCA). We expect that the NHS and local authorities will continue to work closely together on this.

Authorizing a deprivation of liberty

The DOLs process for obtaining a standard authorization or urgent authorization can be used where individuals lacking capacity are deprived of their liberty in a hospital or care home.

The Court of Protection can also make an order authorizing a deprivation of liberty; this is the only route available for authorizing deprivation of liberty in domestic settings such as supported living arrangements. This route is also available for complex cases in hospital and/or care home settings.

Individuals may also be deprived of their liberty under the Mental Health Act if the requirements for detention under that Act are met.

Further information

In the first instance professionals should contact their organization's MCA DOLs lead for further information.

House of Lords Select Committee Report on Mental Capacity Act 2005[41]

The Select Committee put forward 39 Recommendations on the Mental Capacity Act which showed considerable concern about the DOLs regime and to which the Government responded.

Recommendation 13 Comprehensive review of DOLs legislation with a view to replacing it with provisions compatible in style and ethos with the MCA.

Recommendation 14 The independent body responsible for oversight and coordination of implementation of the MCA develop a comprehensive implementation action plan to accompany new legislation, in consultation with professionals, individuals, families and unpaid carers.

Recommendation 15 Replacement legislation provisions would make a clear link to the principles of the MCA to ensure consistency with the empowering ethos of the Act as a whole.

Recommendation 16 Replacement legislative provisions and associated forms are to be drafted in clear and simple terms to ensure that they can be understood and applied effectively by professionals, individuals, families and carers.

Recommendation 17 Better understanding of the purpose behind the safeguards is urgently required, and we recommend that achieving this be made a priority by the independent oversight body

Recommendation 18 Government consider how the role of the Relevant Person's Representative could be

strengthened in replacement legislative provisions to provide an effective safeguard.

Recommendation 19 Effective oversight of any future supervisory body function be provided in the replacement provisions for DOLs

Recommendation 20 Replacement legislative provisions extend to those accommodated in supported living arrangements.

Recommendation 21 A new Bournewood gap has been inadvertently created by the attempt to prevent an overlap with MHA we recommend that replacement legislative provisions close this gap.

Government Response to House of Lords Select Committee report[42]

Chapter 7 of the Govt response is on DOLs.

In general it accepted the recommendations of the House of Lords Report.

It is to consider the case for establishing a new independently chaired Mental Capacity Advisory Board.

It will ask the Law Commission to consult on and potentially draft a new legislative framework that would allow for authorization of a best interests deprivation of liberty in supported living arrangements. + It would consider any improvements that might be made to the Deprivation of Liberty Safeguards. (The Law Commission has accelerated its program and is to publish its draft by the end of 2016 instead of 2017.) In the short term the Association of Adult Directors of Social Care (ADASS) will lead a task group to consider the implications of the Supreme Court judgment on DOLs and the Government will commission a revision of the current standard forms that support the DOLs process.

A project to review the forms and make them less bureaucratic and cumbersome to be completed by November 2014.

Update to date guidance on case law to be completed by December 2014.

A new chapter in MHA Code of Practice has been added to explain the interface between deprivation of liberty under MCA and the MHA and which regime should be used (see Chapter 13 of this book).

Only the Court of Protection can authorize deprivation of liberty in supported living cases (DOLs only available for care homes and hospitals). New legislation is to be considered and the Law Commission has been asked to consult and draft. New legislation should be firmly rooted in the MCA.

The Government does not believe that there is a new Bournewood gap. If necessary the inherent jurisdiction of the court could provide any further authorization that may be required to deprive a patient detained under MHA of their liberty for medical treatment unrelated to the patient's mental disorder. Given the small number of cases in which this will arise, we do not propose to introduce legislative amendments.

Cases on specific issues

In the sixth ICSA report the case of DE and an NHS trust 2013[46] (Case Study 5.10) is discussed to show the importance of seeking evidence that all practicable steps have been taken to help people make their own decisions and for staff not just to seek a DOLs authorization but also to actively promote the liberty of people within care

Case Study 14.3 *Rochdale Metropolitan Borough Council* v. *KW and Others* [2014][43]

In this case Mostyn J took up some of the themes raised in the Chester and Surrey cases heard by the Supreme Court.

KW suffered brain damage after an operation 18 years before and was at the center of a test case about whether she was being deprived of her liberty in the course of receiving 24 h care. She was ambulant with the use of a wheeled Zimmer frame. Mentally she was trapped in the past and believed it was 1996 and that she was living at her old home with her three small children. The cost of her care was being met by Rochdale LA and by the local NHS clinical commissioning group. Lawyers for Rochdale argued that the high level of care received amounted to a deprivation of liberty. Judge Mostyn in the Court of Protection ruled that the care had not violated her liberty. He distinguished the situation of K from that of MIG's situation in the Chester and Surrey case.[44] K's ambulatory functions were poor and deteriorating whereas MIG had full motor functions. The second part of the acid test was not satisfied in K's case. "She 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." He also stated that if care had to be overseen by the judiciary it would create a huge burden on local authorities and courts. It would also affect tens, if not hundreds of thousands of similar cases. Mostyn J gave permission for the case to go to the Court of Appeal and hoped that it would be heard speedily and possibly permission would be granted to go to the Supreme Court. Mostyn agreed that there must be no discrimination against the disabled, but "For me, it is simply impossible to see how such protective measures can linguistically be characterised as a 'deprivation of liberty'. The protected person is, as Mill says, merely 'in a state to require being taken care of by others, [and] must be protected against their own actions as well as against external injury'." He realised that he had to follow the majority in Chester case even though he personally agreed with Parker and the Court of Appeal in the MIG and MEG and with the Court of Appeal in the Chester case.

Mostyn J wanted the matter to be reconsidered by the Supreme Court. He would have been prepared to grant a leapfrog application had that been possible, but Rochdale did not consent to a leapfrog certificate.

Subsequently the Court of Appeal upheld an appeal against Mostyn J's judgment (*KW and others v Rochdale Metropolitan BC* [2015] EWCA Civ 1054).

Case Study 14.4 *W City Council be Mrs L* [2015][45]

In another case of the definition of deprivation of liberty, Bodey J had to determine whether there was a deprivation of liberty where a 93-year-old lady with Alzheimer's dementia was deprived of her liberty in her home, where care and safety arrangements had been set up for her between her adult daughters and the LA. The LA contended that she was, but her daughter, L, acting as litigation friend that she was not. She had lived in the property for 35 years and the daughters had arranged a fence and two gates enclosing the garden which she could access when she wished. Sensors monitored if she were to leave the property at night and an alarm system would alert one of the daughters. Bodey J held that in viewing all the circumstances, not simply because she was living at home, she was not deprived of her liberty.

Case Study 14.5

Re UF [2013][47] raised the issue as to whether the mother could continue as litigation friend when there was a conflict of interest (Charles J concluded not and held that the Official Solicitor should act). It also raised the issue of non-means tested legal aid being available when the standard authorization was not in force. (This is considered in Chapter 17.)

Case Study 14.6 *TA* v. *AA Knowsley* [2013][48]

This case was concerned with the right to appeal to the Court of Appeal against a decision by a Court of Protection judge who refused permission to appeal. The Court of Appeal held that it did not have jurisdiction to hear the appeal: the intention of the MCA and CoP Rules is that the statutory right of appeal at all levels in the Court of Protection should be restricted by the requirement to obtain permission to appeal.

Case Study 14.7 *Somerset* v. *MK* [2014][49]

In this case there was a highly critical judgment of the LA in relation to the rights of P a young woman with severe learning disabilities and autism. A standards DOLs authorization was sought by the LA. HH Judge Marston criticized the actions of LA and stated that P was deprived of her liberty and there was a period when this was unlawful. He quoted from the Neary case[50] (Case Study 14.8) and said "These findings illustrate a blatant disregard of the process of the MCA and a failure to respect the rights of both P and her family under the ECHR. In fact it seems to me that it is worse than that, because here the workers on the ground did not just disregard the process of the MCA they did not know what the process was and no one higher up the structure seems to have advised them correctly about it."

The Official Solicitor intended to pursue a claim for damages for breach of P's rights under Articles 5, 6, and 8.

planning. The case is further discussed in Chapter 5 on best interests and male sterilization.

There are many other cases on Deprivation of Liberty Safeguards too numerous to discuss in detail here, but a short note of their rulings is given in the following. It is likely that if significant changes are made to DOLs as a result of the House of Lords Scrutiny committee recommendations and the Government response, many of these decisions will be superseded.

Case Study 14.8 *London Borough of Hillingdon* v. *Neary and another* [2011][51]

Steven Neary, who suffered from autism and severe learning disabilities, was taken into respite at the request of his father for a few days in December 2009. He remained there until December 2010 against both his and his father's wishes. The father and son contended that the LA's actions were unlawful. The LA claimed that initially the father had consented to the stay and thereafter Steven was kept in the home lawfully as a result of using Deprivation of Liberty Safeguards. Mr Justice Jackson held that the DOL authorizations relied upon flawed assessments. The LA had failed to accept the principle that all other things being equal Steven should have been cared for by his family, they had failed to appoint an independent mental capacity advocate speedily and had delayed in referring the matter to the Court of Protection. The LA therefore had breached Steven's rights under Articles 8, Article 5(1), and 5(4). Mr Justice Jackson held that "there is an obligation on the State to ensure that a person deprived of liberty is not only entitled but enabled to have the lawfulness of his detention reviewed speedily by a court."

Mr Justice Peter Jackson said at paragraph 33 that

> The DOL scheme is an important safeguard against arbitrary detention. Where stringent conditions are met it allows a managing authority to deprive a person of liberty at a particular place. It is not to be used by a local authority as a means of getting its own way on the question of whether it is in the person's best interests to be in that place at all. Using the DOL regime in that way turns the whole spirit of the MCA on its head, with a code designed to protect the liberty of vulnerable people being used instead as an instrument of confinement. In this case far from being a safeguard the way in which the DOL process was used to mask the real deprivation of liberty which was the refusal to allow Stephen to go home.

Case Study 14.9 *Re X and others (Deprivation of liberty)* [2014][52]

The President sought to set out a streamlined process to seek to enable the court to deal with deprivation of liberty cases in a timely, just, fair, and ECHR-compatible way. He set out 25 key questions and answers to form a standardized and so far as possible streamline process for the proper handling of DOLs cases.

The future

Increase in applications

It was reported in October 2014[61] that new figures released by the Health and Social Care Information

Case Study 14.10 *Westminster City Council* v. *Sykes* [2014][53]

This case involved MS's liberty, residence, and care. MS ("Ms S"), who was 89 years old and had dementia, was deprived of her liberty at QX Nursing Home by virtue of a standard authorization granted by her local authority under the Mental Capacity Act 2005. On numerous occasions, Ms S expressed the wish to return to her own home.

She had been subjected to several standard authorizations and the issue before the court was whether she should be able to return home even though the local authority would not be able to fund the package of 24 h care which she required and she did not have the means herself, nor children who could assist. District Judge Eldergill reviewed the legal position with regard to the six requirements and concluded that the only requirement over which there was any doubt was that relating to the best interests requirement. (His consideration of the eligibility requirement is considered on page 259.) His consideration of this is discussed in Chapter 5 on best interests (Case Study 5.23). The judge concluded that in his view it was in Ms S's best interests to attempt a one-month trial of home-based care.

Case Study 14.11 *GJ* v. *The Foundation Trust & Anor* [2009][54]

This was the first case to discuss DOLs. It was brought under s. 21A of the Mental Capacity Act 2005 (as amended by the Mental Health Act 2007) in respect of a standard authorization given under Schedule A1 to the MCA which authorizes "the detention of GJ in a hospital—for the purpose of giving him care or treatment—in circumstances that amount to a deprivation of liberty" (see paragraphs 1(2) and 2 of Schedule A1).

GJ had a diagnosis of vascular dementia and Korsakoff's syndrome and amnestic disease due to alcohol and suffered from mental disorder as defined in the Mental Health Act. He also had diabetes requiring insulin treatment and close monitoring.

Charles J reviewed the legal background and the provisions of the MCA since this was the first time the Deprivation of Liberty Safeguards had been considered by the court. He concluded that the standard authorizations only authorized GJ to be a person accommodated in hospital, in circumstances that amount to a deprivation of his liberty, for the purpose of him being given treatment for his diabetes and GJ was not within the scope of the MHA 1983.

Charles J stated that the MHA is to have primacy when it applies and that medical practitioners referred to in sections 2 and 3 of the MHA cannot pick and choose between the two statutory regimes of the MHA and MCA. He subsequently modified his views on the primacy of the MHA in the case of *AM* v. *South London and Maudsley NHS Foundation Trust* [2013][55] (Case Study 14.12).

Case Study 14.12 *AM* v. *South London & Maudsley NHS Foundation & Anor* [2013][56]

Charles J amended what he had said previously in *GJ* v. *The Foundation Trust & Anor* [2009][57] and emphasized that any analysis that is based on or includes the concept of primacy of the MHA in the sense used in paragraph 58 of *GJ* v. *Foundation Trust* (or any other sense) should be case specific. He acknowledged that the two statutory schemes were not always mutually exclusive. He applied a "but for" test. If the only reason for P's detention is for treatment of a physical disorder, then he was not ineligible to be placed under DOLs.

Case Study 14.13 *A County Council* v. *MB and Others* [2010] EWHC 2508 CoP

Extensive guidance was given by Charles J on the implementation of DOLs.

In this case the best interests assessor concluded that a deprivation of liberty was not in P's best interests but there appeared to be no suitable alternative to P's placement. The judgment is described by 39 Essex as essential reading for all best interests assessors and those involved in administering DOLs. The court granted a declaration that Mrs B had been unlawfully deprived of her liberty from the expiry of the standard authorization until the court declared the deprivation of liberty lawful at a subsequent hearing.

Centre reveal that 21 600 DOLs applications were made to 130 English Councils between April and June 2014. In 2013 the annual total was 12 400.

A post-legislative scrutiny by the Health Committee of the House of Commons[62] of the Mental Health Act 2007 found that the effective application of DOLs profoundly depressing and complacent and recommended that the DH initiated an urgent review of the implementation of DOLs. The Government responded in October 2013.[63] It would work through a newly set up Mental Capacity

Case Study 14.14 *AJ* v. *A Local Authority* [2015] EWCOP 5

Baker J gave detailed guidance for local authorities to ensure that those deprived of their liberty in care homes are afforded effective access to the CoP to secure their rights under Article 5. The facts of the case were that AJ an elderly lady lived in an annex to the house of her niece and her husband Mr C. AJ developed vascular dementia and was dependent upon Mrs C. They wished to go on holiday and AJ was taken to X house with a view to her living there permanently. She objected to being there and wished to return home. Mr C was appointed RPR. AJ was moved to Y house and stayed there under several standard authorizations.

Mr R was appointed IMCA. Lack of communication between Mr R and Mr C led to no legal challenge to the standard authorization. Mr R eventually made a S 21A application on her behalf and Mr R was replaced by the Official Solicitor as AJ's litigation friend. The OS raised concerns about the care plan not reflecting the type and degree of physical interventions being used, made a claim under Section 7 of the Human Rights Act that articles 5(4) and 8 had been breached. Baker J held that Mr C should not have been appointed RPR and the LA should have acted earlier when it was clear that AJ was protesting about her loss of liberty. The appointment of an IMCA did not relieve the LA of further responsibility.

He laid down eight stages which the LA should follow. They are (in summary):

1. Plan ahead for the necessity for DOLs.
2. Be aware of respite care where the intention is actually for permanent placement and give proper consideration to Article 5 rights.
3. The best interests assessor should ensure that an RPR is appointed only after consideration of the criteria for the appointment (Regulation 3 MCA Regs 2008) and that the duties (under Schedule A1 Para 140) will be complied with.
4. The LA should also check on stage 3 before the appointment of RPR.
5. LA and best interests assessors should be aware of a possible conflict were a close relative or friend favoring a move to residential care to be chosen as RPR was unlikely to challenge the authorization.
6. IMCA must act speedily to ensure any challenge to authorization was brought before the courts.
7. LA still had responsibility to protect P's Article 5 rights even if an RPR or IMCA were appointed.
8. Where RPR or IMCA had failed to take sufficient steps to challenge authorization, then LA should consider bringing matter before the court itself.

> **Case Study 14.15** *Re X No 1 and No 2* [2014][58]
>
> An attempt by the President of the Court of Protection Munby L J to speed up the process of hearing the vast increase in numbers of cases relating to deprivation of liberty in assisted accommodation and at home by suggesting that P need not be present at the hearing but should be consulted was thwarted by the Court of Appeal which held that while his decision could not be appealed against it was a principle of domestic law and of the Human Rights Convention that P is a party to proceedings relating to deprivation of liberty.[59] New practice directions have been introduced as a consequence of the Cheshire case and are considered previously.

> **Case Study 14.16** *Milton Keynes Council* v. *RR and SS and TT Ors* [2014] EWCOP B19.[60]
>
> RR, an 81-year-old woman with vascular dementia, was removed from her home (to which her son SS and her companion TT had moved to care for her) because of safeguarding alerts about a physical injury. The LA did not receive authorization till 2 weeks later. The CoP held that she had been unlawfully removed and detained.

Act Steering Group to review DOLs and support improvements in their use. It has revised the Code for Practice for the MHA 1983 Act which includes guidance on the interface between the 1983 Act, the Mental Capacity Act 2005, and DOLs. It concluded that it will feed consideration of all the recommendations into future work programs in particular the revision of the Code.

In June 2015 the House of Commons was told by Alistair Burt the Minister for Community and Social Care that the Law Commission's Review of the legislation underpinning the Deprivation of Liberty Safeguards was to be accelerated. The Law Commission had agreed to publish its draft by the end of 2016 instead of 2017 as originally agreed. The Minister stated that work was in hand to reduce the number of application forms from 32 to 13, that the law Society was producing guidance to assist in identifying a true deprivation of liberty, and that an extra £25 million for LAs had been announced. The debate had been called by Ann Coffey MP who wanted to highlight "an expensive bureaucratic nightmare" which was engulfing councils up and down the country.

Conclusions

Even though the review of legislation by the Law Commission has been accelerated, there is unlikely to be any major legislative changes to DOLs until 2017 and in the meantime, judges, lawyers, supervisory bodies, health and social services providers, and informal carers will have to work hard to understand the complexities of the current law and ensure that DOLs are used effectively to safeguard the human rights of those in hospital and care homes. In addition the human rights of those in assisted living accommodation should also be protected. The CQC has stated that it would not unfairly punish providers for technical breaches in failing to meet the 21-day legal framework for processing DOLs applications because of the increase in the number of applications. However the CQC stated that a do-nothing approach by providers was unacceptable and they must have in place a plan for ensuring DOLs assessments are made in a timely manner. Concern was also expressed in Parliament about the implications of instructions from the Coroner that deaths, even natural deaths, of those subject to DOLs should be reported to the coroner since they should be treated as deaths in custody. Significant changes to DOLs are likely to be in place by the end of 2017.

Quick fire quiz, QFQ14

1. In what circumstances would a care home manager apply for authority to deprive a person of his or her liberty?
2. Who is the relevant authority to whom the application has to be made?
3. What assessments will be required?
4. Does an independent mental capacity advocate have to be appointed?
5. When is a person not eligible to be detained under a DOLs authorization?
6. How long does a standard authorization last?

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CHAPTER 15

Organ and tissue removal, storage, and use

THIS CHAPTER CONSIDERS THE FOLLOWING TOPICS

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Introduction

Specific protections are provided for those adults incapable of giving consent to the removal and subsequent use of their tissue or organs by the Mental Capacity Act (MCA) 2005 and the Human Tissue Act (HTA) 2004 and regulations[1] made under that legislation.

Removal of tissue from deceased persons

The HTA 2004 applies to this situation.

Where a person has died and has not given instructions relating to the removal of tissue or organs from his or her body after his death, then the provisions of the HTA apply. Guidance is provided by the Codes of Practice issued by the Human Tissue Authority (see section "Code of Practice issued by the Human Tissue Authority"). The legality of the removal, use, and storage of the tissue depends upon the reasons why it is required. No consent of relatives is required when a postmortem is ordered by a coroner and tissue is removed as a consequence of the postmortem. However there are now strict rules relating to the storage and retention of the tissue, once the postmortem is completed.

Consent is required for:

- The continued storage or use of material no longer required to be kept for the coroner's purposes
- The removal, storage, and use for the following scheduled purposes:
  Anatomical examination
  Determining the cause of death
  Establishing, after a person's death, the efficacy of any drug or other treatment administered to them
  Obtaining scientific or medical information, about a living or deceased person, which may be relevant to any other person now or in the future ('a future person')
  Public display
  Research in connection with disorders, or the functioning, of the human body

Legal Aspects of Mental Capacity: A Practical Guide for Health and Social Care Professionals, Second Edition. Bridgit Dimond.
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Transplantation
Clinical audit
Education or training relating to human health
Performance assessment
Public health monitoring
Quality assurance.

Where the deceased person did not give consent pre-death to any of these purposes or was incapable of giving consent, then consent can be given firstly by a person nominated by the deceased for that purpose. If there is no such person, then consent can be given by a relative. The HTA sets out a hierarchy of relatives:

- Spouse or partner (including civil or same-sex partner)
- Parent or child (in this context a *child* can be any age)
- Brother or sister
- Grandparent or grandchild
- Niece or nephew
- Stepfather or stepmother
- Half-brother or half-sister
- Friend of long standing

It is to be noted that S.54(9) states for these purposes a person is another person's partner if the two of them (whether of different sexes or the same sex) live as partners in an enduring family relationship.

Consent is not required for:

- Carrying out an investigation into the cause of death under the authority of a coroner
- Keeping material after a postmortem under the authority of a coroner
- Keeping material in connection with a criminal investigation or following a criminal conviction

Removal of tissue from living persons

If tissue needs to be removed for diagnostic or treatment purposes, it can only be done with the consent of that person or, where the person lacks the capacity to give the necessary consent, within the provisions of the MCA 2005. This means that the health professional, having a reasonable belief in the absence of the requisite capacity, must have a reasonable belief that the removal of the tissue is in the best interests of P according to the criteria laid down in Section 4 (see Chapter 5). Scenario 15.1 provides an example. If the removal is required in the course of intrusive research, then either the individual must have the requisite capacity to give consent or, if he or she lacks the capacity, will be protected by Sections 30–34 of the MCA 2005 which govern participation in intrusive research or by the clinical trials regulations (see Chapter 10 and the scenarios in that chapter).

> **Scenario 15.1** Removal of tissue for diagnostic purposes.
>
> Rachel has severe learning disabilities and it is feared that she may be suffering from breast cancer. The doctor recommends that she should have a biopsy taken to determine whether it is malignant. Rachel is incapable of giving consent to the operation.

Removal of tissue for diagnostic purposes

In Scenario 15.1 the MCA 2005 applies to the taking of the biopsy. It may come under the definition of serious medical treatment (see Chapter 5), and if there is no family member or friend who could be consulted over Rachel's best interests, an independent mental capacity advocate (IMCA) would be appointed to support Rachel and provide a report on what is in her best interests (see Chapter 8). Only if there were an appropriate person who could be consulted, or if it were an emergency situation and there was no time for the appointment of an IMCA, could the requirement to appoint an IMCA be dispensed with.

Storage and use of tissue removed from living persons

Scheduled purposes (see Statute Box 15.1)

The HTA 2004 covers the situation where storage and use of tissue removed from living persons arise and distinguishes between scheduled purposes where consent is required (or there are specific provisions where a person is incapable of giving consent) and other purposes where consent is not required. The definition of scheduled purposes is contained in Schedule 1 of the HTA 2004 and is shown in Statute Box 15.1.

Where a person lacks the specific capacity to give consent to the storage and use of tissue for the purposes set

Statute Box 15.1 Schedule 1 to the Human Tissue Act 2004.

Specified purposes requiring consent: general

1. Anatomical examination.
2. Determining the cause of death.
3. Establishing after a person's death the efficacy of any drug or other treatment administered to him.
4. Obtaining scientific or medical information about a living or deceased person which may be relevant to any other person (including a future person).
5. Public display.
6. Research in connection with disorders, or the functioning, of the human body.
7. Transplantation.

Statute Box 15.2 Section 6 of Human Tissue Act 2004 (simplified).

Where—

a) an activity for the storage and use of material from a body of a person who
 i) is an adult, and
 ii) lacks capacity to consent to the activity, and

b) neither a decision of his to consent to the activity, nor a decision of his not to consent to it, is in force,

there shall for the purposes of this Part be deemed to be consent of his to the activity if it is done in circumstances of a kind specified by regulations made by the Secretary of State. (Regulations came into force on September 1, 2006.[2])

Scenario 15.2 Storage and use of tissue for a scheduled purpose.

On the facts of Scenario 15.1, medical staff asked if they could store the biopsy taken from Rachel and use it for clinical and research purposes. What are the legal requirements?

out in Statue Box 15.1, then the provisions of Section 6 of the HTA 2004 apply. Section 6 is shown in a simplified format in Statute Box 15.2. Scenario 15.2 illustrates a situation involving the storage and use of tissue for a scheduled purpose.

In Scenario 15.2, the storage and use of the tissue taken for the biopsy would come under the provisions of the HTA 2004. This storage and use would come under the regulations for persons who lack capacity to

Statute Box 15.3 Ethically approved research.

The circumstances required by Regulation 8 are that:

- the research is in connection with disorders, or the functioning of the human body,
- there are reasonable grounds for believing that research of comparable effectiveness cannot be carried out if the research has to be confined to, or related only to, persons who have capacity to consent to taking part in it, and
- there are reasonable grounds for believing that research of comparable effectiveness cannot be carried out in circumstances such that the person carrying out the research is not in possession, and not likely to come into possession, of information from which the person from whose body the defined material has come can be identified.

give consent which came into force on September 1, 2006.[3] Regulation 3 provides for the storage and use of materials from adults who lack the capacity to give consent. The purposes for which it permits tissue to be stored and used without the consent of an adult lacking mental capacity include:

> Obtaining scientific or medical information about a living or deceased person which may be relevant to any other person (including a future person) if it is reasonably believed to be in P's best interests or its use for research purposes.

Further information would be required as to exactly what the doctors wish to do with the tissue. If the purpose is research which had begun before the research provisions of the MCA came into force, and the research is ethically approved according to Regulation 8 (see Statute Box 15.3), then its storage and use would appear to be legitimate and covered by the regulations.

An example of the workings of Regulation 8 is shown in Scenario 15.3 on page 283.

Brian has to obtain the consent of the research ethics committee (REC) to undertaking the research in accordance with Regulation 8.[4] Statute Box 15.3 sets out the wording of Regulation 8. The REC must have approved the research in the following circumstances:

- The research is in connection with disorders, or the functioning of the human body. This condition is satisfied since Alzheimer's disease is a disorder of the human body.
- There are reasonable grounds for believing that research of comparable effectiveness cannot be carried out if the

> **Scenario 15.3** An example of the workings of Regulation 8.
>
> Ruth has had Alzheimer's for over 15 years and is being cared for in a nursing home. Brian, a researcher into the chemistry of those suffering from Alzheimer's, is conducting research to ascertain if the disease can be accounted for by excess protein in the body. He therefore puts proposals before the research ethics committee to obtain approval for carrying out his research on those who suffer from Alzheimer's. He then approaches the manager of the nursing home to obtain consent for the taking of a blood sample from Ruth. What is the law?

research has to be confined to, or related only to, persons who have capacity to consent to taking part in it. This condition is also satisfied, since most people with Alzheimer's disease would not be able to consent.

- There are reasonable grounds for believing that research of comparable effectiveness cannot be carried out in circumstances such that the person carrying out the research is not in possession, and not likely to come into possession, of information from which the person whose body the defined material has come can be identified.

These conditions must apply to Ruth before the research can be deemed to come within the regulations and therefore be permissible.

Regulations for persons who lack capacity to give consent and transplant regulations came into force on September 1, 2006.[5] Regulation 3 provides for the storage and use of materials from adults who lack the capacity to give consent. It permits tissue to be stored and used without the consent of an adult lacking mental capacity if it is for:

1. Obtaining scientific or medical information about a living or deceased person which may be relevant to any other person (including a future person) if it is reasonably believed to be in P's best interests.
2. Transplantation if in P's best interests.
3. A clinical trial which is authorized and conducted in accordance with the clinical trials regulations.
4. Intrusive research and complies with S. 30(1)(a) and (b) of the MCA (i.e., it is authorized by an appropriate body and complies with Sections 32 and 33 of the MCA—see Chapter 10).
5. A situation where P lost capacity after the research had commenced and S.34 of the MCA applies (see Chapter 10).
6. A situation where the research began before the research provisions of the MCA came into force and is ethically approved according to Regulation 8 (see Statute Box 15.3).

Code of Practice issued by the Human Tissue Authority

The Code of Practice on consent in relation to the HTA[6] issued by the Human Tissue Authority gives guidance in relation to the use of human tissue taken from adults who are incapable of consent. It emphasizes the importance of presuming that the adult is capable of giving consent and encouraging the person to understand the decision to be made:

> 38. The ability of adults with learning difficulties, or with limited capacity, to understand should not be underestimated. Where appropriate, someone who knows the individual well, such as a family member or carer, should be consulted as he/she may be able to advise or assist with communication.

It also points out that the storage and the use of tissue outside the provisions of the HTA 2004 and the regulations may be a criminal offence.

Additional Codes of Practice on various topics have been published including "Donation of solid organs for transplantation" (Code of Practice No. 2), "Disposal of human tissue" (Code of Practice No. 5), "Donation of allogeneic bone marrow and peripheral blood stem cells for transplantation" (Code of Practice No. 6), and "Research" (Code of Practice No. 9). All are available online from the Human Tissue Authority website.[7] All the codes were updated in 2014.

Specified purposes not requiring consent

Under Section 1(10) of the HTA, the following activities are lawful, and consent is not required for the storage for use and the use from living persons for the following purposes:

- Clinical audit
- Education or training relating to human health (including training for research into disorders, or the functioning, of the human body)

- Performance assessment
- Public health monitoring
- Quality assurance

Exceptions to the licensing regulations

Regulations came into force in September 2006[8] which define research as ethically approved where it is approved by a research ethics authority. They also except from licensing requirements the storage of relevant material by a person who intends to use it for a scheduled purpose in the following circumstances:

A Where it is to be used for any purpose specified in paragraphs 2–5 or 8–12 of Part 1 of Schedule 1 to the Act (i.e. determining the cause of death, establishing after a person's death the efficacy of any drug or treatment administered to him, obtaining information which may be relevant to another person, public display, clinical audit, education or the purpose of qualifying research)

B Storage of relevant material is excepted where:
  - **i)** The person storing it is intending to use it for the purpose of transplantation.
  - **ii)** It is an organ or part of an organ and the storage period is of less than 48 h.

C Storage of relevant material from the body of a deceased person is excepted where:
  - **i)** It is for the purpose of research.
  - **ii)** The relevant material has come from premises in respect of which a license is in force and is stored by a person intending to use it for the sole purpose of analysis for a scheduled purpose other than research.
  - **iii)** It will be returned to premises in respect of which a license is in force when the analysis is completed.

Analysis of DNA (Regulation 5)

Where a person lacks capacity to consent to analysis of his DNA, the purposes for which his DNA may be analyzed are shown in Statute Box 15.4.

A situation involving the analysis of DNA is shown in Scenario 15.4

In Chapter 7 the case of *LG* v. *DK* [2011][9] is discussed. In this case the court had to determine whether it was in the interests of P to have a paternity test and held that the court had jurisdiction under section 21(4) of the Family Law Reform Act 1969 not under the MCA. This section enables a bodily sample to be taken from a person who lacked capacity (as defined in the MCA) to give consent, if the court gave consent in a direction under Section 20 or by a donee under a LPA or by a deputy with power to that effect.

Statute Box 15.4 Analysis of DNA (Regulation 5).

Analysis of the DNA of a person incapable of consenting is permitted for the following purposes:

a) any purpose which the person carrying out the analysis reasonably believes to be in P's best interests;
b) the purposes of a clinical trial which is authorised and conducted in accordance with the clinical trial regulations;
c) the purposes of intrusive research which is carried out on or after the relevant commencement date in accordance with the requirements of Section 30(1)(a) and (b) of the Mental Capacity Act 2005 (approval by appropriate body) and compliance with Sections 32 and 33 of that Act (see Chapter 10);
d) the purposes of intrusive research—
  - **a)** which is carried out on or after the relevant commencement date
  - **b)** in relation to which Section 34 of the Mental Capacity Act 2005 (loss of capacity during research project) applies, and
  - **c)** which is carried out in accordance with regulations made under section 34(2) of that Act; (see Chapter 10) or

e) research which is carried out before the relevant commencement date and which, before that date, is ethically approved within the meaning of regulation 8 (see Statute Box 15.3).

Scenario 15.4 An example of the analysis of deoxyribonucleic acid (DNA) and Regulation 5.

There is a dispute over the paternity of Elizabeth, who suffered severe brain damage at birth as a result of negligence by midwifery and obstetric staff. She was awarded compensation of £3 million. Her mother is in dispute with two men, both of whom claim to be the father of Elizabeth. The Social Services Department believes that there should be a DNA test to identify which of the two is the father of Elizabeth. Elizabeth is unable to consent to the DNA test. What is the law?

Scenario 15.4 comes under the HTA 2004 and the regulations made under that Act.[10] Regulation 5 permits the DNA of a person incapable of giving consent to be analyzed if one of the reasons is "any purpose which the person carrying out the analysis reasonably believes to be in P's best interests." If it is considered to be in Elizabeth's best interests for the DNA to be analyzed, then permission can be given. This should clearly be documented. If there is a dispute as to whether it is in Elizabeth's best interests for the DNA to be analyzed, then an order of the court could be sought, and if the court determined an analysis of DNA was in her best interests, consent would not be required, since a court order is an *excepted* purpose.

Exceptions to the consent provisions and the analysis of DNA

An offence is not committed under this section if the results of the analysis are to be used for *excepted* purposes. *Excepted* purposes include:

- Medical diagnosis of that person
- Coroner's purposes
- Criminal investigation or prosecution
- National security
- Court order
- Clinical audit, education and training, etc.
- Research, provided the sample is anonymized and the research is REC approved

Transplants and the mentally incapacitated adult

Section 33 of the HTA 2004 makes it a criminal offence to remove any transplantable material from the body of a living person intending that the material be used for the purpose of transplantation. However in certain circumstances approval can be given by the Human Tissue Authority to the transplantation of organs (or part of organs), bone marrow, and peripheral blood stem cells. Regulations drawn up under the HTA specify the conditions which must be satisfied. Regulation 11 specifies the circumstances in which the restriction on transplants involving a live donor is lifted. The regulation is shown in Statute Box 15.5.

Statute Box 15.5 Regulation 11. Cases in which restrictions on transplants involving a live donor are lifted.

1 Sections 33(1) and (2) of the HTA (offences relating to transplants involving a live donor) shall not apply in any case involving transplantable material from the body of a living person if the requirements of paragraph 2–6 are met.

2 A registered medical practitioner who has clinical responsibility for the donor must have caused the matter to be referred to the Authority.

3 The Authority must be satisfied that:
- **a)** no reward has been or is to be given in contravention of section 32 of the Act (prohibition of commercial dealings in human material for transplantation), and
- **b)** when the transplantable material is removed—
  - **i)** consent for its removal for the purpose of transplantation has been given, or
  - **ii)** its removal for that purpose is otherwise lawful.

4 The Authority must take the report referred to in paragraph 6 into account in making its decision under paragraph 3.

5 The authority shall give notice of its decision under paragraph 3 to:
- **a)** the donor of the transplantable material or any person acting on his behalf
- **b)** the person to whom it is proposed to transplant the transplantable material ('the recipient'), or any person acting on his behalf, and
- **c)** the registered medical practitioner who caused the matter to be referred to the Authority under paragraph 2.

6 Subject to paragraph 7 one or more qualified persons must have conducted separate interviews with each of the following:
- **a)** the donor
- **b)** if different from the donor, the person giving consent, and
- **c)** the recipient,

and reported to the Authority on the matters specified in paragraphs (8) and (9).

7 Paragraph 6 does not apply in any case where the removal of the transplantable material for the purpose of transplantation is authorised by an order made in any legal proceedings before a court.

8 The matters that must be covered in the report of each interview under paragraph (6) are:
- **a)** any evidence of duress or coercion affecting the decision to give consent,
- **b)** any evidence of an offer of a reward, and
- **c)** any difficulties of communication with the person interviewed and an explanation of how those difficulties were overcome.

9 The following matters must be covered in the report of the interview with the donor and, where relevant, the other person giving consent:

a) the information given to the person interviewed as to the nature of the medical procedure for, and the risk involved in, the removal of the transplantable material,

b) the full name of the person who gave that information and his qualification to give it, and

c) the capacity of the person interviewed to understand:

i) the nature of the medical procedure and the risk involved, and

ii) that the consent may be withdrawn at any time before the removal of the transplantable material.

10 A person shall be taken to be qualified to conduct an interview under paragraph 6 if—

a) he appears to the Authority to be suitably qualified to conduct the interview,

b) he does not have any connection with any of the persons to be interviewed, or with a person who stands in a qualifying relationship to any of those persons, which the Authority considers to be of a kind that might raise doubts about his ability to act impartially, and

c) in the case of an interview with the donor or other person giving consent, he is not the person who gave the information referred to in paragraph (9)(a).

The operation of Regulation 11 and the donation of a transplant by a person lacking mental capacity are shown in Scenario 15.5 on page 287.

Under Regulation 12 the Authority's decision as to the matters specified in Regulation 11(3) are to be made by a panel of no fewer than three members of the Authority, when the donor of the transplantable material is an adult who lacks capacity to consent to removal of the material, and the material is an organ or part of an organ if it is to be used for the same purpose as an entire organ in the human body.

The Authority has the right to reconsider its decision if it is satisfied that any information given for the purpose of the decision was in any material respect false or misleading or there has been any material change of circumstances since the decision was made. The doctor who referred the case to the Human Tissue Authority and the donor or recipient also have the right to require the HTA to reconsider any decision it has made (Regulation 13).

Information to be provided by a person who has removed transplantable material from a human body

Under regulations[11] which came into force in September 2006, a person who has removed transplantable material from a human body to be transplanted to another person must supply to NHS Blood and Transplant (a special health authority established by SI 2005 No 2529) the information set out in Schedule 1 to the regulations (this includes information about the removal of the transplantable material and the donor). Under the same regulations, a medical practitioner who receives transplantable material must supply to NHS Blood and Transplant the information set out in Schedule 2 to the regulations (this includes information about the receipt and the transplantable material).

Best interests and organ donation

Earl Howe in the House of Lords was anxious to prevent it being possible for the doctor of a client/patient to be allowed to agree to organ or tissue donation in his or her best interests[12]:

> Removing an organ, bone marrow or any other sort of tissue from a patient, whether mentally incapacitated or not, is an invasive process which is not without some risk. One cannot say that it will provide direct therapeutic benefit to the patient, although it is certainly possible to argue that looked at in a wider context it is in the person's best interests for the tissue to be removed. Indirectly, it may be of huge value to the person that a close relative, for example, will be given the chance of therapeutic treatment by virtue of such a transplant—a relative who may also be a carer, say.
>
> There are all kinds of scenarios that one can imagine in which the best interests of the person are best served by permitting the donation of tissue. But I am uncomfortable with the thought that a doctor, acting jointly with a relative or attorney, might take such a decision on his or her own.

Earl Howe's concerns are answered by the provisions in the MCA and in the HTA and the regulations made under it and the functions of the Human Tissue Authority. Clearly the principles of the MCA, the definitions of mental capacity, and the criteria for determining best interests must all be applied in determining whether it is in the best interests of a person lacking the requisite

Case Study 15.1 Best interests and bone marrow donation. *Re Y* [1997].[13]

The claimant, aged 36 years, sought a declaration from the court that two preliminary blood tests and a conventional bone marrow harvesting operation under general anesthetic could be lawfully taken from and performed upon her sister Y. The facts were that the applicant was suffering from a preleukemic bone marrow disorder. She had undergone extensive chemotherapy and a blood stem cell transplant. She had started to deteriorate and was likely to progress to acute myeloid leukemia over the next three months. Her only realistic prospect of recovery was a bone marrow transplant operation from a healthy compatible donor. Preliminary investigations suggested that Y her sister would be a suitable donor. Y was 25 years and severely mentally and physically handicapped. She had lived in a community home for 8 years. She was incapable of giving consent to the donation of bone marrow. The court had to decide whether it was in the best interests of Y for a declaration to be made for the blood tests and the bone marrow harvesting to take place.

capacity to become an organ or tissue donor (see Scenario 15.1 and Case Study 15.1). The difficulties of determining what is in the best interests of a person who has never had mental capacity are illustrated in the case shown in Case Study 15.1.

The judge made it clear that it was the best interests of Y which were in dispute. The best interests of the sister were not relevant save in so far as they served the best interests of Y. The judge argued as follows: if the sister did not have the bone marrow transplant, she would die. This would be a devastating blow to her mother, who suffered from ill health. They were a very close family. The mother would find it more difficult to visit Y in the community home, especially as, after the death of Y's sister, the mother would then have to look after her only grandchild. Y would suffer as a result of the lack of contact with her mother. The risk of harm to Y from the blood tests was negligible. Although a general anesthetic posed some risk, it was a low risk. She had already had a general anesthetic for a hysterectomy without any apparent adverse ill effects. The bone marrow would regenerate. It was to Y's emotional, psychological, and social benefit for her to be a donor.

It would, therefore, be in the best interests of Y for her to have the blood tests and be a donor for her sister. Clearly it was essential that in determining best interests there would have to be consultation with the carers and the wider family and her closeness to her sister would have to be determined. It would also have to be decided as to whether it was likely that she would wish to help her sister by the donation of tissue to her. The judge applied a best interests test to the decision making, taking into account what she would probably have wanted had she been able to make the decision.

There are dangers that a case such as that of *Re Y* could start a slippery slope. If bone marrow is justified, why not a kidney? It would be morally unacceptable for our community homes for those with learning disabilities to be seen as the source of spare parts and organ donations. Yet in an American case decided before *Re Y*, it was held that a mentally handicapped patient could be a live kidney donor for his brother.[14] It is to prevent any such slippery slope that there are now tighter precautions to protect those who are incapable of giving consent to transplantation.

Present procedure

The case in Case Study 15.1 was decided before the HTA 2004 and the MCA 2005 were enacted and was decided upon principles of the common law. However if the same issue was to arise after the HTA, while the actual proceedings would now be according to the new procedures, the actual decision would probably not be different. Scenario 15.5 looks at the situation under the HTA 2004 and the regulations made under that Act.

Since Julie lacks the capacity to give consent, then she is protected by the regulations issued under the Human Tissue Act (HTA). The Code of Practice No. 6, "Donation of allogeneic bone marrow and peripheral blood stem cells for transplantation,"[16] notes that mental capacity for an adult to give consent is determined by the provisions of the MCA and the best interests assessment:

Scenario 15.5 A request to use P as a transplant donor under Regulations 9–14 of the regulations.[15]

A request has been made to use the bone marrow of Julie, a person with severe learning and physical disabilities, for a transplant for her sister who has leukemia. Julie is incapable of giving consent to the transplant.

> Any decision to proceed with the removal of bone marrow or PBSC for donation from an adult who lacks capacity should therefore be governed by a test of best interests. Prior to any HTA assessment or medical procedure being undertaken, the case must be referred to a court for a ruling on whether the proposed intervention is lawful. This decision will be made on the basis of the potential donor's best interests. [Para 98]
>
> Where court approval has been obtained and the proposed intervention is deemed to be in best interests of the donor, consent to storage and use for transplantation may then be given by the person acting on the donor's behalf. The case will then be referred to the HTA for approval. [Para 99]

Appendix A of the Code provides more detailed guidance on requirements for court approvals, including guidance on the process through which an application to a court is made.

Donation of an organ or part organ

If the Scenario in 15.5 related to the donation of an organ, then the Code of Practice on transplants published by the HTA[17] provides guidance:

> 52. Where an adult lacks the capacity to consent to the removal of an organ or part organ, the case must be referred to a court for a declaration that the removal would be lawful. Donation may then only proceed if court approval has been obtained and following court approval the case is referred to, and approved by, an HTA panel.

As a consequence of the regulations governing the use of tissue from persons who lack the capacity to give consent,[18] the procedure specified in Regulation 11 would have to be followed both in Scenario 15.5 and in a situation where an organ donation was being considered. Regulation 11 requires the Human Tissue Authority to ensure that following referral to the HTA by a registered medical practitioner having clinical responsibility for the donor:

- No reward has been or is to be given in contravention of Section 32 of the HTA 2004.
- Either consent has been given or the removal is lawful, that is, has been approved by the court.
- A report has been provided by a qualified person who has conducted interviews with the donor, the person giving consent and the recipient, and the Authority takes this report into account. The report must cover any evidence of coercion or an offer of reward, any difficulties of communication, and how these were overcome. In addition the report must also include details of the information given to the person who was interviewed on the risks involved, the full name of that person, and the capacity of that person to understand the nature of the medical procedure and the risk involved

There must be at least three members of the Authority on a panel considering a case where the donor of the transplantable material lacks the capacity to give consent (Regulation 12(1) and (3)).

Under Regulation 13 there is a right to seek reconsideration of the decision by the Authority made under Regulation 11(3) if it is satisfied that any information given for the purpose of the decision was in any material respect false or misleading or there has been any material change of circumstances since the decision was made. Specified persons who can seek a reconsideration of the decision include the donor of the transplantable material, or any person acting on his or her behalf, the recipient of the material, or any person acting on his behalf, and the registered medical practitioner who caused the matter to be referred to the Authority under Regulation 11(2). Regulation 14 lays down the procedure to be followed on reconsideration of the decision.

Conclusion

The combined provisions of the HTA 2004 and the MCA 2005 should give effective protection to those lacking the requisite mental capacity where organ and tissue removal, storage, and use are concerned. The Human Tissue Authority as regulator has the responsibility for ensuring that those lacking the requisite capacity to consent to organ and tissue donation are protected. It published freedom of information requests, financial information, its policies, lists of license holders, and the reports of inspections together with Codes of Practice.

Quick-fire quiz, QFQ15

1 Is consent required for the investigation of the cause of a death under a coroner's investigation?

2 For what purposes can tissue be stored and used without the consent of an adult lacking mental capacity?

3 What is meant by *ethical research*? (See Regulation 8.)

4 In what circumstances can the DNA of a person who lacks the requisite capacity to give consent be analyzed?

5 Kate, who has severe learning disabilities and lives in a care home, requires a biopsy to be carried out to determine whether she has breast cancer. She is incapable of giving consent. Who would give consent on her behalf?

6 James appears to be a compatible donor of bone marrow for his brother who has leukemia. James lacks the requisite capacity to give consent to the donation. What is the legal situation?

References

1 Human Tissue Act 2004 (Persons who Lack Capacity to Consent and Transplants) Regulations 2006 (SI 2006/1659).
2 *ibid*.
3 *ibid*.
4 *ibid*.
5 *ibid*.
6 Human Tissue Authority (2006 updated in 2014). Code of Practice on consent.
7 www.hta.gov.uk
8 Human Tissue Act 2004 (Ethical Approval, Exceptions from Licensing and Supply of Information about Transplants) Regulations (SI 2006/1260) as amended by SI 2008/3067.
9 *LG* v. *DK* [2011] EWHC 2453.
10 Human Tissue Act 2004 (Persons who Lack Capacity to Consent and Transplants) Regulations 2006 (SI 2006/1659).
11 Human Tissue Act 2004 (Ethical Approval, Exceptions from Licensing and Supply of Information about Transplants) Regulations (SI 2006/1260) as amended by SI 2008/3067.
12 House of Lords, January 25, 2005, Column 1239.
13 *Re Y (adult patient) (transplant: bone marrow)* [1997] Fam 110; [1997] 2 WLR 556.
14 *Strunk* v. *Strunk* (1996) 445 SW 2d 145 (Ky CA).
15 Human Tissue Act 2004 (Persons who Lack Capacity to Consent and Transplants) Regulations 2006 (SI 2006/1659).
16 Human Tissue Authority Code of Practice no 6 on the Donation of allogeneic bone marrow and peripheral blood stem cells for transplantation 2014.
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18 Human Tissue Act 2004 (Persons who Lack Capacity to Consent and Transplants) Regulations 2006 SI 2006/1659.

CHAPTER 16
The informal carer

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Introduction

It is probable that the majority of adults who lack the mental capacity to make specific decisions are cared for by family and friends rather than by paid care assistants or registered health and social services professionals. The question arises as to how much of the mental capacity legislation applies to the informal carer and to what extent it affects their duties and responsibilities and their accountability for their actions or omissions. A useful guide to the role of the informal carer has been published by the Office of the Public Guardian (OPG).[1] It provides a general outline of the Mental Capacity Act (MCA), explains mental capacity, and covers the key principles and other areas in which it is useful for the unpaid carer to be aware of.

Definition

The informal carer is the person close to the individual lacking mental capacity (P) who cares for, lives with, or in some way takes responsibility for P. By definition this person is not paid, nor are they acting in a professional capacity toward P. Informal carers may include close friends, family members, neighbors, or others who provide continuous or intermittent care for P. There is no statutory definition of an informal carer in the MCA

Legal Aspects of Mental Capacity: A Practical Guide for Health and Social Care Professionals, Second Edition. Bridgit Dimond.

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2005, so where this question arose reference could be made to earlier legislation such as the Carers (Recognition and Services) Act 1995 and the Carers and Disabled Children Act 2000. The Carers (Recognition and Services) Act 1995 defines a carer as "an individual who provides or intends to provide a substantial amount of care on a regular basis for the relevant person" (S.1(1)(b)), and this same definition is used in the Carers and Disabled Children Act 2000 where the individual is over 16 years and provides a substantial amount of care on a regular basis for another individual aged 18 or over (S.1(1)(a)). Under Section 13(6) of the Care Act 2014, a *carer* means an adult who provides or intends to provide care for another person. Section 44 of the MCA creates a new offence where a person who has care of a person lacking the requisite mental capacity ill-treats or wilfully neglects him or her (see Chapter 11). Most of the convictions under this section have been of paid carers, and we await a judicial definition of a person who has the care of in relation to the unpaid person.

In the case of *D* v. *Barnet Healthcare Trust and another* (2000)[2] which is discussed in Chapter 5, the Court of Appeal held that a person is caring for another where the services provided are more than minimal and they need not have been provided for the long term. This was with reference to the definition of nearest relative under mental health legislation where the relative who ordinarily resides with or cares for the patient would be deemed the nearest.

Statute Box 16.1 Section 5 of MCA.

1. If a person ("D") does an act in connection with the care or treatment of another person ("P"), the act is one to which this section applies if
   - **a)** before doing the act, D takes reasonable steps to establish whether P lacks capacity in relation to the matter in question, and
   - **b)** when doing the act, D reasonably believes—
     - **i)** that P lacks capacity in relation to the matter, and
     - **ii)** that it will be in P's best interests for the act to be done.
2. D does not incur any liability in relation to the act that he would not have incurred if P
   - **a)** had had capacity to consent in relation to the matter, and
   - **b)** had consented to D's doing the act.
3. Nothing in this section excludes a person's civil liability for loss or damage, or his criminal liability, resulting from his negligence in doing the act.
4. Nothing in this section affects the operation of sections 24–26 (advance decisions to refuse treatment).

Section 6 considers the legality of the restraint of a person lacking mental capacity. (This is considered in Scenario 16.1 and also in Chapter 5.)

Scenario 16.1 Informal caring.

Mavis is caring for her son, David, who has Down's syndrome. He hates having a bath or shower, but she insists that he has a bath or shower at least once a week. He complains to a young care assistant at the day center, who says that he has rights under the Mental Capacity Act (MCA) and should seek legal advice.

Duty of care of the informal carer

Section 5 (set out in Statute Box 16.1) covering acts in connection with care and treatment brings the activities of the informal carer into the ambit of the MCA. Section 5 is discussed in Chapters 4 and 11, but effectively it means that any action taken by an informal carer in relation to a person who lacks mental capacity to make decisions must comply with the statutory provisions.

Section 5 would appear to apply to all those making decisions on P's behalf including informal carers. It implies that they should take account of the definition of mental capacity for specific decisions and apply the principles set out in Section 1 and discussed in Chapter 2 to the role of the informal carer. In addition they should take into account all the considerations set out in Section 4 relating to best interests in deciding what should be done. Provided that they have complied with the statutory provisions, they will obtain the protection of the Act, just as if they had had the consent of a mentally capacitated adult when carrying out that activity or making that decision. (While Section 5 protects D (the person caring for P) against an action for trespass to the person, it does not provide immunity if D is guilty of negligence or a criminal wrong. See Chapter 11 and civil proceedings on page 296.)

Scenario 16.1 illustrates the situation.

It is unfortunate that the advice given to David is more likely to lead to dispute and disruption to the

relationship of David and his mother, Mavis, than to a resolution. The starting point of the problem must be the issue of competence. Does David have the mental capacity to make decisions about bathing and personal hygiene?

If the answer to that question is *yes*, then he should be left with that power, albeit his carers may impress upon him the benefits to himself and to others of his being clean and sweet smelling. Maybe something as simple as a choice of soap and other items may influence David's decision.

If the answer to the question is that David lacks the mental capacity to decide whether or not he should have a bath, then his mother has to act in his best interests, following the principles set out in Section 1 of the MCA (see Chapter 3) and applying the criteria for the best interests as set out in Section 4 (see Chapter 5). It is hopefully not an issue with which lawyers should be concerned. However if he resists bathing or showering, what action can his mother take? She may be able to obtain advice from the day center on how to overcome David's reluctance to be washed. It may be that there is some specific fear which he has which can be assuaged. It may be that the day center would be prepared to arrange for him to be bathed or showered at the day center.

Could restraint be used?

Mavis may feel that she needs to use some form of restraint on David to encourage him to be bathed.

She would be bound by Section 6 of the MCA, which is considered in Chapter 5 on best interests. If Mavis does an act that is intended to restrain David, following the basic principles of the MCA and using the criteria of best interests as set out in Section 4 (see Chapter 5), she must satisfy two conditions:

1. She must reasonably believe that the restraint is necessary to do the act in order to prevent harm to David.
2. The restraint which she uses must be a proportionate response to the likelihood of David's suffering harm and the seriousness of that harm.

Mavis uses restraint on David if she either uses, or threatens to use, force to secure the doing of an act which David resists or she restricts David's liberty of movement, whether or not David resists.

It may be that Mavis will need the assistance of another carer to ensure that David is bathed. If so, they must ensure that only reasonable restraint is used and it is in proportion to David's suffering if he should be unwashed.

Reference should be made to the report by Sir Stephen Bubb on mechanical restraint and seclusion which is considered in Chapter 5.

Standard of duty of care

Once a duty of care is assumed, even if it is on a voluntary basis, it must be carried out at a reasonable standard, and failure to comply with this duty could lead to an action for breach of the duty of care in the law of negligence. In addition, the informal carer may be liable to criminal proceedings as a result of Section 44. This section makes a person who has the care of P guilty of an offence if he ill-treats or wilfully neglects P (see Chapter 11). There is no definition of the words "has the care of a person ('P')" in the MCA (but see the definitions previously used in earlier legislation), and case law will develop following prosecutions of those who claim that they were not carers. It is probable that the words would not cover the neighbor who occasionally does some shopping for P, but would cover a person living with P or a person who is in regular contact with P and undertakes basic tasks of day-to-day living for P.

Informal carer as donee of a lasting power of attorney

P, before he or she lost mental capacity, may have appointed the informal carer as the donee of a lasting power of attorney (LPA). There must be clear evidence that the informal carer has explicitly accepted that appointment and that the provisions of the Act and the relevant Code of Practice have been followed (see Chapter 6). Failure by a donee of an LPA to comply with the donor's instructions could lead to action being taken by the OPG (see Scenario 16.2 on page 293).

It is specifically stated in the MCA that the donee of an LPA could be guilty of a criminal offence if he ill-treats or wilfully neglects P (S.44(1)(b) and (2)). This would apply whether the LPA is for personal welfare or for property and affairs.

In Scenario 16.2 initially every effort should be made to resolve this dispute between brother and sister by

Scenario 16.2 Informal carer as a donee of a lasting power of attorney.

Victoria appoints her son, John, as the donee of a lasting power of attorney. He accepts the appointment for attorney of both personal welfare and finance and property. The respective forms are completed and executed by Victoria and John. Both powers of attorney give general powers to act in the best interests of Victoria. Subsequently Victoria suffers brain damage during a surgical operation and is transferred to a care home. John disputes with the care home manager as to whether his mother should be given antibiotics for a chest infection. He considers that she is unlikely to be discharged from the care home and return home, so he arranges for her house to be put up for sale. His sister, June, who disagreed that John should have had the power of attorney, believes that he is not acting in the best interests of their mother. She considers that the mother should receive active treatment and that the house should remain unsold, until such time as there was a clear prognosis of her mother.

discussion and counseling. The Code of Practice describes a similar disagreement:

> Mrs Roberts has dementia and lacks capacity to decide where she should live. She currently lives with her son. But her daughter has found a care home where she thinks her mother will get better care. Her brother disagrees. Mrs Roberts is upset by this family dispute, and so her son and daughter decide to try mediation. The mediator believes that Mrs Roberts is able to communicate her feelings and agrees to take on the case. During the sessions, the mediator helps them to focus on their mother's best interests rather than imposing their own views. In the end, everybody agrees that Mrs Roberts should continue to live with her son. But they agree to review the situation again in six months to see if the care home might then be better for her.[3]

Another example of the use of informal methods of dispute resolution could be where parents of a person lacking the requisite mental capacity were divorced and were in disagreement over where their son should live. It may be possible for the social worker to resolve the dispute by arranging counseling, advice, and mediation in order to reach a consensus decision. In this way the need to involve the Court of Protection or the appointment of a deputy could be avoided. The outcome for any such discussion must be the best interests of the person lacking the requisite mental capacity, unless another requirement is cited in the LPA or in the advance decision.

In contrast to these two situations, in the Scenario 16.2 John has an LPA, with powers to make decisions on Victoria's personal welfare. He would have a duty to act according to the instructions in the LPA, and if these were only general, then he would have to use the criteria of best interests as set down in Section 4 of the MCA (see Chapter 5). John cannot assume that it is in Victoria's best interests for her not to have life-sustaining treatment. If the dispute cannot be resolved, then the most appropriate action would be to contact the OPG for guidance and advice. Staff at the OPG should be able to provide advice and guidance on the appropriate steps to take. If the guidance fails to resolve the issue, then an application could be made to the Court of Protection for a declaration as to what was in Victoria's best interests.

Informal carer as a deputy appointed by the Court of Protection

Similarly the informal carer may be the person selected by the Court of Protection to be appointed as the deputy, in which case the carer would have to follow the statutory provisions and the relevant Code of Practice (see Chapter 7) (see Scenario 16.3).

It is specifically stated in the MCA that a deputy appointed by the Court of Protection could be guilty of a criminal offence if he ill-treats or wilfully neglects P (S.44(1)(c) and (2)).

In Scenario 16.3 in the first instance Enid should check with her father on what is being spent on Stuart's behalf, and if she continues to be dissatisfied, then she could contact the OPG for guidance. She could ask the OPG to investigate the role of the father as deputy. He would probably be asked to report on how Stuart's moneys were being spent and to produce an account. If Enid remained dissatisfied with the father's actions as deputy, the OPG might decide to appoint a visitor. Eventually it may be necessary for an application to go to the Court of Protection for an order replacing Ralph as deputy and making orders as to the future care of Stuart's finances.

Misappropriation of funds by a deputy could lead to criminal prosecution.

Scenario 16.3 Informal carer as a deputy appointed by the Court of Protection.

Stuart received compensation following a serious road traffic accident which left him with severe brain damage. He is living at home, supported by his parents and paid carers who provide 24-h coverage. His father, Ralph, has been appointed as deputy by the Court of Protection to supervise payments from Stuart's trust fund and pay for his day-to-day care. Stuart's sister, Enid, believes that the father is not spending the money appropriately. Ralph has a gambling addiction and she considers that more could be done to improve Stuart's quality of life.

Statutory principles and best interests

Section 1 of the MCA sets out the principles which must be followed when decisions have to be made on behalf of a person lacking the requisite mental capacity for a specific decision. These principles are discussed in Chapter 3. One of these basic principles of the Act is that an act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests (S.1(5)). When is an action or decision made under the Act as opposed to outside the Act? One view is that the Act applies whenever there is a decision that a person lacks mental capacity to make decisions and to all actions taken on his or her behalf. Another more restricted view is that the Act applies only to the more formal decision making by health or social services professionals, those appointed in a formal capacity as donees of lasting powers of attorney, and deputies and officials of the Court of Protection.

The Code of Practice takes the interpretation of the wider remit of the impact of the Act in its first paragraph:[4]

> 1.1 The MCA 2005 (the Act) provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. Everyone working with and/or caring for an adult who may lack capacity to make specific decisions must comply with this Act when making decisions or acting for that person, when the person lacks the capacity to make a particular decision for themselves. The same rules apply whether the decisions are life-changing events or everyday matters.

In paragraph 2.2 it states that:

> The statutory principles apply to any act done or decision made under the Act. When followed and applied to the Act's decision-making framework, they will help people take appropriate action in individual cases. They will also help people find solutions in difficult or uncertain situations.

It is therefore surprising that informal carers are not one of the categories of persons who are required by the legislation to follow the Code of Practice (see section "Informal carer and the Code of Practice").

It remains to be seen from the decisions of the Court of Protection and other civil or criminal proceedings the extent to which the courts hold that all carers, informal as well as professional, are bound by the Act and regulations made under it.

Decisions within their remit

Informal carers are only able to make decisions as to the best interests of a mentally incapacitated adult at a certain level. Serious decisions about health and accommodation would be made by others, probably registered health professionals, after, where appropriate, the instruction of an independent mental capacity advocate (IMCA) to advise the authority. For example, decisions relating to serious medical treatment and accommodation under Sections 37–39 would appear to have to be made by health or local social services authorities. Regulations define what is meant by serious medical treatment[5] and have extended the number of situations where an independent advocate must be appointed[6] (see Chapter 8).

Conflicts with statutory authorities and health and social services professionals

In the event of a dispute between an informal carer and a health or social services professional about either whether or not P lacks mental capacity or what is in P's best interests, every effort should be made to resolve the dispute through discussion or by more formal means of resolution, such as mediation or independent advocacy. If there is a dispute with the statutory services, it may be necessary to have recourse to the complaints procedure for the National Health Service (NHS) or social services (see Chapter 17). (These procedures are different between England and Wales (see Chapter 18 on the devolved assemblies).)

If all these methods of resolution fail, then eventually an application could be made to the Court of Protection to determine the issue. In such circumstances the Court of Protection could make a specific order, or appoint a deputy (see Chapter 7).

Informal carer and the Code of Practice

The informal carer is not one of the persons who are required by the Act to follow the Code of Practice (see Section 42(4) and Chapter 17). This does not mean, however, that Codes of Practice are irrelevant to the informal carer. On the contrary the view was expressed by the Joint Committee that:

> We agree that only those acting in a professional capacity or for remuneration should be under a duty to abide by the Codes of Practice. However we believe that family members and carers should be strongly encouraged to follow the Codes of Practice.[7]

The Joint Committee felt that it was inappropriate to impose upon informal carers a strict requirement to act in accordance with the Codes of Practice, but they did consider it essential that the informal carers have sufficient guidance and assistance, both to promote good practice and to impress upon them the seriousness of their actions and the need to be accountable for them.

Failure by informal carer to follow the Code of Practice

What would happen if the informal carer failed to follow the Code of Practice? What redress does P have?

The answer depends on the circumstances and the seriousness of the informal carer's conduct and failures in respect of P. For example, a minor failure would probably have no consequences at all for P or for the carer, but a serious failure could lead to criminal or other proceedings (see Scenarios 16.4 and 17.3).

In Scenario 16.4 it is clear that in failing to assist Hilda in making her own decisions and communicating, Brenda is failing to follow the basic principles of the MCA as set out in Section 1 (see Chapter 3):

> A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success. (S.1(3))

Scenario 16.4 Informal carer and the Code of Practice.

Brenda lived with her mother, Hilda, who had had multiple sclerosis for twenty years. Hilda was confined to a wheelchair and had had a lift installed in the house. Recently Hilda's condition had deteriorated, and there were times when she was unable to speak and make her views known. Prior to this she had been discussing with Brenda the possibility of her moving into a care home. Brenda was opposed to this, since the house was in her mother's name, and she was concerned that if her mother moved to residential accommodation, the house would have to be sold to pay the fees and she might be evicted. She considered therefore that it was better if Hilda was not encouraged to communicate and that the status quo was maintained for as long as possible. The district nurse who visited Hilda was concerned that a speech therapist had not been brought in to assist Hilda's communication. When she suggested this to Brenda, Brenda said that there was no need as she could understand Hilda and was meeting all her requirements.

Brenda is also not facilitating Hilda's capacity to communicate and is therefore in breach of Section 3(2) of the MCA:

> A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means).

In addition Brenda has failed to follow the guidance in the discussion of principle 2 (Paragraphs 2.6–2.9) and Chapter 3 of the Code of Practice on the steps which can be taken in assisting Hilda to communicate and make her own decisions.

In particular Brenda has not done the following:

- Use any aids which might be helpful, such as pictures, photographs, pointing boards or other signaling tools, symbols and objects, videos, or tapes.
- Find out what the person is used to—for example, Makaton or some way of communicating that is only known to those who are close to them.
- If the person has hearing difficulties, consider using appropriate visual aids or sign language.
- Consider using any appropriate mechanical devices such as voice synthesizers or other computer equipment.
- In extreme cases of communication difficulties, considered other forms of professional help, such as an expert in clinical neuropsychology.[8]

What sanctions are available against Brenda?

Since Brenda appears to be the main carer, it would be difficult for health or social services to take action to protect Hilda's interests unless there was clear evidence that Brenda was acting contrary to Hilda's best interests. Unfortunately it may be easier to prove financial improprieties by an informal carer than produce evidence of a failure to comply with the MCA statutory requirements. Her failure to follow the Code of Practice is unlikely to result in action being taken. Only if there were evidence of abuse or a breach of Section 44 of the MCA (ill-treatment or wilful neglect) is there likely to be intervention by the statutory authorities. If Hilda had other children or friends who were concerned about the fact that her communication skills were deteriorating and she was not therefore making her own decisions, then there is more likely to be intervention on behalf of Hilda. However the social services have a statutory duty to ensure that actions are taken in the best interests of Hilda, and they will be required to monitor the situation, provide appropriate advice to Brenda, and take action if necessary to secure the protection of Hilda.

Accountability

Informal carers may be held accountable for failures in fulfilling their duty of care to P. They could face civil and/or criminal proceedings.

Informal carer and civil proceedings

In Chapter 11 on the protection of the vulnerable adult and accountability, the law of negligence was discussed, and it was pointed out that health and social services professionals would be expected to provide the reasonable standard of care according to the Bolam test.[9] The informal carer also owes a duty of care to P, who could be represented in a negligence action against the informal carer (see Chapter 11). The person alleged to be lacking the requisite mental capacity, represented by a litigation friend, would have to establish on a balance of probabilities that a duty of care was owed, that there had been a failure to follow a reasonable standard of care and therefore a breach of the duty of care, and that this breach had caused harm to the patient. How would the standard of care to be provided by an informal carer be measured?

Scenario 16.5 Informal carer and civil proceedings.

On the facts of Scenario 16.4, Brenda left her mother locked in the living room when she went shopping. She argued that it was to protect the mother who might go into the kitchen and harm herself. The district nurse was concerned when visiting one day that she could not get into the house, but tried to talk to Hilda through the living room window. The district nurse considered that Brenda was acting illegally and if Hilda could not be safely left on her own, then Brenda should arrange for carers to be present when she left the house. She felt that it was a breach of Hilda's human rights and also a breach of the duty of care which Brenda owed to Hilda.

In the past the courts have used the standard of the reasonable man on the Clapham omnibus. The question would be asked, what would a reasonable person, caring for the personal well-being and/or the property and finances of this person who lacked specific mental capacities, expect to undertake, and what risks would he or she be reasonably expected to anticipate and to take steps to guard against? (See Scenario 16.5.)

The harm could be personal injury or death, or it could be loss or damage to property. Clearly there is little point in suing the informal carer, if the latter lacks the resources to pay any compensation awarded or is not insured for such compensation payment. However there may be advantages to P if it were to be established that the informal carer was not acting in P's best interests so that others could be appointed to oversee his personal care and welfare and his property and finance.

In Scenarios 16.4 and 16.5 Brenda is in breach of the duty of care which she owes to her mother. She would also appear to be in breach of some Articles of the European Convention on Human Rights:

- Article 3: No one shall be subjected to torture or to inhuman or degrading treatment or punishment.
- Article 5: Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law.

However under the Human Rights Act 1998, these articles are only binding on public authorities or organizations exercising functions of a public nature. Where local authorities (LA) are arranging for the provision of home care services and P is in a situation which could be seen as a loss of liberty, then action may arise against the

Scenario 16.6 Informal carer and criminal proceedings.

Rachel lived with her sister, Mary, who had severe learning disabilities, with a mental age of 5 years. Mary attended a day center on weekdays while Rachel was working. At weekends, other relatives would occasionally take Mary on outings, but usually Mary stayed at home. One morning when Rachel was out shopping, Mary used some matches and set fire to the living room sofa. Firemen were called, but Mary suffered burns and damage from smoke inhalation. Police are investigating the possibility of a criminal prosecution being brought against Rachel.

LA following the decision of the Supreme Court in the Chester case[10] which is discussed in Chapter 14.

A civil action brought against Brenda is probably unlikely to be an effective remedy for Hilda. A basic principle of legal action is that there is little point in suing a person who would be unable to pay compensation, and it is not compensation which Hilda requires but a regime where her human rights are protected and her quality of life enhanced. Clearly a judgment has to be made on the balance of benefits and risks to Hilda in determining what action to take in relation to Brenda.

It may be that with help, support, and advice, an agreement could be reached with Brenda to ensure that Hilda's quality of life was protected. For example, it may be possible to point out that since Brenda lives in the house with Hilda, social services could not evict Brenda in order to fund the means-tested benefits were Hilda to move to a care home. It may be a situation where social services might consider the benefits of the appointment of a deputy by the Court of Protection and make the appropriate application. If there were evidence of ill-treatment and wilful neglect by Brenda, then different considerations would apply (see Scenario 16.6).

Informal carer and criminal proceedings

Section 44 creates a new criminal offence of ill-treatment and wilful neglect (see Chapter 11). An informal carer could be guilty of a criminal offence in respect of his or her care and treatment of the patient. Obviously any theft of P's property could be followed by criminal prosecution. The new offence created by the MCA could also apply to the informal carer. Under Section 44(2), if a person D has the care of a person P who lacks, or whom D reasonably believes to lack, capacity, then it is an offence to ill-treat or wilfully neglect that person. The offence is considered in Chapter 11.

In Scenario 16.6 is Rachel guilty of a criminal offence under this section? Has she wilfully neglected Mary? Much of course would depend upon the details of Mary's condition which are not given in this scenario. Should Mary have had a carer with her at all times? Was the failure to ensure that the matches were locked away from Mary's use evidence of wilful neglect? Was it reasonably foreseeable to Rachel that if Mary were left alone, harm could befall her? Wilful implies an intentional disregard for the possible consequences of Mary's being left on her own. Cases on willful neglect are considered in Chapter 11.

Informal carers and advance decisions

Where a person (P) has drawn up an advance decision, it is likely that he or she has told his or her closest relatives or friends of its existence. If P then loses his or her mental capacity to make treatment and care decisions, then the informal carer should ensure that the existence of this advance decision is drawn to the attention of the health and social services professionals. It may be that the advance decision nominates a specific person to act on behalf of P, should P lose the requisite mental capacity. It is important that the informal carer appreciates that he or she has no power to overrule the contents of a valid and relevant advance decision. In addition unless P specified that the advance decision was to apply to life-sustaining treatments, then life-sustaining treatment should be given. For P's prohibition on life-sustaining treatment to be valid, P must have specified this in writing and signed it (or another person has signed it in P's presence and by P's direction), and this signature must have been made or acknowledged by P in the presence of a witness who signs it or acknowledges his or her signature in P's presence (see Chapter 9) see Scenario 16.7 on page 298.

Where there is a doubt as to whether an advance decision is applicable to a given situation, then there would have to be a referral to the Court of Protection for a declaration as to its applicability (see Chapter 9). Section 25(4)(c) states that an advance decision is not applicable to the treatment in question if there are reasonable grounds for believing that circumstances exist which P did not anticipate at the time of the advance

Scenario 16.7 Informal carer and an advance decision.

Harold drew up an advance decision following a diagnosis of multiple sclerosis. In this he said that were he to require ventilation, artificial nutrition, or hydration, he would not wish to be given that and would prefer to be allowed to die. He told his wife, Angela, what he had done and asked her to witness the document. He carried a copy at all times in his wallet. He was injured in a shopping arcade when a ladder used by painters fell onto him. He was taken unconscious to hospital, accompanied by Angela. The nurses found the advance decision in his wallet. Angela said that it did not apply to this situation, since he was thinking of an intolerable state during the later stages of multiple sclerosis. The consultant said that he needed to be ventilated and said that he would have made preparations for him to be taken to intensive care, but in the light of the advance decision, he decided that he should be allowed to die. What is the legal situation?

decision and which would have affected his decision had he anticipated them (see also Scenario 9.3). In Scenario 16.7 when Harold drew up the advance decision, he was contemplating the final stages of multiple sclerosis, but he was not contemplating being injured by a falling ladder. It is therefore likely that the Court of Protection would hold that the advance decision did not apply to his being ventilated at that time. Since the decision of the Court of Protection may take some time, the provisions of S.26(5) are extremely important, since this subsection states that:

Nothing in an apparent advance decision stops a person:

a) providing life-sustaining treatment, or

b) doing any act he reasonably believes to be necessary to prevent a serious deterioration in P's condition,

while a decision as respects any relevant issue is sought from the court.

Harold can and should receive all necessary lifesaving treatment while the validity is determined.

Informal carer and research

Where a person lacks the requisite mental capacity to give consent to research, there is a statutory duty upon the researcher to consult the informal carer about P's participation in the research. The informal carer should ensure that he or she is given all the relevant information about the research and any likely risks or discomfort to

Scenario 16.8 Informal carer and research.

Margaret's son, Henry, has cerebral palsy. His speech therapist, Jenny, asks him if he would take part in a research project to test out new equipment for communicating. Margaret is unhappy at Henry's involvement and does not consider that he has the mental capacity to agree to participation in the research. What action can she take?

P in taking part. The informal carer will be the person most concerned at protecting P's interests and should check against any advance decision or advance statement drawn up by P as to whether he has recorded a refusal to participate.

The informal carer would also need to be vigilant throughout the research process and ensure that, at any time when it would appear that P is showing signs of resistance and objection to the research, P's involvement ceases, unless it can be justified because it is intended to protect him or her from harm or to reduce or prevent pain or discomfort. Considerable responsibility would appear to rest on the informal carer where P is taking part in the research to ensure P's rights are safeguarded (see Chapter 10 and Scenarios 10.2 and 16.8).

In Scenario 16.8 Margaret would first of all take her concerns to the researcher, Jenny. She would want to receive the details of the research project and details of its approval by the research ethics committee (REC). She would also want to know how, if at all, Jenny assessed Henry's ability to give consent to participation. If she were not satisfied with the answers, she could endeavor to raise the issues with those responsible for the research project (if that were someone different from Jenny). Ultimately she could apply to the Court of Protection for a declaration on the capacity of Henry to give consent to research participation. Clearly it is open to Henry at any time to withdraw from the research project.

Informal carer and the IMCA

There is a statutory duty upon NHS organizations and LA to ensure that P is receiving the support of an IMCA when decisions over serious medical treatment and accommodation are being taken and action to protect a vulnerable adult is being considered. However this is subject to the organization concerned

being satisfied that there is no person, other than one engaged in providing care or treatment for P in a professional capacity or for remuneration, whom it would be appropriate for them to consult in determining what would be in P's best interests (Ss.37(1)(b), 38(1)(b) and 39(1)(b)) 39A(3), 39C(3), or 39D(2)). This means that where there is an informal carer, then that person would be expected to represent and support P. (This proviso does not apply when protective measures are being considered where an IMCA may be appointed.)

What if there is a dispute between the informal carer and those employed by the statutory authority over what would be in P's best interests? Possibly in such circumstances it could be argued that it would not be appropriate for that person to be consulted over what was in P's best interests. This would enable the authorities to arrange for the appointment of the IMCA, even though an informal carer existed. This is further discussed in Chapter 8 on the IMCA and the scenarios in that chapter.

In addition if for any reason the informal carer or other family member or friend refused to act as the representative of P, or was too ill or there were some other reason why it was not appropriate to rely upon them (e.g., they might live too far away), then in such circumstances it would be necessary for an IMCA to be appointed in the situations set out in the statute and the regulations (i.e., serious medical treatment, accommodation by NHS or LHA, and care reviews). (Where an IMCA is required for protection purposes, there is no requirement that there should be reliance upon a family member or friend or informal carer to act as an advocate, but an IMCA may be appointed.) See Scenario 16.9.

Scenario 16.9 Informal carer and independent mental capacity advocate.

Cathy and Mark care for their son, Andrew, who has learning disabilities. Andrew attends a day center and works on a project packaging screws, for which he is paid pocket money. Working with him is Sandra, who also has severe learning disabilities and lives at home with her parents. He and Sandra decide that they would like to live together and move out of their respective family homes. They are encouraged by the day center manager to plan for this outcome, and discussions commence with social services to find appropriate accommodation. When Cathy and Mark hear of the plan, they are opposed to it. They consider that they are giving Andrew a good quality of life and that it would not be in his best interests to move out. The local authority knows that under Section 39 of the MCA (see Chapter 8), it has a responsibility to seek advice from an independent mental capacity advocate (IMCA) when it is considering the provision of residential accommodation for a person P who lacks capacity to agree to the arrangements. Cathy and Mark however claim that they are able to be consulted on the question of Andrew's accommodation and therefore an IMCA is not required.

In Scenario 16.9, the first question to be asked is, does Andrew have the necessary mental capacity to decide if he wishes to move out of his parents' home and into alternative accommodation? If the answer to that question is *yes*, then there is no question of an IMCA being appointed and being consulted, though he may need the support of social services or even a solicitor to assist him in furthering his ambitions.

If however Andrew is assessed as lacking the requisite capacity, then the possibility of the appointment of an IMCA must be considered. The duty to seek the advice of an IMCA arises "if the local authority is satisfied that there is no person, other than one engaged in providing care or treatment for P in a professional capacity or for remuneration, whom it would be appropriate for them to consult about P's best interests." Would Cathy and Mark be seen as persons whom it would be appropriate to consult about Andrew's best interests? Even though they disagree with Andrew's wishes, they would still be able to provide the LA with information about Andrew. They would probably not, however, be best placed to provide an independent view as to what would be in Andrew's best interests. However *independence* from those consulted is not a requirement of the MCA. Case law will eventually determine whether people in Cathy's and Mark's situation come within the definition of "appropriate for them to consult about P's best interests."

Access to personal information and the duty of confidentiality

Frequently when an informal carer is the main person responsible for the personal welfare of a person lacking mental capacity, the informal carer will be the person

Scenario 16.10 Informal carer and confidentiality.

Tom was admitted to a care home with incipient Alzheimer's disease. He was visited regularly by his daughter, Janice, who was concerned that he seemed to be getting very weak and lethargic. She made inquiries from the home manager and discovered that blood tests had been taken three months before and he had been found to be anemic. He was given iron supplements and extra vitamins. She was concerned that she had not been told about this change in his condition and was anxious that further tests should be carried out to discover if there was any underlying cause of the anemia. The home manager stated that since Tom was 92 years, it was not thought that any further tests were in his best interests, since it could reveal a chronic condition for which blood transfusions and hospitalization may be required. Such further interventions would only cause him unnecessary discomfort and therefore were not felt to be in his best interests. Janice disagreed and considered that she should have been kept fully informed of his condition. In addition she believed that any underlying condition should be treated even if he had to be admitted to hospital. What is the law?

from whom professionals seek information as to the personal history, health, and financial situation. The informal carer would probably pass any necessary information on, if he or she is satisfied that that would be in the best interests of P. However there may be situations where the informal carer is seeking information from paid carers. What rules then apply? Scenario 16.10 explores a possible situation.

Two separate issues are raised by Scenario 16.10. The first is, what rights does Janice have as the daughter and possibly next of kin of Tom to be told confidential information about his condition? The second issue is that of the determination of Tom's *best interests*.

a) Should Janice have been told about Tom's condition?
The care home staff have a duty of confidentiality toward Tom. If Tom had the capacity to give consent, then he could agree that personal information about his condition could be passed to his daughter, Janice. However he appears to lack the capacity to give consent to this (though this would have to be checked). The care home staff would be entitled to pass on to Janice any personal information about Tom if he lacked this requisite capacity, provided that it could be shown that it is in the best interests of Tom for Janice to be told.

Chapter 16 of the Code of Practice gives advice on confidentiality, and the NHS Code of Confidentiality provides further guidance.[11]

It is no easy task for the care home staff to determine what information should be given to Janice and what should be withheld, but they need to make this judgment and also document what information has been released and why. Clearly if Janice considers that Tom is not receiving the appropriate investigations into his condition, she would need to be given sufficient information to satisfy herself that the GP and the care home were acting in Tom's best interests.

b) What are Tom's best interests?
The definition of best interests is considered in Chapter 5, and the same criteria (set down in Section 4) would apply to decision making, whether by a professional or by an informal carer. In answering the question "What is in Tom's best interests?," account would have to be taken of his general health and well-being, overall prognosis, and any beliefs and views he had expressed when he had the requisite mental capacity. Section 4(5) states that:

> Where the determination relates to life-sustaining treatment he (i.e. the decision maker) must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.

In other words carers, whether professional or informal, cannot say to themselves that Tom would be better off dead, and so it is not worth carrying out tests on him.

The basic principle is that health and social services professionals can disclose confidential information to informal carers if it is in the best interests of the person who lacks the requisite capacity to give consent. The disclosure would not include information which P has specifically asked not to be disclosed and must be confined to what is relevant for the informal carer to have in P's best interests. There would be a duty on the informal carer to respect the duty of confidentiality so that this information was not passed on to anyone who did not need to have it in P's best interests (see section "Principles of confidentiality and exceptions to that duty").

Access to personal information by the donee of an LPA or a deputy

Where the informal carer has been appointed as the donee of an LPA or a deputy by the Court of Protection and can therefore be viewed as the agent of P for specific purposes, then there are statutory provisions about the right of access to P's personal information under the Data Protection Act 1998. The deputy or a donee acting under an LPA is able to obtain information as agent of P, which is relevant to the functions which he is undertaking and which is within the scope of his authority. The Information Commissioner has advised in the Legal Guidance which he has issued on the Data Protection Act 1998[12] that an attorney acting under an enduring power of attorney or a receiver "who has general authority to manage property and affairs" may make a subject access request. Therefore a deputy who has been granted authority to act only in relation to specific matters (rather than a general power) may make a subject access request on behalf of the person who lacks capacity, for such information as relates to the matter within his/her limited authority, without applying to the court.

The right of access would also be subject to those exceptions to subject access under the Data Protection regulations, that is, access will be refused to information which could cause serious harm to the mental or physical health or condition of the applicant or another person or which would disclose information about the identity of a third person, not being a health professional involved in the care of P, where the third person has not agreed to that identification.

Principles of confidentiality and exceptions to that duty

There are considerable advantages in any informal carer ensuring that P's right to a private life under Article 8 of the European Convention on Human Rights is respected, even though the Human Rights Act 1998 Schedule 1 setting out the articles of the European Convention on Human Rights (with some omissions) is not actionable against a private individual. The informal carer should also recognize the duty to respect the confidentiality of information which he or she obtains about the personal health and welfare or property and financial matters of P. This duty of confidentiality is subject to specified exceptions:

- Disclosure with the consent of P (but this implies that P has the mental capacity to give consent)
- Disclosure in the best interests of P
- Disclosure required by court
- Disclosure required by Act of Parliament (e.g., notification of infectious diseases, Prevention of Terrorism Acts, road traffic legislation)
- Disclosure required in the public interest (e.g., if serious harm is feared to P or another person)

Any informal carer disclosing information confidential to the patient would be advised to keep details of what has been disclosed and the justification for the disclosure.

Documentation and the informal carer

It would be unfortunate if the effect of the MCA were to lead to a heavy burden of paperwork on the informal carer. However it is clear that in cases of potential dispute, an informal carer would need to keep some documents or records relating to the actions he or she had taken and discussions with others about whether or not P lacked the requisite mental capacity and the factors which were taken into account in determining P's best interests. For example, when determining what are in the best interests of P, the MCA requires the decision maker to take into account all the relevant circumstances as well as the list of criteria specified in Section 4. It would be of value if the informal carer made a note of the circumstances which had been taken into account in making any specified decision.

It is possible that some of the charities representing specific conditions and illnesses which could lead to impairment of mental capacity would design simple forms which an informal carer could keep (see list of websites setting out some of these organizations). Any informal carer who takes on a formal role such as the donee of an LPA, or is appointed as a deputy by the Court of Protection, would be required to keep records of his or her actions. The deputy in particular may be required to provide the OPG with a report of the actions which have been taken.

Scenario 16.11 The informal carer and documentation.

Joan cares for her mother, Sarah, who lives alone. Joan regularly shops for her and collects her pension. Joan's brother, Malcolm, is convinced that Joan is using Sarah's money for herself and not spending it on Sarah. Joan denies that.

The court may require a deputy to give to the Public Guardian such security as the court thinks fit for the due discharge of his functions and to submit to the Public Guardian such reports at such times or at such intervals as the court may direct (S.19(9)).

In addition since the deputy is entitled to be reimbursed out of P's property for his reasonable expenses in discharging his functions and can, if the court so directs, obtain remuneration out of P's property for discharging his functions, it is vital that the deputy keeps records of both expenses and remuneration, since these will be subject to scrutiny by the OPG.

In Scenario 16.11 if Joan were able to produce for Malcolm a cash book relating to the receipts and payments on Sarah's behalf, this might help convince him that Joan was not defrauding their mother. It may be that Joan has been appointed as an appointee by the Department for Work and Pensions (DWP) to claim, receive benefits, and spend money on Sarah's behalf. If Malcolm is not satisfied by Joan's evidence, he could apply to the DWP, stating that Joan is not acting in Sarah's best interests. If his allegations prove correct, then Joan could be removed as appointee.[13] Regulation 33 of the Social Security (Claims and Payments) Regulations 1987[14]enables the statutory appointment of an appropriate person to receive and deal with the pension and also gives power to revoke the appointment.

Record keeping guidance

In the absence of any advice from the Department of Health or organizations concerned with specific conditions where mental incapacity can arise, the following brief guidelines for records to be kept by an informal carer may prove useful.

Records should:

- Identify problems that have arisen, the decisions made, and the action taken.
- Be factual, consistent, and accurate.
- Be written as soon as possible after an event has occurred.
- Be accurately dated, timed, and signed.
- Not include meaningless phrases, irrelevant speculation, and offensive subjective statements.
- Be readable on any photocopies.
- Be written, wherever possible, with the involvement of P.
- Where records include financial information about expenses of the carer or purchases made on behalf of P, a simple cash book should suffice with details and dates of entries.

How long should any such documentation be kept?

Where the carer is looking after P, a person who lacks mental capacity, then the time limits for court action on behalf of P do not start until P's death or the recovery of P's mental capacity. The advice is therefore that any records should be kept for three years after P's death. This is specially so where he or she has suffered an injury for which compensation may be payable. Scenario 16.12 illustrates the effect of the time limits. Scenario 16.13 illustrates many of the issues faced by the informal carer.

Informal carer and time limits

The usual time limit for bringing a court action in respect of personal injury is three years from the injury occurring or three years from the knowledge that this has occurred. However there is an exception to this time limit in respect of children and those who are under a mental disability. The time limit within which children have to bring a legal action does not start to run until the child becomes an adult at 18 years. For those under a mental disability, the time limit within which the court action must be commenced does not start to run until the disability ends (see Chapter 11 on time limits). Because James in Scenario 16.12 lacks the requisite mental capacity to bring a court action, there is no time

Scenario 16.12 Informal carer and limitation of time for bringing action.

James, who is now 35, has Down's syndrome and has always lived in the family home with his widowed mother, Janice. When he was 22 he was accidentally scalded when Janice put him in a bath without checking the water first. She dressed the wounds herself and she did not think that he needed hospitalization. Some years later a paid carer inquired about the scars on James' legs, and Janice explained how it had happened. The care assistant felt that James should obtain some compensation from the insurance policy which covered the house. Janice felt that it was too long ago to bother about it.

limit on suing for compensation as long as he is alive. If Janice's insurance cover provides for accident insurance, then James could bring a claim on the basis of his mother's negligence in causing him to be scalded. The fact that the accident occurred over 13 years ago would not be a defense. Clearly any record made by Janice at the time would be essential evidence.

Multiple issues

Scenario 16.13 illustrates the multiple issues which an informal carer may face.

The first question to be asked in Scenario 16.13 is the level of mental capacity of Stan. Does he have the capacity to make his own decisions? While he was under a compulsion to eat, did he realize that stealing from the shop was a crime? It must also be established if it is in his best interests to face the consequences of his crime or to be protected as his parents wish. It may be for example that it would be in Stan's best interests to be cared for in a community home, where he was taught to control his eating, where he learned to accept the consequences of his wrong doing and where he could become more independent. The key principles of *Valuing People*[15] (rights, independence, choice, and inclusion; see Chapter 11) should be observed in developing a care plan for Stan. While it is not impossible for these principles to be followed by informal carers, there may come a time where it is in the best interests of the person to move to a care home. If his parents opposed such a move, then it may be appropriate for an IMCA to be appointed (see Chapter 8).

Scenario 16.13 Multiple issues.

Stan, aged 35 years, has Prader–Willi syndrome and is looked after by his elderly parents. He has the ability to make decisions about his clothes and activities, but his parents lock the fridge and the pantry and he has no choice over the food which he is given. They find him eating from a box containing a gross of chocolate bars and realize that he has stolen it from a nearby shop. They go to the shop to return the half-eaten box and pay for the bars which Stan has eaten. They ask the shopkeepers not to report him to the police because he has stolen before and they are afraid of his being sent to prison.

The future

The first recommendation of the House of Lords Select Committees[16] in its overview of the working of the MCA was that:

> In the first instance we recommend that the Government address as a matter of urgency the issue of low awareness among those affected, their families and carers, professionals and the wider public.

In its response[17] the government stated that "Raising awareness of the MCA is everyone's responsibility" and the Department of Health was to run an internal MCA awareness campaign over the coming year to draw the attention of all policy makers in the Department to how the MCA can support them in reaching their goals. The government also intended to "hold a national MCA event in 2015 both to raise awareness of the Act and to listen to professionals and the public about how the system as a whole can have greater impact. This event will require the active contribution of the entire system."

In Paragraph 5.16 of its response, the government stated that:

> It is important also that carers have access to information about the MCA so that they understand the rights it confers on individuals who may lack capacity. Likewise, it is vital that when making best interests decisions, professionals consult with those who know the individual best—which would include families and carers wherever possible. The Standing Commission on Carers advises Government on priority issues for carers to inform policy development. The Standing Commission will consider the House of Lords report and this Government response at its upcoming meeting with a view to identifying carers' information needs with respect to the MCA.

Recommendation 31 of the Select Committees' report stated that:

> We recommend that the Government, and in future the independent oversight body, provide clearer guidance to public authorities regarding which disputes under the Act must be proactively referred to the Court by local authorities. This should include situations in which it is the person who is alleged to lack capacity who disagrees with the proposed course of action. Efforts must be made to disseminate this guidance to families and carers as well as to local authorities.

The government's response was that it agreed that clearer guidance should be provided to public authorities on which disputes should be immediately referred to the court and following a review "dissemination of guidance will be part of the wider work outlined above to raise awareness. This will also form part of our general awareness raising with the public."

It remains to be seen how effective these measures will be in raising the awareness of the public and the informal carers in particular of the significance of the MCA and its impact on the lives of everyone.

Conclusions

Informal carers should be comforted by the fact that although the MCA would at first sight appear to be an overwhelming change in the lives of those who lack the requisite mental capacity and therefore a huge burden on the informal carer, in practice many of the principles set down in the Act reflect the position which already existed at common law (i.e., judge made or case law). In addition many of the new tools such as the LPA and the new Court of Protection with its jurisdiction to cover matters of personal welfare in addition to property and financial affairs and the power to appoint deputies should make it easier for decisions to be made and disputes to be resolved. Most informal carers already act in the best interests of those they care for and who lack mental capacity. It is hoped that the recommendations of the House of Lords Select Committees and the government's positive response will lead to a growth in public awareness and understanding of the implications of the legislation for the informal carer.

Checklist for informal carer

- Is there a decision to be made?
- Can the assumption that P has the requisite mental capacity be followed?
- If not, how is P's capacity to make that specific decision assessed?
- Can the Code of Practice over what has to be taken into account in determining capacity be followed?
- If capacity to make that specific decision is lacking, how are P's best interests decided upon?
- Can the criteria set out in Section 4 (Chapter 5) be applied?
- Should others be involved in the decision making, such as NHS or local authority staff?
- What documentation for the basis for the decision making and the actions which have taken should be kept?

Quick-fire quiz, QFQ16

1 Does an informal carer have a statutory duty to follow the Code of Practice?
2 What is the significance of Section 5 for the informal carer?
3 Could an informal carer be prosecuted under Section 44 for ill-treatment of a mentally incapacitated adult?
4 Could an informal carer overrule an advance decision which was not in the best interests of the person lacking the requisite mental capacity?
5 What is the role of the informal carer if a researcher wishes P, a person lacking the mental capacity, to give consent to participate in a research project?
6 What documentation should an informal carer keep on the care and treatment of the person for whom he or she cares?

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9 *Bolam* v. *Friern Hospital Management Committee* [1957] 1 WLR 582.
10 *P (by his litigation friend the Official Solicitor)* v. *Cheshire West and Chester Council & Anor; and P and Q (by their litigation friend, the Official Solicitor) (Appellants)* v. *Surrey County Council (Respondent)* [2014] UKSC 19.
11 Confidentiality: NHS Code of Practice, November 7, 2003. Available on the Department of Health website: www.gov.uk. Gateway reference 2003; product 33837.
12 See the Information Commissioner's website at https://ico.org.uk; and see para 4.1.7 of the Legal Guidance.
13 www.gov.uk/government/organisations/department-for-work-pensions
14 Social Security (Claims and Payments) Regulations 1987 (SI 1987/1968).
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16 House of Lords Select Committee on the Mental Capacity Act 2005. Report of session 2013–4, HL Paper 139. Stationery Office, March 2014: www.publications.parliament.uk.
17 HM Government valuing every voice respecting every right: making the case for the Mental Capacity Act, the Government response to the House of Lords Select Committee on the Mental Capacity Act, June 2014.

CHAPTER 17

Implementation, resources, and Code of Practice

THIS CHAPTER CONSIDERS THE FOLLOWING TOPICS

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Introduction

Even before the passing of the Mental Capacity Bill by Parliament, steps were being taken in preparation for its implementation. A draft Code of Practice was prepared to assist Parliament in determining what was appropriately left for inclusion in a code and what should be part of the statutory provisions. In fact the Joint Houses of Parliament criticized the fact that it had not been prepared at an earlier time. The Department of Health was also asked for figures on the likely consequential costs of the new provisions and in particular the provision of an Independent Mental Capacity Advocacy/Advocates (IMCA) service. After the passing of the Act, implementation teams were set up, a best practice tool for organizations likely to be involved developed, and the mental capacity implementation programme was established within the Department for Constitutional Affairs (DCA)[1] (now the Ministry of Justice[2]). This chapter considers the legal significance of the Code of Practice and looks at some of the initiatives used in implementation.

Implementation within a hospital context

It is probably true to say that every single section or specialty within a district general or community hospital has been affected by the changes brought about by the Mental Capacity Act 2005, though clearly some are more involved than others. Almost all hospital specialties on occasions have patients who are incapable of making their own decisions. Although the Mental Capacity Act 2005 is concerned only with the person over 16 years, there are provisions which could apply to children younger than that, as Chapter 12 explains.

Legal Aspects of Mental Capacity: A Practical Guide for Health and Social Care Professionals, Second Edition. Bridgit Dimond.
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> **Scenario 17.1** Implementing the act.
>
> Jake is chief executive of a National Health Service trust which includes two district general hospitals and a community unit. He asks Ken to take on the responsibility for ensuring the implementation of the Mental Capacity Act across the whole trust and allocates him a budget for the task. What are the significant changes which Ken will have to oversee and what aids are there for implementation?

It is hoped that in Scenario 17.1 the NHS trust is already part of the NHS implementation programme, which is explained in the following.

Key to Ken's work will be the following:

Training sessions and training materials on the impact of the legislation

A strategy to ensure that every employee has an understanding of the legislation and how it relates to their specific work must be drawn up, and Ken would be assisted by an implementation team covering all specialties and staff. Ken would need to access initial training sessions and ensure that those who receive the initial training are able to cascade the lessons to the rest of the staff, in the hope that eventually all staff will receive an initial training in the basic principles of the Act, definition of capacity and criteria for best interests, and its relevance to their specific work.

Policies and procedures covering

- Consent procedures on behalf of a mentally incapacitated person who does not have the requisite capacity to give consent
- The use and legal significance of advance decisions
- Research and the adult with specific mental incapacities
- Applications to the Court of Protection
- Property and finance of patients unable to take action on their own behalf
- Independent Mental Capacity Advocacy Service
- Role and powers of donees of lasting powers of attorney
- Role of deputies appointed by the Court of Protection

The implementation team would be responsible under Ken for ensuring these policies were developed. However in preparing these policies for use across the NHS trust, the team would be wise to take advantage of policies and procedures produced nationally, by neighboring trusts and other organizations, so that maximum use is made of all the available materials. The Social Care Institute for Excellence (SCIE) produces material on all areas relevant to the MCA.[3]

> **Scenario 17.2** Implementation of the MCA in a care home.
>
> Justin, a registered nurse for learning disabilities, has been the manager of a care home for 30 elderly persons for over 10 years. The home is owned by a private company. Justin had heard from a colleague working in the NHS that his NHS trust was setting up training sessions on the MCA. He asked his regional manager if the care home company was planning similar events to those in the NHS. The regional manager said he did not know anything about it and thought that the Act was only for the NHS.

Implementation of the training and policies and procedures

Ken and his implementation team would probably also have the role of overseeing the implementation of the policies across the trust. This will be a slow process as new problems arise on the impact of the legislation, and a task force to advise on the questions and issues raised by individuals and specialties could be established. Lessons from these discussions could be spread across the trust. Perhaps a mental capacity newsletter may be of value for dissemination of the information.

Implementation in a care home

The regional manager in Scenario 17.2 is of course completely wrong. As has been seen from this book, the MCA applies to every situation where decisions have to be made on behalf of an adult who lacks the requisite mental capacity. The decisions relate to care and treatment, property, and affairs; in fact every possible decision that might have to be made on behalf of a person over 16 years lacking the requisite mental capacity.

Justin has a professional responsibility to keep up to date. He must therefore check the regional manager's statement and find out how the MCA applies to his work in the care home. He could do this by looking at the many online information services about the MCA, which can be found on the Government website, including the Department of Health and Ministry of Justice and the websites of voluntary organizations. Once he has confirmed how the MCA is relevant to his work, he may be

able to find a workshop or training session that he could apply to join. Since he would probably require the approval of the regional manager to attend such a seminar, he would need to give him evidence of the significance of such a session for the care home.

After attending a training session, Justin would have a responsibility to ensure that his staff understood the implications of the MCA for their work. Internal training, policies, and procedures and monitoring of the implementation of the MCA would be required within his home. Justin should also attempt to persuade senior management within the company of the importance of the MCA, so that eventually all home managers and staff are trained in its implementation and significance.

Implementation for carers

The task of ensuring that the family and friends and informal carers of those with limitations in mental capacity have instruction in the significance of the mental capacity legislation is huge. The Ministry of Justice and Office of Public Guardian have published leaflets both for the informal carer and also for those with limited mental capacity. Much training and guidance material is available from the SCIE.[4] Inevitably the task of ensuring that this information is disseminated will fall upon the health and social services professionals and the voluntary and charitable organizations concerned. While informal carers are not identified in the statute as being bound by the Code of Practice, there are many practical reasons why the Act and the Code of Practice should be brought to their attention, so that they can benefit from its guidance. Inevitably it will probably take a considerable time for the millions of people involved in making decisions on behalf of mentally incapacitated adults to be familiar with the provisions, and in the meantime the professionals will have a duty to point out the implications (see Chapter 16 on the informal carer). The House of Lords[5] in its post-legislative scrutiny of the MCA made recommendations that there should be wider dissemination of the significance of the MCA and the Government responded positively.[6]

In Scenario 17.3 Jane should obtain some of the leaflets produced by the Ministry of Justice, the Alzheimer's Society, and SCIE and explain their significance to Avril, discussing with her what decisions Olga could make for herself and how other decisions which are outside her capacity could be made.

Scenario 17.3 Carers and the MCA.

Jane was a social worker with responsibilities for the elderly. One of her clients was Olga, aged 85 years, with early-stage Alzheimer's who lived with her daughter Avril and her son-in-law. Jane was concerned that Olga appeared to be having no say in some of the decisions which were being made. It seemed to Jane that Olga would have benefited from attending a day center but Avril opposed this. Jane tried to explain to Avril the implications of the MCA but Avril did not consider that this was relevant to her or to Olga.

Codes of Practice

For the early discussions of the Bill and the Joint Committee consideration, the DH had not at that time prepared a draft Bill, and this was criticized by the Joint Committee[7]:

> Although we re-iterate our anxiety to keep up the momentum and ensure that introduction of the Bill is not unduly delayed, we recommend that the Bill should not be introduced to Parliament until it can be considered alongside comprehensive draft Codes of Practice.[8]

As a consequence of these criticisms, a draft code was prepared and made available for the later Parliamentary debates.

General principles are set out in the first section of the Mental Capacity Act which must be followed in the determination of mental incapacity and in making decisions on behalf of a person lacking the requisite capacity. In addition guidance was to be provided by the Secretary of State on a wide range of topics in one or more codes. A code is defined as a code prepared or revised under Section 42 (S.42(7)).

Subjects covered by codes

The Lord Chancellor has a statutory duty under Section 42 to prepare and issue one or more Codes of Practice on the topics shown in Statute Box 17.1

The Lord Chancellor has the power to revise a code from time to time and may delegate the preparation or revision of the whole or any part of a code so far as he considers expedient (S.42(2) and (3)).

Statute Box 17.1 Duty to prepare codes of practice (S.42(1))

The Lord Chancellor must prepare and issue one or more codes of practice:

a) For the guidance of persons assessing whether a person has capacity in relation to any matter
b) For the guidance of persons acting in connection with the care or treatment of another person (see S.5)
c) For the guidance of donees of lasting powers of attorney
d) For the guidance of deputies appointed by the court
e) For the guidance of persons carrying out research in reliance on any provision made by or under the Act (and otherwise with respect to Ss. 30–34)
f) For the guidance of independent mental capacity advocates

fa For the guidance of persons exercising functions under Schedule A1 (Deprivation of Liberty Safeguards)

fb For the guidance of representatives appointed under Part 10 of Schedule A1 (added by the MHA 2007) (Deprivation of Liberty Safeguards)

g) With respect to the provisions of Ss. 24–26 (advance decisions and apparent advance decisions)
h) With respect to such other matters concerned with the Act as he thinks fit

The italicized subparagraphs fa and fb were added by the Mental Health Act paragraph 8(2) of Schedule 9.

Following the legislation relating to Deprivation of Liberty Safeguards, a supplementary Code of Practice has been published.[9] This is considered in Chapter 14. The Code of Practice relating to the Mental Health Act 1983 was updated in 2015 and includes consideration of the interface between the MCA and the MHA[10] (see Chapter 13).

Legal force of codes

It is the duty of a person to have regard to any relevant code if he is acting in relation to a person who lacks capacity and is doing so in one or more of the ways set out in Statute Box 17.2.

It is interesting that the list set out in Statute Box 17.2 omits the informal carer, that is, the friend or relative who is caring for a person lacking mental capacity and is not paid. However it is hoped that in practice an informal carer will find codes of practice of considerable help to his or her decision making and activities on behalf of the mentally incapacitated person. Failure by an informal carer to follow code of practice guidelines would not have the implications that it does for those listed under Section 42(4) (see Chapter 16 and the scenarios in that chapter).

Statute Box 17.2 Persons upon whom the Code of Practice is binding—S.42(4).

It is the duty of a person to have regard to any relevant code if he is acting in relation to a person who lacks capacity and is doing so in one or more of the following ways:

a) As the donee of a lasting power of attorney
b) As a deputy appointed by the court
c) As a person carrying out research in reliance on any provision made by or under the Act (see Sections 30–34)
d) As an independent mental capacity advocate

(da) In the exercise of functions under Schedule A1

(db) As a representative appointed under Part 10 of Schedule A1 (added by the MHA 2007)

e) In a professional capacity
f) For remuneration (S.42(4))

The italicized subsections (da) and (db) were added by the Mental Health Act 2007 paragraph 8(3) of Schedule 9.

For those listed under Section 42(4) as shown in Statute Box 17.2, the effect of failure to have regard to the code is that if it appears to a court or tribunal conducting any criminal or civil proceedings that a provision of a code or a failure to comply with a code is relevant to a question arising in the proceedings, the provision or failure must be taken into account in deciding the question (S.42(5)).

The explicit setting out of the legal effect of the code was a recommendation of the Joint Committee. This stated that:

> The value of the Codes, [was] one essential means by which the State fulfils its obligations to ensure public authorities act in compliance with the Human Rights Act 1998. We seek reassurance that the wording used in the Bill will ensure that the Codes of Practice are afforded sufficient status to comply with human rights obligations.[11]

In the case of *R (on the application of Munjaz)* v. *Mersey Care NHS Trust* [2006][12], the House of Lords gave guidance on the status of the Code of Practice which was prepared under the Mental Health Act 1983, and this guidance is likely to be followed by the courts in considering the status of the Code of Practice under the Mental Capacity Act. The Code was seen as guidance not instruction and does not have the status of a statute or statutory instrument; but it should be followed unless there are clear reasons against that.

These reasons would include that the guidance is contrary to the law and does not meet the best interests of an individual or following it would lead to a breach of P's human rights. Any failure to follow the Code should be explained to the court.

Guidance for deputies appointed by the court

A code provided for the guidance of deputies appointed by the court (S.42(1(d)) may contain separate guidance for deputies appointed by virtue of paragraph 1(2) of Schedule 5 (functions of deputy conferred on receiver appointed under the Mental Health Act) (S.42(6)).

Procedure to be followed in the preparation of codes

The Lord Chancellor has a statutory duty to consult the National Assembly of Wales (NAW) (see Chapter 18) and such other persons as he considers appropriate before preparing or revising a code (S.43(1)). In addition, the code cannot be issued unless a draft of the code has been laid by him before both Houses of Parliament and the 40-day period (further defined in Section 43(4) and (5)) has elapsed without either House resolving not to approve the draft (S.43(2)).

The Lord Chancellor must arrange for any code that he has issued to be published in such a way as he considers appropriate for bringing it to the attention of persons likely to be concerned with its provisions (S.43(3)).

Revision of codes

Under Section 42(2) the Lord Chancellor may from time to time revise a code of practice and must follow the same procedures set out under Section 43 for the preparation of the code. The Joint Committee expressed hopes that the DCA (now the Ministry of Justice) would make use of a wide range of expertise in the drafting of the code; welcomed the consultation provisions, and emphasized the use of the valuable experience from Scotland.

Assessment of capacity, supporting decision making, and best interests

The Joint Committee was concerned that there needed to be more guidance on the assessment of capacity, and this was added to the subjects for which the Lord Chancellor should provide a code of practice—see Section 4(1)(a) (see Chapter 4). Similar concerns were expressed about supported decision making[13] and determination of best interests,[14] and guidance was therefore included in the Code of Practice.

Decision makers acting under formal powers

In the Joint Committee discussions,[15] the Master of the Court of Protection suggested that there should be a number of obligations which should be imposed on decision makers, in addition to their specific duties, which might include obligations:

- To act reasonably
- To act diligently
- To act honestly and in good faith
- To act within the scope of his or her authority
- To limit interference in the life of the person without capacity to the greatest extent possible
- To protect him or her from abuse, neglect, and exploitation
- To respect and advance his or her civil liberties and human rights
- To provide such assistance and support as is needed
- Where appropriate, actively to help him or her resume or assume independent or interdependent living
- To involve him or her in all decision-making processes to the greatest possible extent
- To encourage such participation and to help him or her to act independently in the areas where he or she is able
- To encourage him or her to exercise whatever skills he or she has and wherever possible to develop new skills
- To exercise substituted judgment by respecting and following his or her wishes, values, and beliefs to the greatest possible extent, so far as these are known or can be ascertained, and will not result in harm or be contrary to his or her best interests

The Joint Committee recommended that specific requirements of a standard of conduct be included in the Codes of Practice aimed at those exercising formal powers under the Act.[16]

Dilemma of inclusion in the Act or Code?

One of the significant dilemmas confronting the law makers and the Joint Committee was what provisions should be put into the Act (which would therefore have statutory force) and what provisions could be left to be

included in the Code of Practice (which would have less weight). A similar discussion took place on the setting out of principles, and significant amendments were made to include the principles as Section 1 (like Scotland) rather than leave them to be incorporated in a Code of Practice.

Baroness Ashton of Upholland[17] stated that:

> One of the things that will happen when, as I trust, the Bill becomes law is that the code of practice, which I think I described earlier as the "living document" upon which professional practice will be based within the framework of the Bill, will be out for consultation to enable us to engage with all those involved.

She also said[18]:

> For the decision-maker to gain the protection against liability offered by Clause 5, if it is an attorney, a deputy, or an independent consultee acting in a professional capacity or for remuneration, he must have regard to the code of practice, as Clause 40(4) [now section 42(4)] makes clear. It is important to be clear that any code of practice issue will be allowed to be used as evidence in court proceedings and could be taken into account by a court or a tribunal.

Similarly,[19] she said the Code of Practice could include what decisions doctors can make and what must be taken to court as being appropriate for the Code of Practice.

She also stated that[20]:

> Under the best interests criteria, professionals would be expected to consult fully about serious decisions, and it would be open to family or friends to ask for a second opinion, if that had not already happened. Any disputes that could not be resolved locally could ultimately be taken to the Court of Protection. We have also provided for an independent person to be consulted when serious medical decisions are taken for people who are "unbefriended." That independent person can ask for a second opinion if they have any concerns. I support the intention behind my noble friend's amendment—to make sure that right procedures are followed at all times, not left to individual good practice. I hope that Members of the Committee will recognise that, although we agree with the need to take certain cases to court and for a second opinion to be provided wherever it is asked for, it would be bureaucratic and inflexible to provide such safeguards in the Bill. It is the inflexibility about which I would be most concerned. We believe that **the best place is the code of practice**, which reflects existing best practice. On that basis, I hope that the noble Lord will feel able to withdraw his amendment.

The Joint Committee also voiced its concerns about getting the balance right between what was in the Act and what was left to the Code of Practice and expressed concerns that too much was being put in the codes and insufficient in the legislation.[21]

Monitoring implementation of the Codes of Practice

The Joint Committee also recommended that the Codes of Practice should provide details of the OPG supervisory role and the sanctions which may apply in the event of noncompliance with the codes.[22]

> We recommend that the Court of Protection's powers should include the power to remove a donee or deputy who is acting incompetently or failing to comply with the guidance given in the Codes of Practice as to the expected standard of conduct. It should be made clear to decision-makers that if their behaviour falls below the standard of conduct set out in the Codes of Practice, the court has power to remove them as attorneys or deputies and if their conduct is criminal, they will face the prospect and consequences of prosecution.[23]

Best practice tool

This was published by the DH in August 2006 and provided guidance for local authorities, National Health Service Trusts, foundation trusts, and independent sector (private and voluntary) hospitals in England in preparation for the implementation of the Act in April 2007.[24] The best practice tool sets down 37 statements for compliance and suggests that the levels of compliance with these statements are coded red, amber, or green according to the level of preparation. The required action on each statement should be recorded and also the person to undertake the activity and the date by which it should have been completed.

The statements cover the following topics:

- Meeting the five statutory principles
- Availability of the Act, Explanatory Memorandum, regulations, and Code of Practice for staff
- People who lack capacity
- Information for service users who may lack capacity and their carers
- Inability to make decisions
- Best interests

- Acts in connection with care and treatment—limitations on *best interests* decision making
- Paying for goods and services and handling money
- Record keeping
- Lasting powers of attorney
- Resolving disputes
- Declarations by the new Court of Protection
- Deputies
- Advance decisions
- Excluded decisions
- Interface with Mental Health Act 1983
- Research
- Independent mental capacity advocate (IMCA) Service
- Criminal offences
- The new Court of Protection
- The Public Guardian
- Enduring powers of attorney
- Receivers
- Code of Practice
- Implementation leads within organizations
- Regional implementation leads
- Awareness raising: brief summary of Act, easy read summary, regular newsletter, standard PowerPoint presentation
- Education and training
- Training materials
- Commissioning IMCA services
- Local implementation networks

Implementation networks

The directors of adult social services were invited by the DH to nominate a contact person to liaise with the implementation programme via a Chief Executive Bulletin in March 2006. Care Services Improvement Partnerships (CSIP) nominated Regional Implementation Leads. These CSIP implementation leads worked with and supported the work of the local implementation networks and agreed regional plans that provided a number of targeted regional awareness and education/training events. They were decommissioned in December 2008 when the work transferred to the Department of Health and regional strategic health authorities. NHS England took over the functions of the regional authorities in 2013 and, together with the clinical commissioning groups and Public Health England, commission health services.

Local implementation networks

The suggested six tasks of the multidisciplinary local implementation network put forward by the DH were:

1. To ensure an independent mental capacity advocacy service was in place by April 2007
2. To disseminate information and publicity about the Act's implementation
3. To assist in awareness raising of health and social care staff on the implementation of the Act
4. To support the education and training of health and social care staff possibly via the dissemination and use of training materials and by supporting a regional *Training the Trainers* approach
5. To meet with an agreed frequency as a multiagency local implementation with a Chair who attends a regional network meeting on its behalf
6. To sign off, along with directors of adult social services and social services' directors of finance, a local multiagency agreed implementation plan that confirmed how centrally provided training monies would be locally allocated

Training materials and funds

The DH, in partnership with the SCIE, commissioned the University of Central Lancashire to provide a range of training materials to support the Act's implementation. These were provided in five modules to cover:

- Generic, for all health and social care staff affected by the Act
- Acute hospitals
- Mental health services
- Residential accommodation
- Primary/community care

Specialist resources on the MCA are available from the SCIE website.[25]

Resources

The support and protection of mentally incapacitated adults is a resource-intensive service. The Joint Committee complained that no estimate of the cost of the full regulatory impact assessment of the Bill had been provided by the Department.[26]

Only late and highly provisional estimates were provided to the Joint Committee, and the DH was criticized by the Joint Committee, especially in view of the fact that the Bill had been under consideration for so many years.[27] Possible costs were estimated at £171 million over 10 years (but could possibly be lower if account were taken of the money already spent on mentally incapacitated decision making).[28]

Costs of training

The DH stated that these would be low cost, because the MCA simply builds on existing practice. However the Association of Directors of Social Services considered that the MCA had significant service delivery and implementation costs.

The Scottish experience suggested the need for a huge investment in training. There was a danger that, without that investment, a wide range of local interpretations would develop, inevitably leading to inequity.[29] The DH had estimated that about 100 000 professionals would need training under the MCA[30]

Other costs included the support for the Court of Protection, the review of current assessment and care management practice, including risk assessment. The appointment of Directors of Social Services to make welfare decisions would result in additional demands on services which are already at capacity.

Legal aid

The cost implications of legal aid were disputed: on the one hand the DH considered them to be insignificant, because legal aid costs would be restricted to serious legal matters so should not increase costs significantly. On the other hand the Law Society said that the objectives of the MCA would be undermined by the lack of availability of public funding. The Scottish experience suggested that the legal aid costs were not too high.[31] The House of Lords Select Committee[32] made recommendations relating to legal aid and mental capacity suggesting that:

Recommendation 32

We note the pressures on legal aid, but we are concerned by the inconsistent provision of nonmeans-tested legal aid for cases concerning a deprivation of liberty, including those where there is a dispute over whether a deprivation is taking place. We cannot see a justification for such inconsistency and we recommend that the gap in protection that it creates be remedied as a matter of urgency.

Recommendation 33

We recommend that the Government reconsider the provision of resources to the Official Solicitor, with a view to determining whether some cases merit the same unconditional support as is currently afforded to medical treatment decisions.

Recommendation 34

We further recommend that the Government review the policy underlying the availability of legal aid for those who lack the mental capacity to litigate and therefore cannot represent themselves. For such people, denial of legal aid may result in having no access to Court. No one who is found to lack the mental capacity to litigate should be denied access to Court solely because they do not have the means to pay for representation.

The Government responded[33] to the criticisms about means tested legal aid, as follows:

9.12 Civil legal aid is available to anyone who meets a means and merits test, provided that the case is within the scope of the scheme. Each application is considered on an individual basis and is subject to statutory tests of the applicant's means and the merits of the case. The scheme focuses limited resources on those who need them most, for cases that most justify it.

9.13 With the introduction of the Legal Aid, Sentencing, and Punishment of Offenders Act 2012 (LASPO) and consequent drafting of the Civil Legal Aid (Financial Resources and Payment for Services) Regulations 2013, the Government clarified that non-means-tested legal aid should only continue while a challenge to an existing statutory authorization was being pursued under Section 21A of the Mental Capacity Act 2005. Other Mental Capacity Act 2005 matters (that is, not proceedings under Section 21A) that are within the scope of civil legal aid are subject to a means test (as well as to a merits test) including cases involving medical treatment, welfare issues, and other *best interest* decisions.

9.14 We do not agree that proceedings which broadly relate to the deprivation of liberty should by themselves not be subject to the means test. However, there are a number of very specific exemptions to the means test. One of these is in respect of certain proceedings under the Mental Health Act 1983 where statutory detention is being challenged; these cases have historically been exempted from means testing. We regard proceedings in

the Court of Protection under Section 21A of the Mental Capacity Act 2005, where the individual is someone in respect of whom an authorization is in force under paragraph 2 of Schedule A1 to that Act, as analogous to those Mental Health Act proceedings which are not subject to a means test. As a result, the relevant legislation also provides that in the Mental Capacity Act cases described previously, *legal representation* (a specific form of civil legal service) may be provided without a determination as to financial eligibility.

9.15 We do not take the same view however, regarding other kinds of proceedings described in the Committee's report, most of which involve an administrative authorization of detention by a statutory (as distinct from a judicial) body.

In the case of *Re UF* [2013][34] Charles J held that non-means-tested legal aid was available in spite of a change in legal aid rules brought in by the 2013 Regulations on April 1, 2013 which suggested that non means-tested legal aid was only available for P while the standard authorization was in force.

Savings

As far as savings were concerned, the Joint Committee considered that local authorities may be able to levy charges on the property of mentally incapable people for whom they were acting as deputies. In addition if people made advance directions, this might minimize the need for LA intervention.[35]

Cost of possible additions to the Bill

Advocacy

The DH was of the view that there was unlikely to be the necessary available resources to provide a facility for independent advocacy. The Joint Committee stated that although it supported some extra provision for advocacy, it thought that uncertainty about the extent of the DH's commitment to advocacy, and lack of any information about the possible costs entailed, further illustrated the problems of bringing the Bill forward before proper consultation on cost has been carried out.[36]

The uncertainties over whether there would be the resources to implement the Bill, and the fact that the DH had identified but not quantified the benefits, led the Joint Committee to vent its fury at being placed in the invidious position of having to carry out its duty of scrutiny without any detailed indications of what the Bill might cost or what the quantum of benefits might be.[37]

In the House of Lords, Lord Carter sympathized with this dilemma over the resource implications of the Bill.[38] He warned against the dangers of double accounting and emphasized that marginal costs may only be involved in implementing the Bournewood safeguards (now known as the Deprivation of Liberty Safeguards):

> Many of the patients will already have costs attached to them, and it would be wrong to double-count the costs by including in the costs of DOLs, the costs which already apply.

In its response to the House of Lords' scrutiny committee on the MCA recommendations, the Government stated that it would ask SCIE to undertake a comprehensive review of the guidance and training materials available on the MCA. It anticipated that this review might:

> identify gaps in our combined MCA resources. Should this be the case then the Department of Health led MCA Steering Group will identify priority commissions and sources of funding from across the system. Our preference is that wherever possible, we should draw on the skills and expertise of those working at the front line to develop materials that understand the reality of practical implementation of the Act. We shall only seek to develop guidance at the national level where there is a clear gap that cannot otherwise be filled.

Recommendation 22 of the House of Lords Report was that more IMCAs should be appointed: "We believe the costs of greater IMCA involvement should be balanced against the resources required in lengthy disputes or ultimately in litigation."

The Government responded to the recommendations on IMCAs by stating that it was the intention to provide statutory guidance under the Care Act 2014 which will bring together those advocates appointed under the MCA with those appointed under the Care Act (see Chapter 8).

Mental Health Act receivers

Schedule 5 of the MCA made transitional provisions for those persons who have had a receiver appointed under Part 7 of the Mental Health Act 1983. From October 1, 2007 the Mental Capacity Act 2005 applied as if the receiver (R) were a deputy appointed for a person by the court but with the functions that R had as receiver

immediately before that day. The newly constituted Court of Protection has powers over the deputies including the power to end the receiver's (then known as the deputy's) appointment. If as a result of S.20(1) (necessity for the person to lack mental capacity) the receiver may not make a decision on behalf of P, R must apply to the court. If, on the application, the court is satisfied that P is capable of managing his property and affairs in relation to the relevant matter, then the court must make an order ending R's appointment as P's deputy in relation to that matter, but it may, in relation to any other matter, exercise in relation to P any of the powers which it has under Sections 15–19 (i.e., power to make declarations, decisions, and appoint deputies; make decisions in relation to P's personal welfare and in relation to property and affairs) (see Chapter 7).

Interim procedural arrangements

A Practice Note was issued by the Official Solicitor[39] to cover the situation pending the coming into force of the Mental Capacity Act 2005. It set out the jurisdiction of the High Court in dealing with decisions and the lawfulness of proposed medical treatment or withdrawal of treatment and decisions regarding welfare issues. It stated that court applications should be made:

1. Where it was proposed to withdraw artificial nutrition and hydration from a patient in a permanent vegetative state
2. In cases involving the sterilization of a patient for contraceptive purposes where they could not consent
3. In certain termination of pregnancy cases
4. Where there was any serious treatment decision and there was disagreement between those involved
5. Where the proposed treatment would involve the use of force or restraint, or where there were doubts or difficulties over assessment of either the patient's capacity or best interests

In addition the Practice Note gave guidance on the test for capacity, the implications of advance directives, and the relevance of a patient's best interests.

Proceedings would invariably be brought under the Civil Procedures Rules 1998 Part 8. The patient must always be a party. The claimant would usually be the NHS trust or local authority, but any properly interested person could bring proceedings. Incapacitated adults could be assisted by the appointment of the Official Solicitor.

Proceeding such as those listed previously would now be heard in the Court of Protection and the Court of Protection Rules apply[40] (see Chapter 7).

Pilot IMCA schemes

Seven IMCA pilots were set up in January 2006 to help identify the practical issues involved in implementing the IMCA service. They took place in Cambridgeshire, Cheshire and Merseyside, Croydon, Dorset, Hertfordshire, Newcastle, and Southwark.

The aim was to test the practicalities of providing advocacy services to particularly vulnerable people by helping them to make important decisions about medical treatment and changes of residence—for example, moving to a hospital or care home. The results were to be used when considering how to provide this service on a wider basis.

These pilot schemes were evaluated by the Learning Disabilities Research Group at the University of Cambridge, headed by Marcus Redley, and its report is available on the DH website. It noted that decision makers were positive about their experience of working with the IMCA caseworkers, and their involvement improved decision making by providing additional relevant information and kept the clients at the center of the process. Many decision makers did not understand the purpose of the IMCA service, and inappropriate referrals were made.

Recommendations included the need for adequate provision to be made for the supervision of caseworkers; IMCA caseworkers' skill and expertise should be recognized by the future national professional qualification, a national association, and/or an appropriate salary. In addition to avoid an unnecessary strain on IMCA resources, good generic advocacy services may be a necessity. (Further consideration of the role of the IMCAs and the service can be found in Chapter 8.)

Guidance from specific professional organizations and client-specific associations

The implications of the MCA are wide ranging, and many different organizations and associations have provided their members with specific guidance on the

implications of the legislation for their specific needs. A direct web link between the Ministry of Justice and many of these organizations is available on the government website,[41] including the Social Care Institute for Excellence, Age Concern, Alzheimer's Society, CSIP, Carers UK, Mencap, Mind, and Scope. It also provides a direct link to the other relevant Government departments, including the IMCA service, the Office of the Official Solicitor and Public Trustee, and the Public Guardianship Office. Health and social services professionals as well as carers and clients will find the various specialist sites of benefit in understanding the implications of the new legislation.

Disagreements and complaints

Many concerns on how the legislation is being implemented and how the vulnerable adults are being protected are initially the subject of complaints and representations rather than legal action. The Code of Practice recommends that there should be attempts to resolve concerns initially through case conferences and discussions, mediation, and the complaints procedures of the NHS, LA, or independent sector. Chapter 15 of the Code of Practice considers the best ways to settle disagreements and disputes about issues covered in the Act.[42] In addition the preaction protocol of the Court of Protection requires the parties concerned in a dispute to attempt to resolve the issues without an application to the court, where appropriate (some decisions have to go to the Court of Protection—see Chapter 7). Further guidance on how to deal with problems without going to court is provided in the Community Legal Services Information Leaflet, *Alternatives to Court*.[43] Information about mediation services can be obtained from the National Mediation Helpline[44] and the Family Mediation Helpline.[45]

In England new complaints regulations came into force in 2009[46] replacing the scheme which had been in operation since 2004. These establish a statutory procedure for the handling of complaints about NHS and LA services. Complainants could be assisted by representatives of the Patient Advice and Liaison Service, and if the complaint cannot be resolved speedily, the Independent Complaints Advocacy Service could be a source of help and advice. If the complainant is dissatisfied by the attempt at local resolution, he or she can seek an independent review by the Ombudsman or Health Service Commissioner. Patients detained under the Mental Health Act can complain to the Care Quality Commission which took over the functions of the Mental Health Act Commission. Complaints in Wales and the role of the Community Health Council are considered in Chapter 18.

Since 2009 social services departments must comply with the new procedures for the handling of complaints and ensure that the procedure covers the delivery of services, the types of services provided, and failure to provide services.

Care homes in the independent sector now registered with the Care Quality Commission (which replaced the Commission for Social Care Inspection) are each required to have a complaints procedure.

The House of Lords Select Committee on the Mental Capacity Act 2005[47] made significant recommendations following its review of the Act. The Government responded[48] positively to its recommendations and intended to increase public awareness of the provisions of the MCA and implement many other recommendations.

The CQC carries out regular evaluation of the implementation of the Mental Capacity Act. In its 2013 report on the monitoring of Deprivation of Liberty Safeguards, it reported that there was still widespread lack of understanding of the whole of the MCA.

The House of Commons Health Committee[49] considered the handling of complaints and raising concerns about health and social services matters and made recommendations including the need for the Government to evaluate the operation of the complaints system in the light of the post-Francis changes.[50] It also urged fairer treatment of whistle-blowers and those who had suffered serious harm and whose actions are proved to have been vindicated should be provided with an apology and practical redress.

Conclusions

Alongside the Human Rights Act 1998, the Mental Capacity Act 2005 is one of the most important pieces of legislation to affect health and social care over the last half century. Inevitably there has been a period of uncertainty, since the MCA has such vast implications across every aspect of health and social care. There are also resource pressures, since the assessment of capacity

and the determination of what is in a person's *best interests* may take longer than it has in the past. It is essential that those charged with the implementation of the MCA follow the philosophy which underpins the legislation in ensuring respect and support for personal autonomy and a willingness to act in the best interests of those unable to make their own decisions. There is a danger that if the spirit of the MCA is not upheld, its implementation will descend to a bureaucratic nightmare of ticking boxes and paperwork. The recommendations of the House of Lords post-legislative scrutiny of the MCA[51] and the positive response by the Government[52] will undoubtedly lead to significant changes in law. In addition the increase in the number of those placed under authorizations for restriction of liberty under the Deprivation of Liberty Safeguards partly resulting from the wider definition of *deprivation of liberty* by the Supreme Court in the Chester case[53] will increase the pressure on already reduced social services budgets. The challenges for health and social services professionals and for the informal carers are clear.

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CHAPTER 18

Wales, Scotland, and Northern Ireland

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Introduction

The four constituent parts of the United Kingdom now have three sets of primary legislation covering mental capacity between them. The Mental Capacity Act (MCA) 2005 applies to England and Wales (except for two exceptions set out in Section 68(5) evidence of instruments and of registration of enduring and lasting powers of attorney). However increasingly Wales has enacted its own regulations. Scotland has the Adults with Incapacity (Scotland) Act 2000 and Northern Ireland has a Mental Capacity Bill 2015 which in contrast with the other two Acts that contain provision for the detention of the mentally disordered. This chapter considers the different regulations in Wales and gives a brief summary of the legislation in Scotland and Northern Ireland.

Wales

A referendum was held on September 18, 1997 which supported the devolution of specific powers to a Welsh Assembly. Subsequently the Government of Wales Act 1998 established the National Assembly for Wales (NAW). This is the representative body with legislative powers. It has 60 elected members and meets in the Senedd in Cardiff. Specific powers to make subordinate legislation, that is, statutory instruments, were devolved to the NAW.[1] This meant that while the main legislative function still remained with the UK Parliament in Westminster, the NAW had the power to vary the details as to how that legislation will be implemented. For example, the NAW set different rates for prescription charges from those which applied in England and from April 2, 2007 abolished them completely.

Legal Aspects of Mental Capacity: A Practical Guide for Health and Social Care Professionals, Second Edition. Bridgit Dimond.
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As a consequence of the Government of Wales Act 2006, from May 2007 the Welsh Assembly Government (WAG) was established as an entity separate from but accountable to the National Assembly of Wales. This meant that all executive and regulatory functions transferred to the WAG are legally expressed as exercisable by the *Welsh Ministers* and not by the NAW. The First Minister appointed by the Queen on the nomination of the Assembly appoints other Ministers and Deputy Ministers with her approval. These Ministers act on behalf of the Crown but would have to resign if they lost the confidence of the Assembly. The Government of Wales Act creates a new executive structure for the Assembly, enhances the Assembly's law-making powers, and reforms the electoral system. The WAG is the devolved government for Wales. It is led by the First Minister and is responsible for health, education, economic development, culture, the environment, and transport. The National Health Service (Wales) Act 2006 places the statutory responsibility for promoting and providing the health service in Wales on the Welsh Ministers.

Wales and the MCA 2005

The MCA 2005 applies to Wales, but the Act recognizes that there can be separate provisions in certain matters for Wales. These are collated briefly in the following text. In particular the MCA 2005 enables certain regulations to be drawn up by the WAG. These have therefore been subject to separate consultation in Wales. Wales uses the same Code of Practice for the MCA as England. However the Lord Chancellor is statutorily bound to consult the NAW before preparing or revising a code.

Under Section 64(1)(c) *local authority* means the council of a county or county borough in Wales,

The areas where Wales has its own Statutory Instruments are:

- Definition of the appropriate body in research
- Loss of capacity during research regulations
- Independent Mental Capacity Advocacy Service regulations

Research

Section 30(1) gives the *appropriate authority* power to draw up regulations specifying who can give approval to a research project (other than a clinical trial research project). Appropriate authority includes the NAW. Consultation on the regulations to define the appropriate body which could give approval to research projects and on the regulations for arrangements where a person had given consent to a study but had lost capacity before the end of the project commenced in August 2006.

The appropriate body in relation to a research project in the Welsh Regulations is:

A committee (or other body):

a) Established to advise on, or on matters which include, the ethics of intrusive research in relation to people who lack capacity to consent to it

b) Recognized for those purposes by the NAW[2]

The appropriate body regulations came into force for the purpose of enabling applications for approval in relation to research to be made on July 1, 2007 and for all other purposes on October 1, 2007.

Loss of capacity during a research project

Section 34 of the MCA enabled regulations to be drawn up to cover the situation where P had consented to take part in a research project that began before the commencement of Section 30 (March 31, 2008), but before the conclusion of the project lost capacity to consent to continue to take part in it, and research for the purpose of the project would be unlawful by virtue of Section 30 of the Act. The Welsh regulations[3] are almost identical to those applying to England but for convenience are given in the following text.

The regulations provide that in such circumstances, despite P's loss of capacity, research for the purposes of the project may be carried out using information or material relating to him if:

a) The project satisfies the requirements set out in Schedule 1.

b) All the information or material relating to P which is used in the research was obtained before P's loss of capacity.

c) Information or material is either:

  i) Data within the meaning of Section 1 of the Data Protection Act 1998

  ii) Material which consists of and/or includes human cells or human deoxyribonucleic acid (DNA)

d) The person conducting the project (*R*) takes in relation to P such steps as are set out in Schedule 2.

Schedule 1 is shown in Box 18.1.

Box 18.1 Schedule 1 to the regulations on loss of capacity during the research project.

Requirements which the project must satisfy:

1. A protocol approved by an appropriate body and having effect in relation to the project makes provision for research to be carried out in relation to a person who has consented to take part in the project but loses capacity to consent to continue to take part in it.
2. The appropriate body must be satisfied that there are reasonable arrangements in place for ensuring that the requirements of Schedule 2 will be met (see Box 18.2 for Schedule 2).

Independent mental capacity advocate (IMCA)

Section 35(1) requires the *appropriate authority* to make arrangements for IMCAs to be available to represent and support persons who lack the capacity to make decisions relating to serious medical treatment, accommodation arrangements by the National Health Service and accommodation arrangements by the local authority. Section 30(7) defines *the appropriate authority* in relation to the provision of the services of IMCAs in Wales, as the NAW.

Under Sections 37 and 38, the NAW has the power to prescribe by regulations the definition of *NHS body* in relation to bodies in Wales for the purposes of Section 37.

Consultation commenced in August 2005 on the Independent Mental Capacity Advocacy Service in Wales[4] and closed on October 31, 2005. It covered the following topics:

- Operation of the IMCA service
- Functions of the IMCA
- Serious medical treatments—definition
- Extending the IMCA service

Different options were put forward for each topic.

The consultation paper stressed that the WAG did not regard the new IMCA service as a replacement or substitute for independent advocacy as it is commonly understood and practiced in the social care sector. The aims of the WAG were to ensure that the IMCA:

- Provides a seamless service
- Does not overlap with other statutory services
- Does not result in a client having to change advocates simply because they now qualify for *statutory* advocacy.

Box 18.2 Schedule 2 to the regulations on loss of capacity during the research project.

Steps which the person conducting the project must take:

1. R must take reasonable steps to identify a person who, (a) otherwise than in a professional capacity or for remuneration, is engaged in caring for P or is interested in P's welfare and (b) is prepared to be consulted by R under this schedule.
2. If R is unable to identify such a person he must, in accordance with guidance issued by the appropriate authority, nominate a person who (a) is prepared to be consulted by R under this schedule but (b) has no connection with the project.
3. R must provide the person identified under paragraph 1, or nominated under paragraph 2, with information about the project and ask him (a) for advice as to whether research of the kind proposed should be carried out in relation to P and (b) what, in that person's opinion, P's wishes and feelings about such research being carried out would be likely to be if P had capacity in relation to the matter.
4. If, any time, the person consulted advises R that in his or her opinion P's wishes and feelings would be likely to lead him to wish to withdraw from the project if he had capacity in relation to the matter, R must ensure that P is withdrawn from it.
5. The fact that a person is the donee of a lasting power of attorney given by P, or is P's deputy, does not prevent him from being the person consulted under paragraphs 1–4.
6. R must ensure that nothing is done in relation to P in the course of the research which would be contrary to (a) an advance decision of his which has effect or (b) any other form of statement made by him and not subsequently withdrawn of which R is aware.
7. The interests of P must be assumed to outweigh those of science and society.
8. If P indicates (in any way) that he wishes the research in relation to him to be discontinued, it must be discontinued without delay.
9. The research must be discontinued without delay if at any time R has reasonable grounds for believing that one or more of the requirements set out in Schedule 1 is no longer met or that there are no longer reasonable arrangements in place for ensuring that the requirements of this schedule are being met in relation to P.
10. R must conduct the research in accordance with the provision made in the protocol referred to in paragraph 1 of Schedule 1 for research to be carried out in relation to a person who has consented to take part in the project but loses capacity to consent to take part in it.

The cost as calculated by the Regulatory Impact Assessment was an estimate of £390K for the running of the IMCA scheme in Wales. It was emphasized that this was a tentative figure based on several planning assumptions on the cost and frequency of cases, and there were many uncertainties.

Operation of the IMCA service

The three options for commissioning the IMCA service were:

1. WAG could directly commission a small number of organizations to provide the service.
2. LAs or Local Health Boards (LHBs) could commission individual advocates (see section LHBs).
3. LAs or LHBs could commission independent organizations.

WAG also questioned whether there should be national standards and if so, whether they should apply to individual advocates, to organizations, or to both.

WAG questioned what current training was considered to be most appropriate for the IMCA service; what learning should be covered; who should develop, deliver, and accredit the training; and to what extent should the IMCA training link with other programs.

On the issue of independence WAG questioned how the independence of IMCAs could be built into the service and how should independence be built into any regulations and/or commissioning guidance or contracts.

On the topic of monitoring and accountability, WAG questioned whether the guidance should specify key objectives for monitoring the IMCA service or should this be left to the commissioning organizations; who should monitor compliance with the standards; what role, if any, should the Assembly Inspectorates play in monitoring the IMCA services; and how should complaints made against an IMCA service be investigated and by whom.

Functions of the IMCA

The key functions of the IMCA are set out in Section 36(2) of the MCA as follows:

- Representing and supporting the person who lacks capacity
- Obtaining and evaluating information
- Ascertaining the person's wishes and feelings as far as possible
- Ascertaining alternative courses of action—for example, looking at different care arrangements or residential homes
- Obtaining a further medical opinion if necessary.

The NAW is empowered under Section 36(1) and 36(2) to make regulations concerning the steps that the IMCA should take in undertaking these functions. WAG consulted on whether there were any steps which should be outlined and whether these steps should be in the regulations or in the Code of Practice. It also consulted on Section 36(3) (which enabled regulations to be drawn up to cover the IMCA challenging the decision maker) should be implemented and whether the IMCA should be able to bring simple cases before the Court of Protection without legal representation and be able to challenge the decision that P lacked the requisite mental capacity. WAG also consulted on what possible additional functions for the IMCAs could be included in the regulations and whether local organizations should have discretion on how they use additional functions. The involvement of IMCAs in care reviews was also the subject of consultation.

Extending the IMCA service

Section 41(1)(a) gives power to the appropriate authorities to prescribe additional circumstances in which the IMCA's advice must or may be sought. WAG therefore consulted on six options:

- Doing nothing
- Revising the assumptions regarding the IMCA
- Providing an IMCA in cases of dispute
- Providing an IMCA where requested by one of the parties
- Providing an IMCA for extra care housing
- Allowing the commissioner of the service to determine priorities.

It also raised more general questions over:

- Whether the groups who qualify for an IMCA should be broadened
- Should additional situations and circumstances be covered
- How should they prioritize to meet those most in need
- What makes someone who lacks capacity but has family and friends particularly vulnerable.

The IMCA Regulations for Wales

The MCA 2005 (IMCA) Regulations for Wales[5] were approved by the NAW on March 13, 2007 and came into force on October 1, 2007. Unlike the two sets of English regulations, there is one set only for Wales.

The regulations define an NHS body as a LHB (see page 325 "LHBs"), an NHS trust (where all or most of its hospitals, establishments, and facilities are situated in Wales), or a Special Hospital Authority performing functions only or mainly in respect of Wales.

Serious medical treatment

The NAW has the power under Section 37(6) and (7) to set the definition of serious medical treatments in its regulations. It consulted on three options: listing specific treatments, focusing on the characteristics of the decision to be taken, and a combination of those two. Eventually it defined serious medical treatment in the same way as the English regulations, that is:

Treatment which involves providing, withdrawing, or withholding treatment in circumstances where:

a) In a case where single treatment is being proposed, there is a fine balance between its benefits to a person (P) and the burdens and risks it is likely to entail for P
b) In a case where there is a choice of treatments, a decision as to which one to use is finely balanced
c) What is proposed would be likely to involve serious consequences for P

The appointment of IMCAs

Subject to any directions which it receives from the WAG, a LHB must make such arrangements as it considers reasonable to enable IMCAs to be available to act in respect of persons usually resident in the area for which the LHB is established and to whom acts or decisions proposed under Section 37 (serious medical treatment), Section 38 (accommodation by NHS), and Section 39 (accommodation by LA) or under the regulations relate.

These arrangements can be made with a provider of advocacy services.

No person may be instructed to act as an IMCA unless that person is approved by the LHB or is employed by a provider of advocacy services to act as an IMCA.

The LHB must be satisfied that the person satisfies the appointment requirements before that person can be approved as an IMCA.

The LHB must ensure that any provider of advocacy services with whom it makes arrangements is required to ensure that any person employed by that provider of advocacy services and who is made available to be instructed as an IMCA satisfies the appointment requirements.

The appointment requirements are that a person:

a) Has appropriate experience or training or an appropriate combination of experience and training
b) Is of integrity and good character
c) Will act independently of any person who instructs him or her to act as an IMCA and of any person who is responsible for an act or decision proposed under Sections 37, 38, and 39 of the Act or under these regulations[6]

In determining whether a person meets the appointment requirement of having the appropriate experience or training, regard will be had to standards in guidance that may be issued by the Assembly.

Before deciding if a person is of integrity and good character, an enhanced criminal record certificate issued under S. 113A or S. 113B of the Police Act 1997 (as amended by Section 163 of the Serious Organised Crime and Police Act 2005) is required. If the purpose for which the certificate is required is not one prescribed under Section 163(2), a criminal record certificate issued under Section 113A of the Police Act 1997 is required.

Functions of an IMCA

The IMCA must determine in all the circumstances how best to represent and support P and must act in accordance with the following requirements. The IMCA must:

a) verify that the instructions have been issued by an NHS body or local authority;
b) to the extent that it is practicable and appropriate to do so
  i) interview P in private, and
  ii) examine the records relevant to P to which the IMCA has access under Section 35(6) of the Act;
c) to the extent that it is practicable and appropriate to do so, consult

i) persons engaged in providing care or treatment for P in a professional capacity or for remuneration, and
ii) other persons who may be in a position to comment on P's wishes, feelings, beliefs or values; and

d) take all practicable steps to obtain such other information about P, or the act or decision that is proposed in relation to P, as the IMCA considers necessary.[7]

The IMCA must evaluate all the information he has obtained for the purpose of:

a) Ascertaining the extent of the support provided to P to enable him to participate in making any decision about the matter in relation to which the IMCA has been instructed
b) Ascertaining how P would feel, what P would wish, and the beliefs and values that would be likely to influence P if he had capacity in relation to the proposed act or decision
c) Ascertaining what alternative courses of action are available in relation to P
d) Where medical treatment is proposed for P, ascertaining whether he would be likely to benefit from a further medical opinion[8]

The IMCA is required to prepare a report for the NHS body or the local authority who instructed him or her (reg 6(5)) and may include in the report such submissions as he considers appropriate in relation to P and the acts or decisions which are proposed in relation to P (reg 6(6)).

Challenges to decisions affecting persons who lack capacity

Where an IMCA has been instructed to act and a decision (including a decision as to P's capacity) is made in relation to P, then the IMCA has the same rights to challenge the decision as if he or she were a person (other than an IMCA) who:

a) Was entitled, in accordance with Section 4(7)(b) of the Act, to be consulted in relation to a matter about which the IMCA is now instructed
b) It would otherwise be appropriate for an NHS body or a local authority to consult

Extension of remit of the IMCA

Like the English regulations, the Welsh IMCA regulations extend the remit of the IMCA to include the review of arrangements as to accommodation and adult protection cases.

Review of accommodation arrangements by NHS body or LA (*care reviews*)

The NHS body or LA *may* instruct a person to act as an IMCA in relation to P in the following circumstances where:

a) An NHS body or LA has made arrangements for the provision of accommodation in a hospital or care home for a person who lacks capacity.
b) An IMCA has been instructed in relation to those arrangements in accordance with Sections 38 or 39.
c) That accommodation has been provided for P for a continuous period of 12 weeks or more.
d) The NHS body or LA propose to review P's accommodation arrangements (whether under a care plan or otherwise).
e) They are satisfied that there is no person other than a person engaged in providing care or treatment for P in a professional capacity or for remuneration, whom it would be appropriate to consult in determining what would be in P's best interests.
f) They are satisfied that it would be of benefit to P to be so represented and supported.[9]

Like the English regulations, this, unlike the duties under Sections 37, 38, and 39, is a discretionary duty, and the Code of Practice has given guidance on when the power to appoint an IMCA should be used in care reviews.[10] The power only applies where the person lacks the requisite mental capacity. The power does not apply where accommodation is provided under an obligation imposed by the Mental Health Act 1983 (see Chapter 13 and Scenario 13.6). The regulations were amended by an SI in 2009[11] to add Sections 39A, 39C, and 39D to regulation 2(2) and to 5(1).

Adult protection cases

Where an NHS body or LA proposes to take or proposes to arrange to be taken, protection measures in relation to a person P who lacks capacity to agree to one or more of the measures, then the NHS or LA *may* instruct an IMCA to represent P if it is satisfied that it would benefit P to be so represented and supported.

The Code of Practice gives guidance on when this discretionary power may be used.[12] The regulations do not require the person in an adult protection situation to have no friends or family to consult. The protective measures must be proposed or taken as a result of an allegation that P is being abused or neglected or is abusing or has abused another person. Protective measures include measures to minimize the risk that any abuse or neglect of P, or abuse by P, will continue and measures taken in pursuance of guidance issued under Section 7 of the LA Social Services Act 1970.[13]

This regulation does not apply where an IMCA has been instructed in accordance with Section 37 (serious medical treatment), and Sections 38 and 39 (accommodation provided by NHS or LA) or Regulation 8 (review of accommodation).

Lasting powers of attorney

The regulations drawn up in relation to LPAs, enduring powers of attorney and the Public Guardian, apply to both England and Wales.[14] However provision is made for any of the forms set out in Schedules 1–7 to include a Welsh version of the form.[15]

Deprivation of liberty safeguards

While the statutory provisions relating to the deprivation of liberty safeguards set out in the Mental Health Act 2007 amending the MCA 2005 apply to Wales (see Chapter 14), Wales has published its own regulations in relation to assessments and statutory authorizations[16] and the relevant person's representative.[17] The former covers the following topics:

Eligibility to carry out assessments
Selection of assessors
Assessment
Request for a standard authorization
Supervisory bodies: care homes
Dispute about the place of ordinary residence
They can be accessed on the legislation website.[18]

The Appointment of the Relevant Person's Representative covers the supervisory functions of LHBs, the appointment procedure and eligibility, the selection procedure, and the termination of the appointment.

The WAG has published guidance booklets to assist managing authorities and supervisory bodies identify key processes in the safe and effective use of DOLs, together with standard forms and letters.[19]

Where there is a dispute over ordinary residence and which local authority should act as the supervisory body, the Welsh ministers will determine cross-border ordinary residence disputes between England and Wales where the person to whom the dispute relates is accommodated in a care home in Wales.

Local Health Boards

In Wales LHBs were the equivalent of the primary care trusts in England (PCTs are now abolished in England). The NAW delivers the IMCA service through LHBs, which have financial responsibility for the service and work in partnership with local authority social services departments and other NHS organizations. The LHBs commissioned the IMCA service from independent organizations, usually advocacy organizations.

In England, a person can only be an IMCA if the local authority approves their appointment. In Wales, the LHB used to provide approval.

In 2009 the NHS in Wales underwent a major restructuring and the 22 LHBs and 7 NHS Trusts were replaced by 7 LHBs which plan, secure, and deliver healthcare services. There are 3 NHS Trusts which provide all-Wales services: the Welsh Ambulance Services Trust, the Velindre NHS Trust which offers services in cancer care, and the Public Health Trust.

The Commissioner for Older People in Wales

The Commissioner for Older People in Wales is established by an Act[20] of the same name and came into force on February 16, 2007.[21] An older person is a person over 60 years. The general functions are set out in Section 2 and include:

- Promoting awareness of the interests of older people in Wales and of the need to safeguard those interests
- Promoting the provision of opportunities for, and the elimination of discrimination against, older people in Wales

- Encouraging best practice in the treatment of older people in Wales
- Keeping under review the adequacy and effectiveness of law affecting the interests of older people in Wales.

The Commissioner also has the power to review the effect on older people of the discharge or failure to discharge of the functions of the Assembly. The Commissioner may review the arrangements for, and the operation of, advocacy, complaints, and whistle-blowing arrangements and can give assistance to older people in making a complaint. Assistance includes financial help as well as representation. The Commissioner may undertake or commission research. Powers of entry and of interviewing are given to the Commissioner or a person authorized by him. The Commissioner is required to work jointly with the Public Services Ombudsman for Wales where a case comes under both their jurisdictions. He/she is also required to establish a complaints procedure in relation to the discharge of his/her functions.

Those organizations and persons whose functions are subject to review by the Commissioner are listed in Schedule 3 and include local authorities, health, and social care bodies such as the Care Council for Wales, a LHB, NHS trust, the Wales Centre for Health, a family health service provider in Wales, an independent provider, and the National Leadership and Innovations Agency for Healthcare. Education and training, arts and leisure, and environment organizations are also listed:

> Advice and support can be given for relevant older people in Wales which is intended to enable and assist them to express their views and wishes orally or using any other means of communication and the provision of advice (including information) about their rights and welfare.[22]

The Court of Protection

Section 45 states that there is to be a superior court of record known as the Court of Protection, which is to have an official seal and may sit at any place in England and Wales on any day and at any time. The court is to have a central office and registry at a place appointed by the Lord Chancellor. The Lord Chancellor may designate as additional registries of the court any district registry of the High Court and any county court office.

Section 63: International protection of adults

Schedule 3—

a) Gives effect in England and Wales to the Convention on the International Protection of Adults signed at the Hague on January 13, 2000 (Cm. 5881) (in so far as this Act does not otherwise do so)

b) Makes related provision as to the private international law of England and Wales

Complaints mechanisms

Wales also has different complaints and inspection mechanisms from those which exist in England. Putting Things Right describes the complaints procedure since April 2011, the role of the CHC, and further steps which can be taken. Further information on the NHS in Wales is available on its website.[23] Dissatisfied complainants can taken their concerns to the Public Services Ombudsman for Wales.[24]

Community health councils

While CHCs (CHC) were abolished in England in 2003 in favor of the establishment of the Patient Advocacy and Liaison Services (PALS), the NAW opted to retain them. The 20 CHCs in Wales were the only statutory lay organizations with rights to information about access to and consultation with all NHS organizations. The Board of CHCs in Wales collates all the information about patients' concerns across Wales and ensures that it reaches the Health and Social Services Committee in the National Assembly. It also has links to the Department of Health if the issue is a joint concern with England or it is a matter of funding beyond the scope of the Assembly.[25] In 2004 the powers and responsibilities of the CHCs in Wales were strengthened to give patients and families a stronger voice and better advice on NHS issues. The changes included:

- An independent complaints advocacy service across Wales
- The right to visit GPs, dental surgeries, opticians, and pharmacies

- The right to visit private nursing homes where NHS patients are being treated
- Setting up of a statutory all-Wales body to support and advise CHCs in their roles.

In 2009 the number of CHCs was reduced to 7 to be coterminous with the new LHBs and are underpinned by 23 area associations with strong local links.[26]

Healthcare Inspectorate Wales

Healthcare Inspectorate Wales (HIW)[27] is a department of the NAW and is responsible for inspecting and investigating the provision of healthcare by and for Welsh NHS bodies. Since April 1, 2005 it has been responsible also for the regulation of the private and voluntary healthcare sector in Wales, having taken over this role from the Care and Social Services Inspectorate for Wales (see section "Care and Social Services Inspectorate for Wales"). It also fulfills the function of the Local Supervising Authority of midwives for Wales HIW's purpose is to promote continuous improvement in the quality and safety of patient care within NHS Wales. It undertakes reviews and investigations into the provision of NHS-funded care either by or for Welsh NHS organizations.

Care and Social Services Inspectorate for Wales

The Care and Social Services Inspectorate for Wales (CSIW), set up in 2002 under the Care Standards Act 2000 now the Care and Social Services Inspectorate,[28] regulates social care, early years and private and voluntary healthcare services in Wales, to ensure standards are enforced and vulnerable people are safeguarded. It is operationally independent of the NAW, and it regulates the sector through a national office, eight regional and three local offices across Wales. It regulates approximately 6000 settings against the regulations and national minimum standards set by the NAW and the WAG. There are four specific aspects to its work:

1. Registration
2. Inspection
3. Complaints
4. Enforcement

Its first priority is to provide protection for service users. It makes every effort to assist providers to meet their legal obligations and to maintain required standards but will take firm enforcement action through criminal or civil proceedings against those providers who fail to comply with the requirements and law.[29]

It has published a booklet on the complaint procedure and guidance for handling complaints in regulated services, which is available on its website.[30] It was updated in 2007 to take account of any changes to the regulations.

The complaint process envisages the following stages: a local resolution procedure followed by a formal investigation procedure if the local resolution proves unsuccessful. However where there is a complaint about the registered person or manager, responsible individual, or the person in charge, then the complaint will go straight to the formal investigation. This would be carried out by the CSSIW. Where the complaint also involves the local authority or the NHS, then the local authority complaints procedure and/or the NHS complaints procedure will apply, and a joint investigation may be the outcome.

Regulations made under the Care Standards Act 2000 require that the complaints procedures operated by regulated services should consider complaints from any service user or any person—including relative or representative—who acts on their behalf.

Public Services Ombudsman for Wales

This office came into force in April 2006. It is a new office which replaces the previous offices of the Local Government Ombudsman for Wales, the Health Service Ombudsman for Wales, the Welsh Administration Ombudsman, and Social Housing Ombudsman for Wales. Its role is to investigate complaints made by members of the public. The complaints are investigated independently and impartially, and when upheld, the Ombudsman states what the public body must do to make amends to the complainant and how the standard of service could be improved. The Ombudsman has issued a statutory guidance under Section 31 of the Public Services Ombudsman (Wales) Act 2005, *Guidance to Local Authorities on Complaints Handling*.

Scotland

Scotland had implemented its legislation relating to adults lacking the requisite mental capacity many years before England and Wales. A short guide to the Adults with Incapacity (Scotland) Act 2000 is available from the Scots Government website.[31] The Act, like its later English counterpart, presumes that an adult is capable of making his or her own decisions and managing their affairs.

For the purpose of the Act, incapable means incapable of acting on decisions, making decisions, communicating decisions, understanding decisions, or retaining the memory of decisions. The following statutory principles must be applied in making decisions on behalf of those who are incapable:

Benefit: any action or decision taken must benefit the person and only be taken when that benefit cannot reasonably be achieved without it.

Least restrictive option: any action or decision taken must be the minimum necessary to achieve the purpose.

Take account of the wishes of the person: present and past wishes and feelings of the person must be ascertained if possible. The individual should be offered assistance to communicate his or her views.

Consultation with relevant others: The primary carer, nearest relative, named person, attorney, or guardian should be consulted if available in the decision-making process

Encourage the person to use existing skills and develop new skills.

The Act covers the following areas:

1. *Part one*. General principles, Judicial proceedings, powers of the sheriff, the Public Guardian, the Mental Welfare Commission, local authorities, and Codes of Practice
2. *Part two: Powers of attorney*. Like the English/Welsh scheme there are two separate powers: one for finance and one for welfare decisions, the latter only coming into operation when the granter has lost capacity.
3. *Part three: Access to funds*. This enables access to a person's bank or building society accounts to meet his or her living costs.
4. *Part four: Management of (care home/hospital) residents' finances*. A certificate of authority may be granted to the manager by the local authority or health board for the manger to be authorized to use a limited amount of the funds and property of those residents who are incapable.
5. *Part five: medical treatment and research* decisions on behalf of those lacking capacity. A second medical opinion can be obtained where there is disagreement and the Mental Welfare Commission holds a list of specialist doctors for this purpose.
6. *Part six: Guardianship orders and intervention orders*: A guardianship application can be made to the sheriff by individuals or by the local authority. After being satisfied that the relevant person lacks the requisite capacity and that there is no other suitable means of safeguarding or promoting the adult's interests, a guardian can be appointed who can be given power to make decisions over property and financial matters or personal welfare.

An intervention order would be issued when a single action or decision is required. Like guardianship, the application would be made to the sheriff by an individual or by the local authority.

The Office of Public Guardian (Scotland) [32]

The Office of Public Guardian (OPG) supervises those authorized to manage the finances and property under the access to funds scheme, intervention, and guardianship. Its functions also include the provision of advice and guidance on the Act, keeping registers of attorneys, intervention, and guardianship orders and supervising financial attorneys and investigation of complaints.

The Mental Welfare Commission[33]

The MWC has a general function of protecting the interests of adults who lack incapacity due to mental disorder. It can visit welfare guardians and those on welfare guardian orders, has the power to investigate complaints, and provides a range of guides for carers, service users, and professionals.

The short guide to the Act, available on the Scotland government website,[34] also provides a list of useful addresses for government organizations and charities involved in the care of those lacking capacity. Copies of the Code of Practice and other guides are available from the OPG.

Northern Ireland

At the time of writing, a mental capacity bill is still being debated by the Northern Ireland Assembly.[35] The bill aims to give effect to the major recommendations of the Bamford Review which was published in 2007.[36] It would introduce a single statutory framework governing all decision making on the care and treatment of a physical or mental disorder which is currently contained in the Mental Health (Northern Ireland) Order 1986. When the Bill is enacted that order will be revoked. The Bill sets out the principles to be followed in making decisions. These are the presumption that a person has the requisite capacity; the person is not to be treated as unable to make a decision for him or herself unless all practicable help and support to enable that person to make a decision have been given without success; the person is not to be treated as unable to make a decision for himself or herself merely because the person makes an unwise decision; a lack of capacity cannot be established merely by reference to the person's age or appearance or condition of the person; and any decision made must be made in the person's best interests.

The Bill contains the following provisions:

Part 1: Principles
Part 2: Lack of capacity: Protection from liability and safeguards including authorizations for certain interventions and rights of review
Part 3: Nominated person
Part 4: Independent advocates
Part 5: Lasting powers of attorney
Part 6: High Court powers: Decisions and Deputies
Part 7: Public Guardian and Visitors
Part 8: Research
Part 9: Transfer between jurisdictions
Part 10: Offences
Parts 11 and 12: Miscellaneous and Supplementary.

The Bill went out for consultation in May 2014 which ended on September 2, 2014. It was introduced in June 2015 and is due to go to the Committee stage in September 2015.

Conclusion

Divergences between England and the rest of the United Kingdom are likely to increase as further powers are devolved. The laws relating to decision making on behalf of the mentally incapacitated in Scotland and Northern Ireland are now distinct from those of England and Wales, being contained in different primary legislation. While the MCA 2005 is binding on both England and Wales, the NHS (Wales) Act 2006 enables Wales to develop its own policies and practice in relation to healthcare, and divergences between these two countries are likely to increase further. Information on the different legal provisions and the regulations can be obtained on the websites for the assembly governments or on the legislation website.[37]

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CHAPTER 19
The future

After the Human Rights Act 1998, the Mental Capacity Act 2005 can be seen as one of the most important pieces of legislation for the last two centuries. It is understandable that the implementation was delayed for over two years, since the training, organizational, and management repercussions are immense. So too are the resource implications.

There are no clear figures on the numbers of those lacking the specific mental capacity who may therefore come within the provisions of the Act. *Valuing People*[1] calculated that there are about 210 000 people with severe learning disabilities in England and about 1.2 million with a mild or moderate disability. Numbers of those suffering from dementia are also uncertain. A study conducted by the London School of Economics and the Institute of Psychiatry Kings College London[2] suggested that at least 700 000 people suffered from dementia in Great Britain, and this figure is likely to increase to more than 1 million by 2025. The current costs of dementia were estimated at £17 billion a year. Then there are the many other conditions which can lead to a lack of capacity: acquired brain injury, chronic psychiatric conditions, as well as motor neurone disease and other debilitating conditions. Nor is there any reliable estimate of the carers, both informal and paid, who are involved in their support and treatment.

It is obvious that there are many millions who directly or indirectly are affected by the MCA and the rules and regulations drawn up under it. For all of these the last few years have presented a steep learning curve as, inch by inch, they have had to learn the basic principles and minutiae of the Act. The Government is carrying out ongoing monitoring of many of its provisions, and the new institutions—the Court of Protection and the Office of the Public Guardian, together with Independent Mental Capacity Advocacy services—have made known their views on the effective implementation of the Act and any perceived weaknesses in its basic provisions, its Code of Practice, and its implementation.

The Deprivation of Liberty Safeguards has proved a challenge not only to care providers but also to lawyers and judges and fundamental changes to simplify and clarify the process for protecting liberty have been urged. Those pushing for change include the Scrutiny Committee of the House of Lords which has made fundamental recommendation for improvements in both the legislation and its implementation. Its recommendations have been discussed in each relevant chapter, together with the Government's response. At the time of writing, many initiatives to improve understanding of the legislation are still awaited. These include a review by the Law Commission of the Deprivation of Liberty Safeguards, with the initial report being brought forward from 2017 to 2016. Following consultation on its recommendations, it could be that a Bill incorporating amendments to the Mental Capacity Act could be introduced into Parliament by 2017 and be implemented by the end of 2017 or 2018.

With all its shortcomings the Mental Capacity Act presents a stable and firm foundation on which the

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protection of the rights of those who lack the capacity to make their own specific decisions can be built. It is hoped that the second edition of this book will provide a brief introduction to the basic provisions of the Act, illustrated by everyday scenarios which readers—lay and professional—are likely to encounter.

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Websites

39 Essex Street Chambers	www.39essex.com
Action on Elder Abuse	www.elderabuse.org.uk
Advance Decision to refuse treatment	www.adrtnhs.co.uk
Age UK	www.ageuk.org.uk
Alzheimer's Society	www.alzheimers.org.uk
Audit Commission	www.audit-commission.gov.uk
Bailii (case and legislation directory)	www.bailii.org
Bipolar UK	www.bipolaruk.org.uk
Care and Social Services Inspectorate (Wales)	www.cssiw.org.uk
Care Quality Commission	www.cqc.org.uk
CARERS UK	www.carersuk.org
Citizens Advice Bureaux	www.citizensadvice.org.uk
Civil Procedure Rules	www.justice.gov.uk
Commission for Equality and Human Rights	www.cehr.org.uk
Community Legal Service Direct	www.clsdirect.org.uk
Contact the Elderly	www.contact-the-elderly.org
Counsel and Care	www.careinfo.org
Court of Protection	www.gov.uk/courts-tribunals/court-of-protection
Department for Work and Pensions	www.gov.uk/government/organisations/department-for-work-pensions
Department of Health	www.gov.uk
Department of Trade and Industry	www.gov.uk/
Disability Law Service	www.dls.org.uk/
Domestic Violence	www.nationaldomesticviolencehelpline.org.uk
Down's Syndrome Association	www.downs-syndrome.org.uk
Family Carer Support Service	www.familycarers.org.uk
Foundation for People with Learning Disabilities	www.learningdisabilities.org.uk
General Medical Council	www.gmc-uk.org
Headway—brain injury association	www.headway.org.uk
Health and Care Professions Council	www.hcpc-uk.org/
Health and Safety Executive	www.hse.gov.uk
Healthcare Inspectorate Wales	www.hiw.org.uk
HM Courts Service	www.gov.uk
Home Farm Trust	www.hft.org.uk
Hospice UK	www.hospiceuk.org

Legal Aspects of Mental Capacity: A Practical Guide for Health and Social Care Professionals, Second Edition. Bridgit Dimond.
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Human Fertilisation and Embryology Authority	www.hfea.gov.uk/
Human Rights	www.equalityhumanrights.com
Independent Mental Capacity Advocacy	www.voiceability.org
Lasting Power of Attorney	www.gov.uk/power-of-attorney/
Law Centres Network	www.lawcentres.org.uk
Law Society	www.lawsociety.org.uk/
Legislation	www.legislation.gov.uk
Linacre Centre for Healthcare Ethics	www.linacre.org
Medicines and Healthcare Products Regulatory Agency	www.mhra.gov.uk
MENCAP	www.mencap.org.uk
Mental Health Alliance	www.mentalhealthalliance.org.uk
Mental Health Foundation	www.mentalhealth.org.uk
Mental Health Lawyers Assoc	www.mhla.co.uk
Mental Health Matters	www.mentalhealthmatters.com/
Mind	www.mind.org.uk
Ministry of Justice	www.justice.gov.uk
Motor Neurone Disease Association	www.mndassociation.org
National Autistic Society	www.autism.org.uk
National Care Association	www.nationalcareassociation.org.uk
National Family Carer Network	www.familycarers.org.uk
National Mediation Helpline,	www.nationalmediationhelpline.com
National Patient Safety Agency	www.nrls.npsa.nhs.uk
National Treatment Agency	www.nta.nhs.uk/
NHS	www.nhs.uk
NHS Health Research Authority	www.hra.nhs.uk
NHS Professionals	www.nhsprofessionals.nhs.uk
NICE	www.nice.org.uk
Northern Ireland	www.niassembly.gov.uk/
Nursing and Midwifery Council	www.nmc-uk.org/
Office of Public Sector Information	www.opsi.gov.uk
Office of the Public Guardian	www.gov.uk/government/organisations/office-of-the-public-guardian
Official Solicitor	www.gov.uk/government/…/officialsolicitor-and-public-trustee
Open Government	www.opengovpartnership.org
Pain website	www.pain-talk.co.uk
Parliamentary and Health Service Ombudsman	www.ombudsman.org.uk
Patient Concern	www.patientconcern.org
Patient's Association	www.patients-association.org.uk
People First Self Advocacy	www.peoplefirstltd.com
Princess Royal Trust for Carers	www.carers.org/
Respond	www.respond.org.uk
Rethink Mental Illness	www.rethink.org.uk
Royal College of Nursing	www.rcn.org.uk
Royal College of Psychiatrists	www.rcpsych.ac.uk
SANE	www.sane.org.uk
Scope	www.scope.org.uk

Scotland	www.scotland.gov.uk/
Sense	www.sense.org.uk
Social Care Institute for Excellence	www.scie.org.uk
Solicitors for the Elderly	www.solicitorsfortheelderly.com
Speakability	www.speakability.org.uk
Speakup Self Advocacy	www.speakup.org.uk/
Stroke Association	www.stroke.org.uk
Together: Working for Wellbeing	www.together-uk.org
True Voice Trust	www.truevoicetrust.org/
Turning Point	www.turning-point.co.uk
UK Homecare Association	www.ukhca.co.uk
UK Parliament	www.parliament.uk
United Response	www.unitedresponse.org.uk
Values into Action	www.valuesintoaction.org
Veterans UK	www.gov.uk/government/organisations/veterans-uk
Welsh Assembly Government	www.assembly.wales www.gov.wales
World Medical Association	www.wma.net/

Answers to quick fire quizzes

Quick fire quiz, QFQ1

1 What two concepts underline the Mental Capacity Act 2005?
Mental capacity and best interests

2 How does the Act define *best interests*?
The Act does not define best interests but sets out the steps to be taken in determining what are the best interests of a mentally incapacitated adult.

3 What are the five principles set out in the Act?
These are set out and discussed in Chapter 3.

4 What is the difference between statute and common law?
Statute law is enacted in Parliament; common law is the body of law created by the decisions of judges in decided cases.

5 How does the Human Rights Act relate to the Mental Capacity Act?
The Human Rights Act places a duty on any organization exercising functions of a public nature to respect the human rights (set out in Schedule 1 of the Act) of those in their care. This duty runs parallel to the statutory duties set out in the Mental Capacity Act 2005.

6 Can a lasting power of attorney be exercised on behalf of a person who has the requisite mental capacity?
Yes in the case of an LPA relating to property and affairs, but not in relation to an LPA covering welfare decisions. The latter can only be exercised when the donor of the power has lost the requisite mental capacity.

Quick fire quiz, QFQ2

1 What is the difference between the Mental Capacity Act 2005 and the Mental Health Act 1983?
The Mental Capacity Act 2005 makes provision for those who lack the requisite mental capacity to make their own decisions. The Mental Health Act 1983 makes provisions for those suffering from mental disorder.

2 Does the doctrine of necessity still apply to decisions relating to those lacking the requisite mental capacity?
The Mental Capacity Act 2005 replaces the doctrine of necessity in relation to decision making on behalf of those lacking the requisite mental capacity. However the inherent jurisdiction of the High Court to make decisions out of necessity has survived the MCA.

3 Does the Supreme Court have the power to change the law?
In theory yes, but in practice it would prefer Parliament to create new laws. See the case of Nicklinson.[1]

4 What is meant by *actionable per se*
A cause of legal action relating to a trespass to the person can be brought without harm having to be proved. This contrasts with an action for negligence where the claimant must establish that he has suffered damage which is recognized by the courts as compensatable.

5 What is a trespass to the person?
A trespass to the person is where it is alleged that the defendant touched the claimant who had not consented to that contact.

6 What is the relevance of Article 5 of the European Convention on Human Rights to the detention of mentally disordered persons?
Article 5(1) recognizes the right to liberty and security of person, but an exception to this principle is the lawful detention of persons of unsound mind. Article 5(4) recognizes the right of everyone who is deprived of his liberty by arrest or detention to be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful. Article 5(2) gives a right to any person arrested to be promptly informed of the reasons and of any charge and Article 5(5) gives a right to compensation for a breach of Article 5.

Quick fire quiz, QFQ3

1 Does the Human Rights Act 1998 give statutory force to the full European Convention on Human Rights?
No. Schedule 1 of the Human Rights Act 1998 sets out those parts of the European Convention on Human Rights which are binding on public authorities and organizations

Legal Aspects of Mental Capacity: A Practical Guide for Health and Social Care Professionals, Second Edition. Bridgit Dimond.
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exercising functions of a public nature. Article 13 of the Convention is not included in the Schedule. (Article 13 gives a right to an effective remedy.)[2]

2 Why is the legislation on human rights still important after the implementation of the Mental Capacity Act 2005?
Because many of the rights set out in Schedule 1 to the Human Rights Act 1998 are not specifically included in the Mental Capacity Act and they increase the protection of those lacking mental capacity.

3 What is the value of incorporating statutory principles into the Act?
While most of the five statutory principles were already recognized at common law, including them in the statute gives a certainty and clarity to them and they place an explicit duty on those making decisions on behalf of mentally incapacitated persons to follow the principles.

4 What is meant by the phrase *the presumption of capacity can be rebutted on a balance of probabilities*?
The starting point in decision making is the assumption that a person has the requisite capacity to make his or her own decisions. However where there is evidence to contradict this, then the civil standard of proof (as opposed to the criminal standard of proof which is beyond reasonable doubt) is used to decide if the person actually lacks the requisite mental capacity.

5 What is the difference between *all practicable steps* and *all reasonably practicable steps*?
The use of the word reasonable means that in assessing whether the steps required to assist a person to have the requisite capacity are practicable, such factors as cost, time, effort, and value can all be taken into account. In contrast the omission of the word *reasonable* means that if a person can be facilitated into having the requisite mental capacity, then that action should be taken. The difference has huge resource implications especially in the use of electronic means of communication. However the principle does not require all possible steps to be taken, so the duty is modified.

6 What is the significance of the decision of the European Court of Human Rights in the Bournewood case?
In the Bournewood case the House of Lords decided that common law powers could be used to detain a person lacking the requisite mental capacity. The European Court of Human Rights held that using such powers was a breach of Article 5. As a consequence the Deprivation of Liberty Safeguards (DOLS) had to be drawn up to protect persons who were threatened with loss of their liberty (excluding those detained under mental health legislation). DOLS are considered in Chapter 14.

Quick fire quiz, QFQ4

1 What are the two stages for determining whether a person has the requisite mental capacity?
The first stage is to determine whether there exists an impairment or disturbance in the functioning of the mind or brain. The second stage is to determine if this impairment or disturbance results in an inability to make or communicate decisions.

2 Could a person's mental capacity be determined merely by reference to a person's age or appearance?
Section 2(3)(a) of the Mental Capacity Act states that a lack of capacity cannot be established merely by reference to a person's age or appearance.

3 In determining mental capacity does it matter if the impairment or disturbance to the brain functioning is permanent or temporary?
The assessment of mental capacity has to be made *at the material time*. This would mean that where a person is suffering from intermittent capacity, if there are interludes of capacity and during that time the person is able to understand the information and can make and communicate the relevant decision, then for the purposes of the MCA that person does not lack the requisite capacity. The Act states that it does not matter if the impairment or disturbance is temporary or permanent.

4 What four criteria are used to determine if a person is able to make a decision?
The four criteria for being able to make a decision are the ability to (a) understand the information relevant to the decision, (b) retain that information, (c) use or weigh that information as part of the process of making the decision, or (d) communicate his decision (whether by talking, using sign language, or any other means).

5 Does the Act specify what information must be given to a person in assessing their mental capacity?
Section 3(4) states that information about the reasonably foreseeable consequences of deciding one way or another or failing to make the decision must be given to the person whose mental capacity is being assessed.

6 What is meant by the functional approach to the determination of mental capacity?
The functional approach to the determination of mental capacity means that a person's mental capacity is defined in terms of the decision which has to be made. Some decisions may require a higher level of mental capacity than others—hence the use of the term *requisite mental capacity* in this book.

Quick fire quiz, QFQ5

1 What steps must be followed in determining the best interests of a person lacking the requisite mental capacity?

Section 4 of the Act states:

1 Do not make unjustified assumptions.
2 Consider all the relevant circumstances.
3 Consider whether capacity is likely to be recovered.
4 Support P's ability to participate.
5 In lifesaving treatment, a desire to bring about death should not be the motivation.
6 Consider P's wishes and feelings, beliefs and values and other factors P would consider.
7 Consult views of specified others about what is in P's best interests and P's wishes, feelings, etc.

2 In what circumstances does the decision maker not have to follow the best interests of the person who lacks the mental capacity to make decisions?

Where the person who lacks the requisite mental capacity has drawn up an advance decision or arranged a power of attorney for welfare decisions then if these are relevant to the decision to be made and would conflict with the best interests, then the best interests of the person do not have to be followed.

3 How is life-sustaining treatment defined?

Life-sustaining is defined as "Treatment which in the view of a person providing health care for the person concerned is necessary to sustain life" (S.4(10)).

4 What is meant by drawing up a balance sheet in determining the best interests of a person lacking the requisite mental capacity?

Refer to Case Study 5.1[3] and the judgment quoted by Dame Butler-Schloss by Judge Thorpe in drawing up a balance sheet to determine best interests with positive benefits on one side against negative effects on the other.

5 What is the difference between a best interests test and a modified best interests test?

A modified best interests test is possible when a person once had the mental capacity and evidence of their earlier wishes and feelings can be provided which may not be their best interests. Scenario 5.6 illustrates the difference.

6 Which people must the decision maker consult with in determining best interests?

Section 4(7) of the MCA specifies the following persons to be consulted by the decision maker:

a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,
b) anyone engaged in caring for the person or interested in his welfare,
c) any donee of a lasting power of attorney granted by the person, and
d) any deputy appointed for the person by the court.

Quick fire quiz, QFQ6

1 When does a lasting power of attorney in relation to health and welfare decisions come into force?

The power only comes into force, for health and welfare decisions, when the donor no longer has the mental capacity to make his or her own decisions and the LPA has been registered and the OPG notified of the loss of mental capacity.

2 How can a valid lasting power of attorney be created?

To create a valid LPA, the conditions laid down in Section 10 must be complied with: (a) it must be registered in accordance with the provisions of Schedule 1 and (b) it must be registered at the time when P executes the instrument, has reached 18, and has capacity to execute it.

3 In what circumstances would the donee of an LPA be acting *ultra vires*?

The donee of the power granted under an LPA is required to act within the powers set out in the instrument. To act beyond these powers is to act *ultra vires*.

4 Is it possible for a person to be named as the donee of an LPA without his or her knowledge?

No. Schedule 1 states that the instrument must include a statement by the donee (or, if more than one, each one of them) that he or she has read the prescribed information and understands the duty imposed on a donee of a lasting power of attorney under Section 1 and Section 4 on the best interests.

5 What is meant by *jointly*, *severally*, and *jointly and severally*?

Jointly means that the donees always act together in any decision and if one fails to meet the criteria in the Act, then a valid LPA will not be created; *severally* means that each donee can act independently; and *jointly and severally* means that the donees can act together or independently.

6 In what circumstances could the donee of an LPA relating to welfare agree to the ending of lifesaving treatment of the donor?

The donee must act in accordance with the powers given in the LPA and where these do not conflict with the explicit instructions in the best interests of the donor. He/she cannot be motivated by a desire to bring about the donor's death. In addition Section 11 states that the LPA authority does not

authorize the giving or refusing of consent to the carrying out or continuation of life-sustaining treatment, unless the instrument contains express provision to that effect, and is subject to any conditions or restrictions in the instrument.

Quick fire quiz, QFQ7

1 Does the Court of Protection have the power to make orders relating to young persons under 16 years?
Usually the Court of Protection's jurisdiction is confined to those over 16, but where it is reasonable to assume that the mental incapacity of the person will extend beyond 16, then it can make orders relating to that person. There is an easy transfer of cases to and from the Family Court and the Court of Protection.

2 Section 16(4) states that a decision of the Court of Protection is to be preferred to the appointment of a deputy. In what circumstances would this apply?
Where there is a single issue to be determined such as the determination of capacity or a decision as to whether it is in the best interests of a mentally incapacitated person to live in specific accommodation, the Court of Protection would make this decision. However where continuing supervision is required, then a deputy would be appointed.

3 In what circumstances can the Court of Protection dispense with the need for a hearing?
The circumstances are set out in Rule 84(3) which is shown in Box 7.4.

4 Would you be permitted to attend a Court of Protection hearing, even if you had no personal nor professional involvement in the case?
The answer is probably *no*. The general principle set out in Rule 90 is that the hearing should be held in private, but under Rule 91 the court can authorize publication of information about the proceedings. Rule 92 gives the court power to hold the hearing in public but the courts have held that there must a good reason for this.

5 What is the overriding objective of the Rules of Court?
The overriding objective of the Rules of Court is to enable the court to deal with cases justly, having regard to principles contained in the Act.

6 What is the role of the Office of Public Guardian in relation to a deputy?
The Office of Public Guardian has the responsibility of establishing and maintaining a register of orders appointing deputies or supervising deputies appointed by the court and can direct a Court of Protection Visitor to visit a deputy appointed by the court.

Quick fire quiz, QFQ8

1 What is the philosophy behind the principle of appointing an advocate?
The philosophy behind the appointment of an advocate, which is given statutory force, is that a person to whom a proposed act or decision relates should, so far as practicable, be represented and supported by a person who is independent of any person who will be responsible for the act or decision (S.35(4)).

2 In what situations should the appointment of an IMCA be considered?
The appointment of an IMCA should be considered for decisions relating to serious medical treatment and the arrangement of accommodation by health service or local authority, review of accommodation and adult protection situations, unless there is a family member or close friend whom it would be appropriate to consult. However in cases where the health authority or local authority are considering taking protection measures in relation to P, there is no requirement to ascertain if there is an appropriate person to represent P.

3 What are the exceptions to the appointment of an IMCA?
The authorities are not required to arrange for the appointment of an IMCA where there is a person nominated by P as a person to be consulted in matters affecting his interests, a donee of a lasting power of attorney created by P, a deputy appointed by the court for P, or a donee of an enduring power of attorney created by P.

4 If a detained patient is being discharged from psychiatric hospital and being provided with accommodation under Section 117 of the Mental Health Act 1983, does an IMCA have to be appointed?
Yes if appropriate. This statutory requirement for the local authority to instruct an independent mental capacity advocate does not apply if P is accommodated as a result of an obligation imposed on him under the Mental Health Act (S.39(3)). However this does not apply to accommodation provided under S 117.

5 Who pays the IMCA?
The IMCA is paid by the IMCA service which employs him or her. The IMCA service is funded by the commissioning organization, that is, the local authority.

6 Which are the two areas where the independence of the IMCA is considered essential?
There are two key areas where independence is essential: Firstly the IMCA must not have any professional or paid involvement with the provision of care or treatment for any

vulnerable person for whom they may be appointed to act. Secondly they must be completely independent of the person responsible for making the decision or doing the act in question.

Quick fire quiz, QFQ9

1 Can a young person of 17 create a valid advance decision?
No. A person must be 18 or over for an advance decision to be valid. However the young person under 18 years can draw up a statement of his or her wishes, beliefs, values, and feelings which can be used in determining his or her best interests.

2 What legal requirements must be followed to refuse life-sustaining treatment in an advance decision?
The advance decision must be made by a person over 18 years, it is in writing; it is signed by P or by another person in P's presence and by P's direction; the signature is made or acknowledged by P in the presence of a witness; the witness signs it, or acknowledges his signature, in P's presence; and it must be clear in the advance decision that P intends the refusal to apply to treatments, even though his or her life would be at risk.

3 What legal action would a health professional face if he or she ignored the existence of a relevant valid advance decision?
To ignore a valid and relevant advance decision and act contrary to its instructions would constitute a trespass to the person and a health professional so acting could face criminal and civil proceedings.

4 In what circumstances can an advance decision be altered or withdrawn?
P may withdraw or alter an advance decision at any time when he or she has capacity to do so. It is not necessary for the withdrawal or a partial withdrawal to be in writing. Nor need an alteration of an advance decision be in writing unless it is applicable to life-sustaining treatment when the requirements set out in answer 2 would apply.

5 Can an advance decision refuse pain relief?
Yes if pain relief is considered to be part of *treatment*. If pain relief is considered to be basic care, it could not be refused by means of an advance decision.

6 Can the advance decision require specific treatment to be given to the patient?
No. An advance decision is concerned with the refusal of treatments. The Burke case illustrates the principle that a patient cannot demand specific treatments (other than direct oral nutrition and hydration, i.e., basic care).

Quick fire quiz, QFQ10

1 What is meant by intrusive research?
Section 30(2) defines intrusive research as:

> research which would be unlawful if carried out on a person capable of giving consent, but without that consent.

2 What conditions must be satisfied before intrusive research can be carried out on a mentally incapacitated adult?
The conditions required before intrusive research can be carried out on a person lacking the requisite mental capacity to give consent are that the research is part of a research project which is approved by an appropriate body as defined in Section 31, complies with the conditions laid down in Section 31 (see Statute Box 10.1), and complies with conditions relating to the consulting of carers and additional safeguards (i.e., Sections 32 and 33).

3 What is meant by the requirement in S.33(3) that the interests of the person must be assumed to outweigh those of science and society?
"The interests of the person must be assumed to outweigh those of science and society" means that a mentally incapacitated person's interests cannot be ignored in preference to the potential benefits to society from the research.

4 In the absence of an unpaid carer for P, does the researcher have to ensure that an independent mental capacity advocate is appointed?
The researcher has to nominate a person to be consulted in the absence of an unpaid carer for P, but at present there is no statutory requirement for an IMCA to be appointed.

5 What are the conditions for urgent research to take place?
Where treatment is to be provided as a matter of urgency and R considers that it is also necessary to take action for the purposes of the research as a matter of urgency, but it is not reasonably practicable to consult under the above provisions of this section, then the following conditions apply: R must have the agreement of a registered medical practitioner who is not concerned in the organization or conduct of the research project or where it is not reasonably practicable in the time available to obtain that agreement, he acts in accordance with a procedure approved by the appropriate body at the time when the research project was approved under Section 31. When R has reasonable grounds for believing that it is no longer necessary to take the action as a matter of urgency, he cannot continue to act in reliance on these urgent provisions (S.32(10)).

6 Can the research, which started before Section 30 came into force (i.e., October 1, 2007), continue if a person with the requisite mental capacity gave consent to participation in

the project but subsequently before completion of the project lost the requisite mental capacity?
Yes, provided the regulations drawn up under section 34 of the MCA are followed. The conditions set by the regulations include the fact that the project satisfies the requirements set out in Schedule 1 (Statute Box 10.3); all the information or material relating to P which is used in the research was obtained before P's loss of capacity, and the person conducting the project (*R*) takes in relation to P such steps as are set out in Schedule 2 (Statute Box 10.4).

Quick fire quiz, QFQ11

1 Which persons can be prosecuted under Section 44(2) of the MCA which makes it an offense to ill-treat or wilfully neglect a person who lacks capacity?
The offense arises if a person D has the care of a person P who lacks, or whom D reasonably believes to lack, capacity or is the donee of a lasting power of attorney, or an enduring power of attorney (within the meaning of Schedule 4), created by P, or is a deputy appointed by the court for P (S.44(1)).

2 In what circumstances could a neighbor be prosecuted under Section 44(2)?
In order to be liable for prosecution under Section 44 the neighbor must have taken on the responsibility of caring for an adult who lacked mental capacity. The care provided must be substantial and the neglect or ill-treatment wilful.

3 How does the Disclosure and Barring Service provide protection for vulnerable adults?
The Disclosure and Barring Service became responsible for the functions transferred from Independent Safeguarding Authority in 2012. The DBS processes requests for criminal records checks, decides whether it is appropriate for a person to be placed on or removed from a barred list, and places or removes people from the DBS children's barred list and adults' barred list for England, Wales, and Northern Ireland. It has published a code of practice for recipients of DBS certificates.

4 In which circumstances does the criminal justice system provide protection for a vulnerable adult caught up in criminal proceedings?
The criminal justice system attempts to protect persons lacking the requisite capacity to ensure that an injustice does not occur in the following areas: requiring mental intent to commit the crime, police procedures on arrest; making a confession; standing for trial; being a witness and being on a jury.

5 What elements are required for an employer to be held responsible for the actions of an employee?
To establish vicarious liability of an employer for the criminal or civil wrongs of an employee, the claimant must establish that there has been a wrong carried out by an employee who was acting in the course of employment.

6 How can a legal action be brought on behalf of a person who lacks the requisite mental capacity to act on his own behalf?
Rule 21.2 of the Civil Procedure Rules requires any person who lacks capacity to conduct proceedings to have a litigation friend to conduct proceedings on his behalf. The court can either appoint the litigation friend or a person may act as the litigation friend (either as claimant or defendant) if he can fairly and competently conduct proceedings on behalf of the protected person. Such a person is required to follow the procedure set out in Rule 21.5.

Quick fire quiz, QFQ12

1 To what age does the MCA in the main apply?
The MCA applies to those over 16 years with some exceptions.

2 What are the provisions of the Family Law Reform Act in relation to young persons?
The Family Law Reform Act lowered the age of consent to surgical, medical, and dental treatment to 16 years while preserving the right of parents to give consent on behalf of their children under 18.

3 Can a parent give consent on behalf of a child of 16 or 17?
Yes. However where the child is refusing the treatment, it would be wise to seek a declaration from the court.

4 What provisions of the MCA only apply to a young person of 18 or over?
A young person below 18 cannot create nor be appointed as the donee of a power of attorney, nor a deputy, nor can he or she create an advance decision nor make a will. The Deprivation of Liberty Safeguards only apply to those of 18 and over.

5 Could the Court of Protection make decisions relating to a child below 16 years?
Yes in decisions relating to property and affairs where the lack of capacity is likely to continue beyond 18 years.

6 You are concerned that a girl with severe mental impairment who is 17 years is to be sterilized for nontherapeutic reasons with the consent of her father and mother. What action if any would you take?
The Code of Practice recommends that a nontherapeutic sterilization on a person lacking the requisite mental capacity

should only be carried out after a court declaration. It is recommended that any person involved in such a decision should ensure that an application is made to the court.

Quick fire quiz, QFQ13

1 What is the definition of mental disorder?
Mental disorder is "any disorder or disability of the mind" under section 1 of the Mental Health Act 1983 (as amended).

2 What is the definition of mental capacity?
A person is held to lack mental capacity if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain (S.2(1) MCA).

3 Can treatment for a physical condition be carried out under the authorization of the Mental Health Act 1983 (as amended)?
Part 4 of the Mental Health Act 1983 authorizes treatment for mental disorder and this has been judicially defined as including treatment for physical conditions which are linked to the mental disorder including the care of basic needs. Treatment for physical conditions not linked to the mental disorder cannot be carried out under the MHA.

4 Can treatment for a physical condition be carried out under the authorization of the Mental Capacity Act 2005?
Acting in the best interests of a person who lacks the requisite mental capacity can include providing treatment for a physical condition. Serious treatments may require the authorization of the Court of Protection and, if P lacks an appropriate person to represent him, the appointment of an independent mental capacity advocate.

5 What is the difference between an independent mental capacity advocate and an independent mental health advocate?
The IMCA is appointed under the provisions of the Mental Capacity Act 2005 to act on behalf of those who lack the requisite mental capacity; the IMHA is appointed under the Mental Health Act 2007 to be available to help qualifying patients.

6 Is there a requirement to consider the appointment of an IMCA when a detained patient is provided with accommodation under Section 117 of the Mental Health Act 1983?
Yes. Such an appointment should be considered, since in the absence of an appropriate carer, an IMCA is required when the local authority is arranging accommodation and S117 accommodation does not lead to the exclusion of the MCA under Schedule 1A.

Quick fire quiz, QFQ14

1 In what circumstances would a care home manager apply for authority to deprive a person of his or her liberty?
If it is necessary to place a person, in a hospital or care home, under continuous supervision and control and limit a person's freedom to leave (which without lawful justification would be a breach of Article 5 of the European Convention of Human Rights), then an application must be made for a standard authorization or in an emergency and urgent authorization. This does not apply if the individual is ineligible because he is excluded from the DOLS provisions according to Schedule 1A (i.e., comes under the provisions of the mental health legislation).

2 Who is the relevant authority to whom the application has to be made?
The application for a person in a care home or hospital would be made to the local authority in which the person is ordinarily resident (Local Health Board or Welsh Ministers in Wales). However, if the person is not ordinarily resident in the area of any local authority (e.g., a person of no fixed abode), the supervisory body will be the local authority for the area in which the care home or hospital is situated.

3 What assessments will be required?
The following assessments are required: age assessment, no refusals assessment, mental capacity assessment, mental health assessment, eligibility assessment, and best interests assessment.

4 Does an independent mental capacity advocate have to be appointed?
If there is no person appropriate to consult (other than a paid carer) about an application, the supervisory body must instruct an IMCA to represent the person. Once a standard authorization has been made, the supervisory body must appoint a relevant person's representative as soon as possible and practicable. The duties imposed on the IMCA then cease to apply. If there is nobody who can support and represent the person (other than a person engaged in providing care and treatment for the relevant person in a professional capacity or for remuneration), the managing authority must notify the supervisory body, who must instruct an IMCA to represent the relevant person until a new representative is appointed. The IMCA's appointment ends when a new representative is appointed. The relevant person and their representative must be told about the IMCA service and can request an IMCA if necessary.

5 When is a person not eligible to be detained under a DOLS authorization?
The eligibility requirement prohibits an incapacitated person from being deprived of their liberty under a standard authorization if he or she comes within any of the groups which

are set out in Schedule 1A of the MCA 2005. DOLS only applies to persons in hospital or care homes.

6 How long does a standard authorization last?
A standard authorization can last up to a year but it is expected that it would normally be for a shorter time. It must be the shortest time necessary to prevent harm and cannot be longer than the time recommended by the best interests assessor.

Quick fire quiz, QFQ15

1 Is consent required for the investigation of the cause of a death under a coroner's investigation?
No. If the coroner requires an investigation to be carried out to establish the cause of death, the request cannot be refused.

2 For what purposes can tissue be stored and used without the consent of an adult lacking mental capacity.
Regulation 3 provides for the storage and use of materials from adults who lack the capacity to give consent. The purposes for which it permits tissue to be stored and used without the consent of an adult lacking mental capacity include obtaining scientific or medical information about a living or deceased person which may be relevant to any other person (including a future person) if it is reasonably believed to be in P's best interests or its use for research purposes.

3 What is meant by *ethical research* (see regulation 8)?
Regulation 8 states that research is ethically approved if approval is given by a research ethics authority in the circumstances shown in Statute Box 15.3.

4 In what circumstances can the DNA of a person who lacks the requisite capacity to give consent be analyzed?
Where a person lacks capacity to consent to analysis of his DNA, the purposes for which his DNA may be analyzed are shown in Statute Box 15.4.

5 Kate, who has severe learning disabilities and lives in a care home, requires a biopsy to be carried out to determine whether she has breast cancer. She is incapable of giving consent. Who would give consent on her behalf?
In the absence of a donee of a lasting power of attorney or a deputy appointed by the Court of Protection, the doctors, parents, and others concerned with her care could agree that it was in her best interests to have a biopsy taken. In the event of any disagreement about whether it was in her best interests, an application could be made to the Court of Protection to confirm that she lacked the requisite capacity and to determine whether it was in her best interests to have the biopsy taken. If there was no one who could be consulted, an independent mental capacity advocate should be appointed.

6 James appears to be a compatible donor of bone marrow for his brother who has leukemia. James lacks the requisite capacity to give consent to the donation. What is the legal situation?
An application would have to be made to the Court of Protection to determine whether the donation of bone marrow was in James' best interests and then the case is referred to the Human Tissue Authority and the requirements set out in Regulations 9–14 must be satisfied.[4]

Quick fire quiz, QFQ16

1 Does an informal carer have a statutory duty to follow the Code of Practice?
The informal carer is not listed in the Mental Capacity Act as having a statutory duty to follow the Code of Practice, but best practice would suggest that the informal carer should be guided by it and the statutory principles set out in Section 1 of the Act.

2 What is the significance of Section 5 for the informal carer?
Section 5 protects the informal carer if he or she has acted in a reasonable belief that the person (P) lacks mental capacity and has acted in P's best interests. It does not however protect against any acts of negligence or criminal wrongs.

3 Could an informal carer be prosecuted under Section 44 for ill-treatment of a mentally incapacitated adult?
Yes

4 Could an informal carer overrule an advance decision which was not in the best interests of the person lacking the requisite mental capacity?
The advance decision is binding on every one, provided that P had the mental capacity when it was drawn up, that the statutory requirements in its formation are met, and that it is relevant to the decision in question.

5 What is the role of the informal carer if a researcher wishes P, a person lacking the mental capacity to give consent to participate in a research project?
There is a statutory duty upon the researcher to consult the informal carer about P's participation in the research. The informal carer should ensure that he or she is given all the relevant information about the research and any likely risks or discomfort to P in taking part. The informal carer should check against any advance decision or advance statement drawn up by P as to whether he has recorded a refusal to participate. The informal carer would also need to be vigilant

throughout the research process and ensure that, at any time when it would appear that P is showing signs of resistance and objection to the research, P's involvement ceases, unless it can be justified because it is intended to protect him or her from harm or to reduce or prevent pain or discomfort.

6 What documentation should an informal carer keep on the care and treatment of the person for whom he or she cares?
Documentation should be kept of all major decisions made on behalf of P and a cash book should record income and expenditure.

References

1 *Nicklinson and Anor R (on the application of) (Rev1)* [2014] UKSC 38.
2 www.echr.coe.int
3 *A Hospital NHS Trust and S (by his litigation friend the Official Solicitor) and DG (S's father) and SG (S's mother)* [2003] EWHC Fam 365.
4 Human Tissue Act 2004 (Persons who Lack Capacity to Consent and Transplants) Regulations 2006 (SI 2006/1659).