Mental Capacity Law Newsletter May 2016: Issue 65

Compendium

Introduction

Welcome to the May 2016 Newsletters. Unusually this month – but proving that we do not simply generate material for the sake of it – we do not have any Health, Welfare and Deprivation of Liberty or Scotland Newsletters because there have been no developments of sufficient note to merit coverage. Note, though, that we are anticipating shortly the interim statement from the Law Commission on their Mental Capacity and Deprivation of Liberty project which we will be covering in our next Newsletter.

Highlights this month include:

(1) In the Property and Affairs Newsletter: causing your own incapacity and the consequences for personal injury proceedings;

(2) In the Practice and Procedure Newsletter: the transparent fall-out from the *C* case;

(3) In the Capacity outside the COP Newsletter: two guest pieces: (1) an introduction to her role by the Amanda Solloway MP, the new Rapporteur on Mental Health for the Joint Committee on Human Rights; and (2) an article by Patricia Rickard-Clarke outlining the provisions of the Assisted Decision-Making (Ireland) Act 2015.

And remember, you can now find all our past issues, our case summaries, and much more on our dedicated sub-site here. 'One-pagers' of the cases in these Newsletters of most relevance to social work professionals will also shortly appear on the SCIE website.

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For all our mental capacity resources, click here.

Causing your own incapacity

AB v Royal Devon and Exeter NHS Foundation Trust [2016] EWHC 1024 (QB) (Queen's Bench Division (Irwin J))

Mental capacity – assessing capacity – finance – litigation

Summary

In this Queen's Bench Division case the court had to decide on various issues concerning the quantum of a claimant's claim for personal injuries resulting from clinical negligence. One of those issues was C's capacity both to litigate and to manage his property and affairs.

The case had been started without a litigation friend but his advisers became concerned as to his capacity so applied to Master Roberts who agreed that C was a protected party, appointed a litigation friend and retrospectively approved a liability settlement.

The want of capacity was caused by a combination of factors one of the most significant being long addiction to class A drugs. It was not caused by the injuries D caused.

The psychiatrists agreed, however, that by the time of the trial because C had abstained from drugs he had the capacity to litigate and could manage his financial affairs as they stood. The Judge held, however, that C's advisers were right not to return to court for the discharge of the litigation friend but instead to take instructions from both the litigation friend and C in a pragmatic way, see paragraph 67.

As regards the future, the Judge held that C would not have capacity to manage the large sum that he would be awarded and that was whether or not he returned to his abuse of class A drugs, see paragraph 69.

The Judge went on to hold that it would take a year to set up a regime that would enable C to mange his award and that thereafter, unless he resumed his abuse of class A drugs, he would have capacity to manage his financial affairs so would not be a protected party, see paragraph 73.

The Judge went on to consider whether C should be awarded any sums for deputyship costs etc in the past and after the first year. He decided that there should be no award as any such damages resulted and would result from C's illegal acts of abusing class A drugs, see paragraphs 85-88.

Comment

This case is a good illustration of the difficulties that can arise with doubtful capacity and fluctuating capacity. The court plainly encouraged a practical approach although what would have happened if, when C had capacity, he disagreed with his litigation friend, is not clear.

It also is of interest to personal injury practitioners for its implications in relation to claims by people whose lack of capacity results from drug abuse. The sums involved were not small. C "lost" over £50,000 in relation to past costs and a claim for over £12,000 per annum for future costs.

Court of Protection practitioners may also want to think about the approach that might have been taken had these matters fallen for consideration in the Court of Protection. For purposes of the Mental Capacity Act, the reason *why* you have a particular impairment is

irrelevant, as it is the fact of that impairment which (if the "causative nexus" is satisfied) gives rise to the relevant lack of capacity. The approach to be taken to the appointment of the deputy would have to be predicated, instead, upon a requirement that the matter be returned to court for further consideration after a specific period of time, or by way of specific limits upon the deputy's authority to act, so that the court could either directly or indirectly provide for the consequences of the individual's conduct if – as a matter of fact – it was (or was not) causing him to lack capacity in the material domains.

Transparently pulling in different directions

V v Associated Newspapers & Ors [2016] EWCOP 20 (Charles J)

Media – anonymity – private hearings

Summary

In the sequel to the decision in C's case, Charles J has considered afresh the Court of Protection's approach to reporting restrictions orders, not least in light of the transparency pilot currently underway.

For present purposes, the facts can be very shortly summarised. C's case came before the Court of Protection for determination as to her capacity to consent to renal dialysis. A reporting restrictions order was made at the outset of the proceedings (in standard terms for a serious medical treatment case) restricting reporting of information leading to the identification of C and her adult daughters. The order was expressed to have effect during C's lifetime. After a hearing at which it was determined that C had the capacity, such that the Court of Protection had no jurisdiction, C died. The case was the subject of considerable media interest, and both the tactics adopted by some reporters and the style of some reporting caused considerable distress to C's family. The adult daughters applied for a continuation of the reporting restriction order; by the time that the matter came finally to be determined by Charles J, the relevant media organisations did not contest that the order should be continued to the 18th birthday of C's teenage daughter, although raised an issue as to whether the order could be made by Charles J as a Court of Protection judge (as opposed to a High Court judge) Subsequent to the hearing, a further application was made that the order be extended to cover C's inquest, which the media organisations did not resist, and which Charles J found to be justified on the particular facts of the case, especially given the prurient nature of the reporting that had taken place.

Much of Charles J's judgment, therefore, consisted of determination of general principles for future guidance, rather than the resolution of a contest as to how they should apply upon the facts of the instant case. In characteristic fashion, the judgment delves into matters in considerable detail, but for practitioners, the following conclusions he reached are key.

First: the Court of Protection has jurisdiction to make a post mortem reporting restrictions order (although in the instant case, and on a "belt and braces approach," Charles J also made the order as a High Court judge to avoid any future jurisdictional arguments). Further, reporting restrictions orders in serious medical treatment cases can extend beyond the death of the subject of those proceedings and there is no presumption or default position that such orders should end on P's death.

Second: the Court of Protection should generally address the following questions:

1. Are there good reasons for the hearing to be in public?

2. If there are, should that public hearing be ordered with or without reporting restrictions? As part of that determination, how effective are any such reporting restrictions likely to be in protecting and promoting the relevant Article 8 rights and how restrictive are they likely to be of the relevant Article 10 rights having regard to the

factors, propositions and public interests that underlie and promote those competing rights?

3. In light of the conclusions as to these questions, and applying the ultimate balancing test required by *Re S (A Child) (Identification: Restrictions on Publication)* [2005] 1 AC 593, should the hearing be in private or in public? If in private, what documents (with or without redactions and anonymisation) should be made public (and when and how this should be done)? If in public, what reporting restrictions order / anonymity order should be made?

Third, the answer to the first question is almost always going to be "yes" because of the benefits of open justice and so almost always the *Re S* exercise will be engaged by addressing the second and third questions.

Fourth, a distinction can be made between (a) cases where pursuant to the default or general position under the relevant Rules or Practice Directions the court is allowing access (or unrestricted access) to the media and the public, and (b) cases in which it is imposing restrictions and so where the court is turning the tap on rather than off. However, Charles J emphasised that this distinction only reflects the strength of the reasoning underlying those Rules and Practice Direction that in many, perhaps most, cases the important safeguards secured by a public hearing can be secured without the press publishing or the public knowing the identities of the people involved. The distinction therefore provides weight to the general arguments for anonymity to promote the administration of justice by the court generally and in the given case. The distinction therefore does not undermine the general proposition that naming people has a valuable function of rendering news stories personal and therefore effective as journalism (see *In re Guardian News and Media Ltd* [2010] UKSC 1). As Charles J reminded us, the CoP needs to remember it is not an editor.

Fifth, the weight to be given to the "naming proposition" and the conclusion as to what generally best promotes the administration of justice will vary from case to case, and may require specific consideration (and reasons) in specific cases. Charles J gave some useful examples of how these considerations might apply in different cases:

(1) If the case involves a celebrity but otherwise is not out of the ordinary, the Court will be exercising a well-known decision making process, and the difficulty or impossibility of providing effective anonymisation may found a decision not to order a public hearing. The question for the trial judge will therefore be what (if any) document or judgment should be made public;

(2) If the case involves a celebrity but raises new or unusual points and so is out of the ordinary this may found a decision for a public hearing with no (or unusual) reporting restrictions;

(3) Where findings of serious mistreatment or malpractice are sought or when a member of a family wants (or has initiated) publicity that identifies P and family members issues will arise whether: (1) there should be a public hearing with no reporting restrictions (so the rival arguments and assertions are made public and linked to identified individuals); or (2) whether there should be a private hearing (with disclosure to relevant bodies or persons).

Charles J also used the opportunity to set out in a

schedule to the judgment a comparison between the Transparency Pilot and the approach to reporting restrictions orders in serious medical treatment cases. His analysis includes a useful – technical – explanation of the reasons why the two are different, a useful discussion of the purpose of notice, and also an invitation to the media and other interested persons to provide comments and contributions as to the practice relating to and the terms of Transparency Pilot Orders and PD13 Reporting Restriction Orders, not least so as to enable the ad hoc Rules Committee he chairs to consider whether separate practice directions and different standard orders should continue in respect of serious medical treatment cases and/or whether the existing practice/template order in such cases should be changed.

Comment

In light of the sorry picture painted of the conduct of the relevant media organisations, it is hardly surprising that Charles J took the (very unusual) step of extending the RRO to cover C's inquest. Of wider significance and longer-term importance, however, are Charles J's observations as to the general approach to be taken and questions to be asked as the CoP continues to look – via the Transparency Pilot – for the best approach to enable it secure the correct balance between Articles 8 and 10 ECHR and thereby correctly promote the powerful (and often competing) public interests they engage and reflect.

Tragedy at the interface

As was reported by a number of newspapers, the Assistant Coroner for Cornwall, Plymouth and Devon is to write to the Health Secretary following the death of a talented musician, John Partridge, who committed suicide at the age of 17. He had autism, mild learning disability, was on antidepressants and was previously known to mental health services following at least one previous suicide attempt.

Following an overdose, he attended hospital where a consultant assessed him as being at high risk of further self-harm. Before a Mental Health Act assessment was convened, John absconded. The police returned him to hospital. But the community adolescent mental health service ('CAMHS') outreach team was not available. Instead he was seen by a junior doctor on rotation and a mental health nurse. He did not co-operate with the capacity assessment but they concluded that he had capacity to decide to self-discharge and was not at risk of immediate self-harm. John returned to his parents' home. The next day he was located in the woodland.

The inquest found there to be inadequate record keeping with regard to the assessments and no clear plan was made with his mother for his discharge. Furthermore, concern was expressed regarding the lack of weekend CAMHS provision, and the interplay between the Mental Capacity Act 2005 and the Children Act 1989. A serious case review had also made 8 recommendations.

Most of the 2005 Act begins at the age of 16. And the 1989 Act concludes at 18. A 16 or 17 year old with capacity to make decisions that conflict with those exercising parental responsibility is certainly therefore a tricky area. But in cases like this, the Mental Health Act 1983 is of course available even for those who are considered to have capacity to self-discharge. So the focus is very much upon the adequacy of the risk assessments, 7-day specialist risk assessors, and the involvement of those who know the person best to help inform those assessments.

Short note: detention, mental health and damages

In *R (O) v Secretary of State for the Home Department* [2016] UKSC 19, the Supreme Court considered a Home Office policy relating to the detention of the mentally ill pending deportation.

O was a Nigerian national who entered the UK illegally. She was sentenced to 12 months' imprisonment for child cruelty and recommended for deportation. Following her release from prison, she was detained in immigration detention.

During the period of her imprisonment and of her detention in an Immigration Removal Centre, O displayed signs of serious mental ill-health, including by a number of attempts at suicide and other acts of self-harm; by suffering hallucinations; and by unpredictable mood-swings and impulsive outbursts. She was mainly treated with high doses of anti-psychotic and anti-depressant medication. A clinical psychologist concluded that O could not access the necessary mental health services in detention and that release would greatly benefit her mental health. O was released from detention and not deported due to mental health concerns.

The Secretary of State's policy regarding immigration powers stated that "those suffering from serious mental illness which cannot be

satisfactorily managed within detention" were normally suitable for detention in only very exceptional circumstances. By failing to properly address O's mental illness, the Secretary of State had to apply the policy when deciding to detain O before her release. However, the Supreme Court held that although the overall refusal to release O was procedurally flawed, a lawful application of the policy would not have secured O's release from detention any earlier than the date of her actual release on bail.

This case highlights a worrying lack of attention being paid to those suffering mental illness in immigration detention. However, whilst the Supreme Court found that there had been a clear procedural breach of the Secretary of State's policy, it also made clear that a claim for judicial review was likely to lead to a declaration of unlawful detention and an award for nominal damages in the sum of £1 only.

Moreover, and of wider significance, although this case was considered in the immigration context, by analogy (see also the *Bostridge* case), the same approach to damages applies where there has been a procedural failure to comply with the DOLS requirements under the MCA. Any claim for substantial damages under Article 5 ECHR will need to demonstrate that the claimant has, in fact, suffered loss.

Rapporteur on Mental and Health and Human Rights for the Joint Committee on Human Rights

[*Editorial Note: we are delighted that Amanda Solloway MP has provided us with a description of her new role as Rapporteur, and wish her all the best in discharging this new and important function*]

The Joint Committee on Human Rights (JCHR) was set up in 2001, shortly after the Human Rights Act 1998 came into operation. The JCHR is a joint committee of both Houses which acts on behalf of Parliament as a whole, with six MPs and six Peers. Our membership includes lawyers, civil liberties campaigners and politicians from across the party spectrum with a range of experience and views on human rights.

The JCHR's remit relates to human rights in the UK (excluding consideration of individual cases). We scrutinise all major government legislation, drawing Parliament's attention to any potential failure to comply with the European Convention on Human Rights and other international obligations binding on the UK. We also undertake thematic inquiries. The current Committee was established in October 2015, and has been operating for just over six months.

In December 2015, the JCHR appointed me to be Rapporteur on Mental Health and Human Rights with a remit of exploring, through informal meetings, contacts and visits, issues of concern in relation to mental health when approached through a human rights framework. I will be reporting back on each issue to the full Committee, which may then choose to seek written or oral evidence, and possibly produce a report on that subject.

The Rapporteur role is new for Select Committees, and one that I feel very privileged and excited to be taking on. This is also the first time that the JCHR has appointed a Rapporteur, partly in response to the House of Commons Liaison Committee recommendation that "Committees experiment with different approaches, such as appointing a Rapporteur to lead on a particular inquiry". As Rapporteur, I am very keen to escape from the 'Westminster

bubble' to engage as fully as I can with the wider public. I want to hear how issues relating to mental health and human rights are affecting people up and down the country, and more importantly how my role can focus on key areas to improve the rights and safeguarding of vulnerable people.

My first subject for investigation is looking at preventable deaths of people suffering from mental health problems, including those in detention, in the light of recent reports such as the Harris Review of self-inflicted deaths in custody and the report from the Equality and Human Rights Commission on preventing deaths in detention of adults with mental health conditions. I am in the process of visiting prisons and meeting with a variety of organisations to discuss their experiences, concerns and expertise in this field. If you would like to share any views or experiences you have related to my first investigation, please email me at JCHR@parliament.uk. I would be delighted to hear from you.

Mental health is an extremely broad topic, and as such, it is important to emphasise that I will be only focussing on mental health issues within the context of human rights. In terms of the human rights that are most relevant in the area of mental health, they are the right to life in Article 2 of the European Convention on Human Rights ("ECHR"); the right not to be subjected to inhuman or degrading treatment in Article 3 ECHR; the right to liberty in Article 5 ECHR; and the right to respect for private life in Article 8 ECHR. There are of course other relevant human rights which are also contained in UN human rights treaties by which the UK has chosen to be bound, including the UN Convention on the Rights of the Child, the International Covenant on Economic, Social and Cultural Rights, and the UN Convention on the Rights of Persons with Disabilities.

In addition to the informal visits and meetings that I'll be undertaking in this role, I would like to invite people (including health care professionals, academics, specialist organisations and anyone who has direct experience of mental health issues within a human rights context) to send me their suggestions for topics of investigations to take forward in the future. You can send suggestions to me at: JCHR@parliament.uk.

You can find out more about the work of JCHR on our website: http://www.parliament.uk/jchr.

The Assisted Decision-Making (Capacity) Act 2015

[*Editorial Note: we are very grateful indeed to Patricia Rickard-Clarke for writing the following article for us outlining the key provisions of the Act recently enacted in the Republic of Ireland which – we suggest – has much to teach those considering law reform in other jurisdictions*]

1 Introduction

The *Assisted Decision-Making (Capacity) Act 2015* (ADMC Act) was enacted in December 2015 and reforms the outdated 19th century legislation on decision-making capacity based on the *Lunacy Regulations (Ireland) Act 1871*. It will enable Ireland to ratify the UN Convention on the Rights of People with Disabilities 2006 (CRPD) and the Hague Convention on the International Protection of Adults 2000 (Hague Convention). The ADMC Act sets out a modern decision-making legislative framework for those aged over the age of 18 years and whose capacity is in question or who lack capacity and will replace the Wards of Court system. It reforms the law on

enduring powers of attorney as contained in the *Powers of Attorney Act 1996* to provide better safeguards in line with best practice in addition to extending the scope of an attorney's authority to include healthcare decisions. The legislation also includes a statutory framework for Advance Healthcare Directives and provides for the appointment of a person to be known as the Director of the Decision Support Service (Director DSS) and confers detailed functions on the Director in relation to the arrangements set out in the ADMC Act. The ADMC Act is not yet in force but it is expected it will be commenced in the latter part of this year.

2 Capacity to be construed functionally

The ADMC Act provides that a person's capacity is to be construed functionally and defines decision-making capacity as the ability of a person to understand, at the time that a decision is to be made, the nature and consequences of the decision to be made by him or her in the context of available choices at that time. However, unlike the Mental Capacity Act 2005 (MCA) and to fully comply with Article 12 of the CRPD there is no 'diagnostic threshold' in the definition of capacity.

Who is the legislation for? It is for a person who is defined as a ***relevant person,*** being -

(a) a person whose capacity is being called into question or may shortly be called into question in respect of one or more than one matter,

(b) a person who lacks capacity in respect of one or more than one matter, or

(c) a person whose capacity is being called into question or may shortly be called into question or who lacks capacity at the same time but in respect different matters.

The ADMC Act provides that a person lacks the capacity to make a decision (similar to the MCA) if he or she is unable –

- to understand the information relevant to the decision,
- to retain that information long enough to make a voluntary choice,
- to use or weigh that information as part of the process of making the decision, or
- to communicate his or her decision (whether by talking, writing, using sign language, assistive technology, or any other means) or, if the implementation of the decision requires the act of a third party, to communicate by any means with that third party.

The functional approach to capacity is further emphasised by provisions such as the *fact that a person lacks capacity in respect of a decision on a particular matter at a particular time does not prevent him or her form being regarded as having capacity to make decisions* on the same matter at another time or indeed the fact that a person lacks capacity in respect of a decision on a particular matter does not prevent him or her from being regarded as having capacity to make decisions on other matters.

3 Guiding Principles

A number of guiding principles which must be given effect to in relation to any intervention are set out in the ADMC Act. (An **'intervention'** is defined as any action taken, court orders made or directions given under the Act in respect of a relevant person). It shall be presumed that a relevant person has capacity unless the contrary is shown. A relevant person shall not be

considered as unable to make a decision in respect of a specific matter unless all practicable steps have been taken, without success, to help him or her to do so. The making of, having made or being likely to make an **unwise decision** is not be considered as a relevant person being unable to make a decision. Any intervention in respect of the relevant person must also be made in a manner that minimises the restriction on the relevant person's rights, freedom of action and must have regard to the need to respect the right of the relevant person to dignity, bodily integrity, privacy, autonomy and control over financial affairs and property. In order to emphasise the principle of least restrictive approach, a further principle provides that in the case of a person who lacks capacity regard shall be had to – *the likelihood of the recovery of the relevant person's capacity…and the urgency of making the intervention prior to such recovery.*

The guiding principles also set out the obligations that any intervener must comply with. These include permitting, encouraging and facilitating, in so far as practicable, the relevant person to participate, *or to improve his or her ability to participate, as fully as possible in the intervention*. The intervener, must *give effect, in so far as practicable, to the past and present* ***will and preferences*** *of the relevant person, in so far as the will and preferences are reasonably ascertainable*, and take into account *the* ***beliefs and values*** *of the relevant person (in particular those expressed in writing), in so far as those beliefs and values are reasonably ascertainable*. The intervener **must *act at all times in good faith and for the benefit of the relevant person***. This latter principle can be compared with the use of the term 'best interests' in the MCA which terminology the Irish legislation eschews.

An important principle inserted into the ADMC Act at a late stage was in respect of what is termed 'relevant information' which an intervener shall not attempt to obtain if it is not reasonably required for the making of a relevant decision. In addition an intervener shall not use relevant information for a purpose other than in relation to a relevant decision and must take reasonable steps to keep the information secure from unauthorised access, use or disclosure.

4 Decision-Making Intervention Options

The ADMC Act provides for a number of different types of intervention options to assist and support a relevant person to make decisions. The type of intervention will depend on the level of capacity that a relevant person has and it is envisaged that different options may be used at the same time in respect of different decisions to take account of the functional approach to decision-making.

(i) Decision-Making Assistance

A relevant person (the appointer) who considers his or her capacity to be in question or may shortly be in question may appoint another person to be known as a **Decision-Making Assistant,** who must be over the age of 18 years, to assist the appointer in making decisions in relation to personal welfare and property and affairs or both. The appointment of the decision-making assistant will be made in a **decision-making assistance agreement** which may be revoked or varied at any time. The appointer can appoint persons to act jointly or jointly and severally, or jointly in respect of some matters and jointly and severally in respect of other matter. The functions of a decision-making assistant are to -

(a) assist the appointer to obtain the appointer's relevant information,

(b) advise the appointer by explaining relevant information and considerations relating to a relevant decision,

(c) ascertain the will and preferences of the appointer on a matter the subject or to be the subject of a relevant decision and assist the appointer to communicate them,

(d) assist the appointer to make and express a relevant decision, and

(e) endeavour to ensure that the appointer's relevant decisions are implemented.

A relevant decision taken by the appointer with the assistance of a decision-making assistant is deemed to be taken by the appointer for all purposes. Regulations will set out the formalities to be complied with for the execution, variation or revocation of a decision-making assistance agreement and also the requirements to notify the Director DSS and other specified persons of the execution of such an agreement. A decision-making assistance agreement shall, be null and void, to the extent that it relates to a relevant decision, where there is, in respect of the relevant decision another intervention option in force (for example a co-decision-making agreement or a decision-making representation order), an advance healthcare directive made by the appointer and the appointer lacks capacity or an enduring power of attorney has entered into force.

(ii) Co-Decision-Making

A person with greater capacity needs has the option of making joint decisions with a trusted family member or friend. A relevant person (appointer) who considers his or her capacity to be in question or may shortly be in question may appoint a 'suitable' person who has attained the age of 18 years, to jointly make, with the appointer, one or more than one decision on the appointer's personal welfare or property and affairs or both.

A person is suitable for appointment as a **Co-Decision-Maker** if he or she is a relative or friend of the appointer and who has such personal contact with the appointer over such a period of time that a relationship of trust exists between them and the co-decision-maker is able to perform his or her functions under the co-decision-making agreement.

The appointment of a co-decision-maker must be made in a **co-decision-making agreement**. In exercising his or her functions as specified in the co-decision-making agreement, a co-decision-maker's role is to -

(a) advise the appointer by explaining relevant information and considerations relating to a relevant decision

(b) ascertain the will and preferences of the appointer on a matter the subject of, or to be the subject of, a relevant decision and assist the appointer with communicating the appointer's will and preferences,

(c) assist the appointer to obtain the appointer's relevant information,

(d) discuss with the appointer the known alternatives and likely outcomes of a relevant decision,

(e) **make a relevant decision jointly with the appointer** (this is distinct from the position of a decision-making assistant where the appointer makes the decisions personally) and

(f) make reasonable efforts to ensure that a relevant decision is implemented as far as practicable.

A co-decision-maker will be entitled to be reimbursed out of the assets of the appointer in respect of fair and reasonable costs and expenses but is not entitled to be remunerated. Such expenses must be reasonably incurred in performing functions as a co-decision-maker, be vouched for in a manner acceptable to the Director DSS and included in a report submitted by the co-decision-maker annually with regard to the performance of his or her functions as such co-decision-maker. An appointer shall not include, in a co-decision-making agreement, provision for the disposal of his or her property by way of gift.

Similar to the provisions relating to a decision-making assistance agreement, a co-decision-making agreement shall, be null and void, to the extent that it relates to a relevant decision, where there is, in respect of the relevant decision another decision-making option in force, an advance healthcare directive made by the appointer and the appointer lacks capacity or an enduring power of attorney has entered into force.

A co-decision-making agreement shall not enter into force until it has been **registered**. The application for registration which must be done within 5 weeks from the date of the signing of the agreement and includes the giving of notice to specified persons. The application for registration must include a statement as to why the less intrusive measure of a decision-making assistance agreement was not chosen.

A relevant decision which is made within the scope of a registered co-decision-making agreement shall not be challenged on the grounds that the appointer did not have capacity to make the decision. Where a co-decision-making agreement stands registered, a relevant decision made otherwise than jointly by the appointer and the co-decision-maker is null and void. Where a relevant decision requires the signing of any document, the relevant decision is null and void unless both the appointer and the co-decision-maker sign the document.

The Director of the DSS **shall establish and maintain a Register of co-decision-making agreements** and shall make the Register available for inspection and may issue an authenticated copy of a co-decision-making agreement. The Director DSS is also obliged to keep a record of any body or person that has inspected the Register or received an authenticated copy of a co-decision-making agreement. The Director DSS is obliged to conduct a periodic review of each co-decision-making agreement on the Register. The co-decision-maker is obliged to inform the Director DSS if the appointer's capacity, has deteriorated to the extent that he or she lack capacity or improved to an extent that he or she has capacity, in relation to the relevant decisions the subject of the co-decision-making agreement.

(iii) Decision-Making Representation

For a person who lacks decision-making capacity and is not capable of availing of either the decision-making assistance or co-decision making options, the **court** will make one or both of the following orders:

- An order making the decision or decisions (**decision-making order**) concerned on behalf of the relevant person where it is satisfied that the matter is urgent or that it is otherwise expedient for it to do so.

- An order (**decision-making representation** order) appointing a suitable person who has attained the age of 18 years to be a **decision-making representative** for the relevant person for the purposes of making one or more than one decision specified in the order on behalf of the relevant person in relation to his or her personal welfare or property and affairs or both.

Where the court proposes to appoint a decision-making-representative and there is no suitable person willing to act, the court will request the Director DSS to nominate 2 or more persons from a panel that is established for consideration by the court for such appointment.

In making a decision-making order or a decision-making representation order, the court shall have regard to the terms of any advance healthcare directive or enduring power of attorney made by the relevant person and shall ensure that the terms of the order are not inconsistent with the directive or the terms of the enduring power of attorney. This is to comply with the spirit of the Council of Europe Recommendation CM/REC (2009)11 which provides – [i]*n accordance with the principles of self-determination and subsidiarity, states should consider giving those methods* [EPAs and AHDs] *priority over other measures of protection.*

The court may appoint one or more than one person as a decision-making-representative and may appoint different persons in respect of different relevant decisions. Where more than one person is appointed as a decision-making representative, the court will make provision as to whether such representatives are to act jointly or jointly and severally or jointly in relation to some decisions and jointly and severally as respect other decisions. Notwithstanding that there is a decision-making representative, the court may confer on the Director DSS the custody, control and management of some or all of the property of the relevant person if the court considers that the Director DSS is the most appropriate person to manage that property. The court is obliged to give effect to the guiding principles and similar to the appointment of a deputy under the MCA, ensure that the powers conferred on decision-making representatives will be as limited in scope and duration as is necessary in the circumstances having regard to the interests of the relevant person the subject of the order.

The court may also vary or discharge a decision-making order or a decision-making representative order. Similar to the obligations imposed on a co-decision-maker, a decision-making representative will be obliged to report to the Director DSS periodically, as to the performance of his or her functions as such decision-making representative. Such report must also contain details of all expenses and remuneration paid or reimbursed to him or her.

In each of the decision-making options the emphasis is on the right of the relevant person to make the decision. Even in the third category, where it is recognised that the relevant person is unable to make a decision even with assistance, the legislation provides that insofar as it is possible, the will and preferences of the relevant person must be ascertained and the person must

be assisted with communicating such will and preferences. The legislation provides that a decision-making representative acts as agent of the relevant person and not as decision-maker per se in relation to relevant decisions.

5 Persons who are not eligible or disqualified

It is evident from the provisions of the ADMC Act that there is an emphasis on safeguarding which include court oversight, review and reporting requirements. In addition the ADMC Act sets out in detail the categories of people who are either not eligible or are disqualified from acting as a decision-making assistant, co-decision-maker, decision-making representative, attorney under an enduring power of attorney or a designated healthcare representative for an advance healthcare directive.

Persons who are **ineligible** include a person who has been convicted of an offence in relation to the person or property of the person, has been the subject of a safety or barring order in relation to the person, is an undischarged bankrupt or is currently in any personal insolvency arrangements or has been convicted of fraud or dishonestly or is a restricted or disqualified director under the provisions of the Companies Acts. However, bankruptcy, personal insolvency or restriction or disqualifications under company law does not debar such a person from acting in relation to personal welfare decisions. Owners or registered providers of nursing homes or mental health facilities are also ineligible to act (to ensure no undue influence or conflict of interest) as are persons convicted of any offence under the ADMC Act or where there is a finding by the court that such a person should not act.

Person who come within the **disqualified** category include persons who were appointed by a relevant person when they were a spouse or civil partner but the marriage or civil partnership is annulled or dissolved. Disqualification also applies where there is a written separation agreement or the parties have ceased to cohabit for a continuous period of 12 months.

6 Review of Existing Wards of Court

The ADMC Act provides that there will be a general review of existing Wards of Court who are adults and such review must take place before the third anniversary of the commencement of the Act. The review is necessitated by the fact that some existing wards will not come within the definition of a *relevant person* under the ADMC Act as it recognises that some wards (applying the functional test) will have capacity to make decisions. In addition, in respect of those persons whose decision-making capacity is in question or who lack decision-making capacity, the court in deciding what continuing supports the person may require must adhere to the principle of the least restrictive intervention of the person's rights and freedom of action.

A ward may personally or a person who has *sufficient interest or expertise in the welfare of the ward* can make an application to the wardship court for a review at any time. (The wardship court will be either the High Court or the Circuit Court – whichever court made the original wardship order). The position of each ward will be reviewed by the wardship court in accordance with the provisions of the new legal framework. The wardship court must –

(a) Declare that the ward does not lack capacity, or

(b) Make one or more than one of the following declarations:

(i) That the ward lacks capacity, unless the assistance of a suitable person as a co-decision-maker is made available to him or her, to make one or more than one decision,

(ii) That the ward lacks capacity, even if the assistance of a suitable person as a co-decision-maker were made available to him or her.

Where the wardship court makes a declaration pursuant to (a) above, it shall immediately discharge the ward from wardship and shall order the property of the former ward to be returned to him or her and give such directions as it thinks appropriate having regard both to the discharge and the circumstances of the former ward.

Where the wardship court makes a declaration pursuant to (b) (i) above, it shall on registration of a co-decision-making agreement, discharge the ward from wardship and shall order the property of the former ward be returned to him or her and give such directions as it thinks appropriate having regard both to the discharge and the circumstances of the former ward. However, where there is no suitable person to act as co-decision-maker for the former ward, or a co-decision-making agreement is not registered within the period set down by the wardship court or any extension of such period, the wardship court will make such orders as it considers appropriate which may include the appointment of a decision-making representative. This will involve the returning of the property to the former ward but where the court makes a decision-making representation order, the property will be returned to the former ward on the appointment of the decision-making representative.

The third possible outcome on the review of individual wards is where the court makes a declaration pursuant to (b) (ii) above, it shall make such orders as it considers appropriate and order the property of the former ward be returned to him or her upon the appointment of a decision-making representative in respect of the former ward.

Under the current Wards of Court regime, once a person is made a Ward of Court, his or her assets are brought under the control of the Court so that they may be used for his or her maintenance and benefit. Money lodged in Court is invested on behalf of the Ward. This practice will cease under the ADMC Act to comply with Article 12.5 of the CRPD – *the right of persons with disabilities to own or inherit property, to control their own financial affairs*. One of the functions of the Director DSS will be to provide information in relation to the management of property and financial affairs to relevant persons and to decision-making-assistants, co-decision-makers, decision-making representatives and attorneys. This means assisting with giving information as to where expert financial advice can be obtained but the Director DSS will not have a role in the direct management of property.

Once the ADMC Act is commenced no new applications for wardship will be made and the *Lunacy Regulations (Ireland) Act* will be repealed.

7 Enduring Powers of Attorney (EPA)

The ADMC Act does not apply to EPAs created under the *Powers of Attorney Act 1996* (1996 Act) whether registered (have come into effect) or not yet registered (not yet come into effect) except

to the extent that a person can make a complaint against a 1996 attorney to the Director DSS. The 1996 Act will not apply to any EPA created after the coming into force of the ADMC Act.

For EPAs created under the ADMC Act, the safeguarding provisions as to suitability, eligibility and disqualification for decision-making assistants, co-decision-makers and decision-making representatives, also apply to attorneys. The ADMC Act provides for more stringent requirements and oversight at both execution and registration stage. There will be oversight by the Director DSS at the time of the registration of the EPA as to whether the criteria set out in the legislation has been complied with and the person/s (proposed attorney/s)making the application for registration continue to be a 'suitable' person/s. There will be detailed reporting and accountability requirements once the EPA has been registered. Within 3 months of registration, the attorney will be obliged to submit to the Director DSS a schedule of the donor's assets and liabilities and a projected statement of the donor's income and expenditure. An attorney under an EPA who has been conferred with authority in relation to property and affairs shall be obliged to keep proper accounts and financial records and submit such accounts and records to the Director DSS periodically or make them available for inspection by the Director or by a special visitor at any reasonable time. Currently, under the 1996 Act once an EPA is registered there is no supervision of the attorney by the Registrar Wards of Courts.

The content of the instrument creating the EPA must include the following statements by the donor that he or she –

(i) Understands the implications of creating the power,

(ii) Intends the power to be effective at any subsequent time when he or she lacks capacity in relation to one or more relevant decisions which are the subject of the power, and

(iii) Is aware that he or she may vary or revoke the power prior to its registration.

This is to be compared with the provisions of the 1996 Act which provides that an application for registration of an EPA can be made when *the donor is or is becoming mentally incapable*. The statement required of a donor of a 1996 EPA is merely to state that *the donor has read the information as to the effect of creating the power or that such information has been read to the donor.*

As with the 1996 Act a legal practitioner must be satisfied that he or she has no reason to believe that the instrument is being executed as a result of fraud, coercion or undue pressure and a registered medical practitioner that in his or her opinion at the time the power was executed, the donor had capacity to understand the implications of creating the power. An additional statement is required by the ADMC Act from a healthcare professional *of a class that shall be prescribed*, that in his or her opinion at the time the power was executed, the donor had the capacity to understand the implications of creating the power. The class of healthcare professional yet to be prescribed are likely to be speech and language therapists and social workers who work on an ongoing basis with people whose capacity is at issue and would be in a position to assist a relevant person in understanding the implications of creating an EPA, assisting them in making a decision and also in communicating their decision in this regard.

The ADMC Act provides that an attorney must state that he or she -

(i) Understands the implications of undertaking to be an attorney for the donor and has read and understands the information contained in the instrument.

(ii) Understands and undertakes to act in accordance with his or her functions as specified in the instrument creating the enduring power of attorney,

(iii) Understands and undertakes to act in according with the guiding principles,

(iv) Understands and undertakes to comply with the reporting obligations and

(v) Understands the requirements in relation to registration of the power.

This detailed statement is to be compared with the statement required under the 1996 Act which merely asks the attorney to state that he or she understands the duties and obligations of an attorney and the requirements of registration. Experience since 1996 of EPAs being used as a tool of abuse, particularly in relation to financial matters, had led to an awareness of the need to have full accountability by attorneys.

Notice of the execution of an EPA must be given to an expanded group of people which may now include a decision-making assistant, a co-decision-maker, a decision-making representative, a designated healthcare representative, any other attorney under the 1996 Act. This is further recognition of the functional approach to capacity where a relevant person may be able to make one or more decision with assistance or needs the assistance of a co-decision-maker for one or more decisions. The EPA will only come into force when the relevant person lacks capacity for the relevant decision.

The **authority that a donor can confer** on an attorney in respect of 'property and affairs' decisions and what are termed 'personal welfare' decisions (which include healthcare decisions) include general authority to act on the donor's behalf in relation to all or a specified part of the donor's property and affairs, or authority to do specified things on the donor's behalf in relation to the donor's welfare or property and affairs, or both and which may, in either case, be conferred subject to conditions and restrictions.

The **scope of the authority** for both 'personal welfare' decisions and 'property and affairs' decisions are circumscribed by the ADMC Act. In the case of 'personal welfare' decisions, the power does not authorise an attorney to do an act that is intended to restrain the donor unless there are exceptional emergency circumstances. Restraint is stated to include the use or indicates an intention to use, force to secure the doing of an act which the donor resists, intentionally restricts the donor's liberty of voluntary movement or behaviour whether or not the donor resists or administers a medication, which is not necessary for a medically identified condition, with the intention of controlling or modifying the donor's behaviour or ensuring that he or she is compliant or not capable of resistance or authorises another to do so. Decisions on restraint also apply to a decision-making representative in the exercise of authority in respect of 'personal welfare' decisions. While decisions on restraint are limited to attorneys and decision-making representatives, the ADMC Act is otherwise silent on the issue of **deprivation of**

liberty. Separate legislation to deal with deprivation of liberty is currently being worked on and is promised in the form of an Equality/Disability (Miscellaneous Provisions) Bill in the coming months.

A donor must not, in an EPA, include a relevant decision relating to the refusal of life-sustaining treatment, or a decision which is the subject of an AHD made by him or her. To the extent that an EPA includes such relevant decisions the power shall be null and void. In other words, even though healthcare decisions can now be included in an EPA, the scope of such decisions does not extend to refusal of life-sustaining treatment which can only be provided for in an advance healthcare directive. In addition, if relevant healthcare decisions are included in an AHD either made before the EPA was created or subsequent to the creation of the EPA the provisions of the AHD will apply. To the extent that an EPA includes such relevant decisions, the power will be null and void. It is interesting to note the distinction that is provided for in this regard in the in the MCA.

In relation to 'property and affairs', an attorney may not dispose of the property of the donor by way of gift unless specific provisions to that effect is made in the EPA. Where the EPA authorises gifting, then subject to any conditions or restrictions in the EPA, the attorney's power to gift shall be limited to gifts made on customary occasions to persons who are related to or connected to the donor and in relation to whom the donor might be expected to make gifts, and gifts to any charity to which the donor might or might be expected to make gifts.

On the receipt of an application for registration of an EPA, the Director DSS is obliged to review the application and review objections to the registration of the EPA that are received and shall carry out such enquiries as he or she considers necessary. The Director also has the responsibility of establishing and maintaining a register of instruments creating EPAs. The Director shall make the Register available for inspection and may issue an authenticated copy of an EPA, or part thereof, on the payment of a prescribed fee. The Director shall also keep a record of those who inspected the Register or who received an authenticated copy of an EPA.

8 Advance Healthcare Directive (AHD)

Advance healthcare directive are legally recognised in Ireland but there has been no statutory provision for them until the enactment of the ADMC Act. A person who has reached the age of 18 years and who has capacity may make an AHD. Similar legislative criteria apply, as are provided for in the MCA, an AHD to be legally binding is concerned with the refusal of treatment and must be complied with if 3 conditions are met:

(a) At the time the ADH is to be followed the person who made the AHD lacks capacity to give consent to the treatment;

(b) The treatment to be refused must be clearly identified in the directive;

(c) The circumstances in which the treatment refusal is intended to apply are clearly identified in the directive.

The legislation confirms that a specific refusal of treatment set out in an AHD is as effective as if made contemporaneously by the directive-maker when he or she had capacity to make that decision. A healthcare professional who has not complied with a refusal of treatment set out in an

AHD will not incur civil or criminal liability and who, at the time in question, had reasonable grounds to believe and did believe, that the AHD was not valid or applicable, or both. Liability will also not be incurred if the healthcare professional had no grounds to believe that the AHD existed or the urgency of the medical condition was such that the healthcare professional could not reasonably delay taking appropriate medical action until he or she had access to the directive.

A **request for a specific treatment** set out in an AHD is not legally binding but must be taken into consideration during any decision-making process which relates to treatment if that specific treatment is relevant to the medical condition for which the directive-maker may require treatment. When a request for specific treatment set out in an AHD is not complied with the healthcare professional must record the reasons for not complying with the request and give a copy of those reasons to the directive maker's designated healthcare representative (if any) within 7 days.

An AHD is not applicable to **life-sustaining treatment** unless it is substantiated by a statement by the directive maker to the effect that the directive is to apply to that treatment even if his or life is at risk. This is an additional safeguard to ensure that directive maker understand the seriousness of the nature of such a directive.

An AHD will not be applicable to **basic care** which includes (but not limited to), warmth, shelter, oral nutrition and oral hydration and hygiene measures but does not include artificial nutrition or artificial hydration (which would come within the definition of treatment – as both are interventions).

Certain personal information about the directive-maker must be contained in the AHD and certain formalities must be followed in order to make a valid AHD. The Minister for Health has power to make regulations with regard to AHDs to include the requirement to give notice to specified persons and to notify the Director DSS of the making of the AHD. The Director is obliged to establish and maintain a **Register of AHDs** so notified to him or her. An AHD must be in writing and any alteration or revocation of an AHD must also be in writing.

The ADMC Act provides for an 'automatic' application to the High Court to determine whether or not a treatment refusal should apply, in the case of a woman who lacks capacity and is pregnant and where her AHD sets out a specific refusal of treatment that is to apply even if she were pregnant and it is considered by the healthcare professional concerned that the refusal of treatment would have a deleterious effect on the unborn.

In relation to a person who is suffering from a 'mental disorder' and is being treated under the provisions of the *Mental Health Act 2001* or the *Criminal Law (Insanity) Act 2006,* the Act provides that the AHD does not have to be complied with. This raises issues of equality of treatment and of compliance with the CRPD. The Report of the Expert Group on the Review of the *Mental Health Act 2001* (published in December 2014) recommended that this matter needed to be dealt with in a more complete and comprehensive manner. In particular, it stated the authority to override a treatment refusal where a person's health as opposed to life is at risk, should be revisited again when the mental health legislation is being revised. A Mental Health (Amendment) Bill is also expected in 2016.

A person in addition to simply making an AHD in writing and complying with the formalities, may designate a named individual known as a **Designated Healthcare Representative**, to exercise the relevant powers contained in the AHD. A designated healthcare representative can be conferred with limited power, simply to ensure that the terms of the AHD are complied with or with wider powers to advise and interpret what the directive-maker's will and preference are regarding treatment or power to consent to or refuse treatment up to and including life-sustaining treatment based on the know will and preference of the directive-maker as determined by reference to the AHD.

A designated healthcare representative must keep a record in writing of any decisions and produce that record for inspection at the request of the directive-maker, if he or she has regained capacity, or at the request of the Director DSS. The Director DSS is tasked with preparing and publishing a **code of practice** for the purposes of the guidance of designated healthcare representatives or healthcare professionals or both.

Importantly, the ADMC Act provides for a 'Hague type' recognition of an advance healthcare directive made outside the State and which substantially comply with the requirements of the ADMC Act, shall have the same force and effect in the State as if it were made in the State.

9 Director of Decision Support Service (Director DSS)

The ADMC Act provides that the Mental Health Commission shall appoint a person to be known as the Director of the Decision Support Service to perform the functions set out in the Act. The Mental Health Commission was established as an independent statutory body by the *Mental Health Act 2001* with the principal function of the *fostering of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of person detained in approved centres* under the act. It was stated in the Oireachtas (House of Parliament) by the Minister for State that the Decision Support Service **will be a separate entity attached to the Mental Health Commission and will not be subsumed by it.** It is intended that the Mental Health Commission will be renamed to take account of its dual mandate in relation to mental health and decision-making capacity.

(i) Functions generally

The functions of the Director DSS will include –

- the promotion of public awareness of the ADMC Act and matters relating to the exercise of their capacity by persons who require or may shortly require assistance in exercising their capacity
- to promote public confidence in the process of dealing with matters which affect persons who require or may shortly require assistance in exercising their capacity
- to provide information to relevant person in relation to their options for exercising their capacity
- to provide information to and to supervise decision-making assistants, co-decision-makers, decision-making representatives, designated healthcare representatives and attorneys in relation to the performance of their functions
- to provide information in relation to the management of property and financial affairs to relevant persons and the various supporting decision-makers
- to provide information and guidance to organisation and bodies in the State in

relation to their interaction with the various supporting decision-makers
- to identify and make recommendations for change of practice in organisations and bodies in which the practice may prevent a relevant person from exercising his or her capacity. (It is recognised that a major cultural shift from imbedded bad practices is required for full implementation of the ADMC Act)
- to disseminate information to the public (by electronic means) to assist members of the public to understand the operation of the ADMC Act and the Director's role and functions in relation to it.

In carrying out his or her functions, the Director DSS may consult with any person who has any functions in relation to the care or treatment of a relevant person. It will be seen that the Director DSS has been given the task of the promotion of public awareness and the dissemination of information about the ADMC Act to a persons and organisations. Given the archaic legislation still on the statute book, with resultant embedded inappropriate practices, it was necessary for the legislators to recognise that the best manner to achieve the 'cultural shift' to the new order was to provide for this in the ADMC Act itself.

(iii) Complaints and Investigative Powers

Any person may make a complaint to the Director DSS about a decision-making assistant, co-decision-maker, a decision-making representative, an attorney (appointed under the 1996 Act or the ADMC Act) or a designated healthcare representative on a number of grounds which includes a complaint that the intervener has acted, is acting or is proposing to **act outside the scope of his or her functions** or that the intervener is not a suitable person. A complaint can also be made that **fraud, coercion or undue pressure** was used to induce a person to enter into a co-decision-making agreement, to appoint an attorney or to make an advance healthcare directive. Following a receipt of a complaint the Director DSS must carry out an investigation and may seek resolution of complaints in such manner (including any informal means) as the Director considers appropriate and reasonable. Where the Director is of the view that the complaint is well founded the Director shall make an application to the court for a determination. The court, if it considers it appropriate, determine that the intervener shall no longer act in relation to the relevant person.

The Director DSS has been given wide **investigative powers**, either on his or her own initiative or in response to a complaint made by any person, to investigate actions of any intervener which may involve a breach of his or her functions or a breach of the provisions of the ADMC Act. The Director DSS may summon witnesses, examine a witness on oath, require the production of any document in the power or control of the witness or require the witness to provide such written information as the Director considers necessary. A person who hinders or obstructs the Director DSS in the performance of his or her functions shall be guilty of an offence.

(iv) Codes of Practice

The Director has been assigned the responsibility of **preparing and publishing codes of practice,** request another body to prepare a code of practice or approve a code of practice prepared by another body. The persons for whom the codes of practice will provide guidance include representatives of healthcare, social care, legal

and financial professionals and for a wide class of persons who will be interacting with relevant persons to include persons acting as **advocates** on behalf of relevant persons.

(v) Panels and Registers

The Director DSS has the responsibility of establishing a panel of suitable persons willing and able to act as decision-making representatives, special visitors (medical practitioners, or other persons who have particular knowledge, expertise and experience with respect to the capacity of persons and who the court or the Director DSS may ask to visit a person and furnish a report), general visitors (persons who possess relevant qualifications to assist the Director in exercising his or her supervisory functions) and court friends (who will assist a relevant person in respect of an application to court and where the relevant person has not instructed a legal practitioner).

10 Offences

The ADMC Act introduces a number of new offences.

- A person who uses **fraud, coercion or undue influence** to force another person to make, vary/alter or revoke a co-decision-making agreement, an EPA or an AHD commits an offence.
- A person who **knowingly creates, falsifies or alters, or purports to revoke an AHD** on behalf of another person without that other person's consent in writing when the other person has the capacity to do so commits an offences.
- A decision-making assistant, co-decision-maker, decision-making representative, attorney for the relevant person or a designated healthcare representative who **ill-treats or wilfully neglects** the relevant person shall be guilty of an offence.

A person guilty of any of the above offences shall be liable on summary conviction to a class A fine or imprisonment for a term not exceeding 12 months, or both or on conviction on indictment, to a fine not exceeding €50,000 or imprisonment for a term not exceeding 5 years or both.

A person who, in an application for registration of a co-decision-making agreement or an EPA, **makes a false statement** which he or she knows to be false in a material particular commits an offence and will be liable on summary conviction to a class A fine or imprisonment for a term not exceeding 6 months or both, or on conviction on indictment, to a fine not exceeding €15,000 or imprisonment for a term not exceeding 2 years, or both.

11 Court Jurisdiction

Except for certain matters that are within the jurisdiction of the High Court, the ADMC Act provides that the Circuit Court (the court) will have exclusive jurisdiction. On an application to it, the court is entitled to make declarations as to capacity. It can make a declaration that the relevant person lacks capacity unless the assistance of a suitable person as a co-decision maker is available to him or her or a declaration that the relevant person lacks capacity even if the assistance of a suitable person as a co-decision-maker were made available to him or her. Where the court has made such a declaration, an application for a review of the declaration may be made to the court at any time by the relevant person. However, the court must, in every case, review declarations at intervals specified by the court when it made the original declaration but in any event within a period of 12 months or if the

court is satisfied that the relevant person is unlikely to recover his or her capacity, within a period not more than 3 years. In making an order, declaration or carrying out a review the court has the power to seek expert reports to assist it in making a decision.

The matters to be determined by the High Court relate to any decision regarding the donation of an organ from a living donor and where the donor lacks capacity or where an application in connection with the withdrawal of life-sustaining treatment from a person who lacks capacity comes before the courts for adjudication. The High Court also has jurisdiction where an issues arises as to whether an AHD is valid or applicable if the application to the court in relation to an AHD relates to considerations relating to life-sustaining treatment. In addition, as stated above there is an automatic reference to the High Court to determine whether or not a treatment refusal contained in an AHD should apply in the case of a woman who lacks capacity and is pregnant and there is a concern that the refusal of treatment would have a deleterious effect on the unborn.

12 Hague Convention on the International Protection of Adults (Hague Convention)

The ADMC Act will give effect to Hague Convention which is set out in the Schedule. The functions under the Convention of a Central Authority will be exercisable by the Director DSS and in relation to jurisdiction the competent authority is both the High Court and the Circuit Court.

The rules relating to jurisdiction, applicable law, recognition and enforcement and co-operation are similar to the rules contained in the MCA.

13 Medical Treatment – the relationship between the ADMC Act and the existing law

It is not intended that the ADMC Act will displace the general common law position where healthcare professionals treat persons who lack capacity to consent or to refuse medical treatment, who have not made an AHD or there is no person with legal authority to make decisions on their behalf. However, the common law position is circumscribed in a number of respects in the Act.

The ADMC Act provides that in respect of a person who lacks capacity and if *any decision regarding the donation of an organ from a living donor* arises there is a mandatory requirement that this decision must be referred to the High Court. With regard to the withdrawal of life-sustaining treatment from a person who lacks capacity, there is recognition from the wording of the legislation that clinical judgment be allowed to operate as there is no mandatory requirement to refer such a matter to the court. However, if an application on such a matter *comes before the court for adjudication,* that application shall be to the High Court. In addition, where an application is made to the Circuit Court, that court has jurisdiction to make interim orders where the court has reason to believe that the relevant person lacks capacity in relation to the matter, and in the opinion of the court, it is in the interests of the relevant person to make the order without delay. The court, if it is called upon to exercise its jurisdiction to make orders in the context of healthcare can call on the assistance of experts including healthcare professionals.

In addition, one of the codes of practice to be published by the Director DSS is a code of practice *for the guidance of healthcare professionals as respects the circumstances in*

which urgent treatment may be carried out without the consent of the relevant person and what type of treatment may be provided. Such a code is admissible in legal proceedings and any failure to comply with the code shall be taken in account by the court in deciding any question coming before it. It is expected that this code will contain detailed guidance as to the circumstances in which a healthcare professional may provide or not provide treatment to a person who lacks capacity and the types of treatment that may be administered without seeking a court determination.

The current position is that healthcare professionals follow the Medical Council's Guide to Professional Conduct and Ethics for Registered Medical Practitioners (7th Edition 2009) which provides: *If no other person has legal authority to make decisions on the patient's behalf, you will have to decide what is in the patient's best interests. In doing so, you should consider: • which treatment option would provide the best clinical benefit for the patient, • the patient's past and present wishes if they are known, • whether the patient is likely to regain capacity to make the decision • the views of other people close to the patient who may be familiar with the patient's preferences, beliefs and values, and • the views of other health professionals involved in the patient's care*. Currently, in respect of persons who are Wards of Court, some clinicians refer a question of treatment to the President of the High Court (who will consider the matter in chambers) without any delay but there is no mandatory requirement to do so. The revised 8th edition of the Medical Council's Guide, which takes account of the enactment of the ADMC Act, is due to be published in mid-May. It is not envisaged that there will be any significant change to the guidance points set out above pending the commencement of the ADMC Act and the establishment of the code of practice. However, the code will reflect the detailed Guiding Principles set out in the Act and which must be given effect to by healthcare professionals.

13 Conclusion

The ADMC Act was signed into law by the President on 30 December 2015 but has not yet commenced. The relevant Ministers (Justice + Equality and Health) have stated recently that new administrative processes and support measures, including the setting up of the Decision Support Service, must be put in place before the legislation comes into force. This includes careful planning and groundwork, and not just funding, to ensure correct and effective commencement of the legislation. Therefore, one of the first tasks for the new Government is to ensure that this important and enlightened piece of legislation is actioned promptly.

The Government has confirmed that Ireland will ratify both the CRPD and Hague Convention in 2016. In preparation of the ratification of the CRPD, the Department of Justice and Equality has published a roadmap of a list of statutes that require amendment to be in compliance with the CRPD.

Book reviews: Vulnerability in principle, law and practice

Adult Protection and the Law in Scotland (Nicola Smith and Nairn R Young, ed Hilary Patrick, Bloomsbury Professional, 2016, paperback/ ebook: c£44)

Vulnerable Adults and the Law (Jonathan Herring, Oxford University Press, 2016, £70)

Two books that recently arrived for me to review make an interesting contrast in methodology, intended audience, and scope. But both bring different perspectives to bear as to how to grapple with essentially the same problem – how to navigate in a principled fashion the Scylla of autonomy and the Charybdis of protection in the context of those whom we have labelled vulnerable.

Adult Protection and the Law in Scotland is more modest in scope. Building on the extremely clear and helpful first edition (published in 2009), it sets out to provide an overview of the key statutory provisions in the area: the Adult Support and Protection (Scotland) Act 2007, the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adults with Incapacity (Scotland) Act 2007, as well as the role of specific bodies concerned with adult protection. Its focus is unashamedly upon the practical issues that arise, and potential pitfalls for those seeking to deploy the various statutory provisions. Importantly, however, it emphasises in stand-alone chapters the crucial role of principles (offering a useful comparison table between the differing and overlapping principles at play across each of the Acts), and also the wider context of human rights legislation. It also – to this English lawyer (albeit one with a working knowledge of the area in Scotland) – strikes the right balance between authoritative identification of the position where it is clear, and crisp discussion of the position where there is doubt. A very good example of this is in relation to deprivation of liberty, and the implications of the *Cheshire West* judgment for social work practice in Scotland.

Although it is a Scottish practitioner textbook, I would strongly urge anyone in England or Wales with an interest in developing the law in this jurisdiction to obtain a copy for the insights it sheds upon the approach taken in Scotland. I would particularly urge those with an interest in developing the inherent jurisdiction of the High Court to grant relief in respect of the so-called "Munby-vulnerable" category of individuals at the fringes of the MCA to get one to study how almost exactly this category of individuals is approached under the Adult Support and Protection (Scotland) Act 2007. Some time ago, I provided an overview of these provisions, and their implications for the inherent jurisdiction in a paper which you can find here, but for a further consideration of the provisions of the Act and its wider context in Scotland, I could not recommend this book highly enough.

I was particularly struck by the potential insights that we could get from Scotland when reading the second book under review, Professor Jonathan Herring's *Vulnerable Adults and the Law.* This book is short in length (just under 270 pages), but amazingly rich and dense in content. In many ways it provides a summary of the state of the art of the debate in this area, much of which has been framed by Professor Herring in previous books. Although avowedly normative, not least in its argument that we should all be seen (and embrace) being seen as vulnerable, it also serves as a valuable descriptive function, including starting with perhaps the single best overview available of the debates surrounding the concept of vulnerability. The book then goes on to discuss in succinct but penetrating terms how English law has responded to different conceptions of vulnerabilities in different contexts. By giving a rapid tour d'horizon of how (for instance) the law of contract has developed such concepts as the "unconscionable bargain," light is shone from different directions upon that elusive concept of the vulnerable person. Importantly, all the way

through Professor Herring both asks whether we should not reformulate that concept, and critiques the legal tools developed both by the courts and Parliament, often in haphazard and almost never in coordinated fashion.

It will come as no surprise to readers of his previous works that some of Professor Herring's most sustained criticism is reserved for the concept of capacity contained in the MCA, based – he contends – on a flawed and unrealistic model of individual autonomy. This leads him on to another argument which will be familiar, namely that the inherent jurisdiction of the High Court can and should be used creatively to address the real life problems caused by the fact that we do not make decision in a vacuum (i.e. that autonomy is relational). This is the one area of the book where I wish that concision had been abandoned in favour of a greater development of the arguments. In particular, it seems to me that Professor Herring glosses over a real issue of principle, namely whether it is right for the inherent jurisdiction to be used not just to grant relief against third parties, but to grant relief directed against the individual in question, in other words (at least in some circumstances) "forcing them to be free" (my words, not his). Professor Herring allows for this possibility, relying on (in my view distinctly questionable) obiter observations of Parker J in NCC v PB and TB, but for my part I would have wished him to have spent more time on this issue. Apart from anything else, if the inherent jurisdiction can be used either directly or effectively to make decisions on behalf of someone, one could very well ask as to the point of the MCA. Further, whilst the flexibility of the inherent jurisdiction is frequently prayed in aid as a virtue, its very flexibility means it is not altogether obvious what principles are to govern its application. We have a very clear set of statutory principles set out in the MCA (even if sometimes they are honoured in the breach), and for my part allowing the inherent jurisdiction to be developed further without an equivalent set of principles is to me troubling.

This brings me back to Scotland. It seems to me that there is much to be learned from the Scottish experience in the Adult Support and Protection Act about how we might develop such a set of principles, not least it contains a ready made set in section 2. Further, the Act is calibrated so as to ensure that there is only very limited scope for relief to be targeted against the individual themselves, the focus being far more on steps directed to ensuring that those who may be adversely affecting the individual and their potential to make decisions, if not in a vacuum, then at least in unpolluted air. The ASP is not perfect (and Smith and Young's book is eloquent as to some of the areas that have been found wanting in practice), but it does to my mind provide fertile ground for consideration of where the law might evolve in my home jurisdiction.

Indeed, if Professor Herring has made a convincing case that the MCA may not respond to the realities of human nature, and has also made an equally convincing case that we can ensure to look at least in part to the law to provide us with answers, for my part I would much prefer to look to the development of that law through the process of legislation and considered debate rather than through judges bouncing on the great safety net of the inherent jurisdiction.

Alex Ruck Keene[1]

[1] [Full disclosure: I am grateful to the publishers for providing me with copies of the works reviewed here. I am always happy to review works in the field of mental capacity (broadly defined). I also commented upon certain parts of Smith and Young's book in draft].

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Conferences at which editors/contributors are speaking

Adults with Incapacity

Adrian will be speaking on Adults with Incapacity at the Royal Faculty of Procurators in Glasgow private client half day conference on 18 May 2016. For more details, and to book, see here.

CoPPA South West launch event

CoPPA South West is holding a launch event on 19 May at Bevan Brittan in Bristol, at which HHJ Marston will be the keynote speaker, and Alex will also be speaking. For more details, see here.

ESCRC seminar series on safeguarding

Alex is a member of the core research team for an-ESRC funded seminar series entitled 'Safeguarding Adults and Legal Literacy,' investigating the impact of the Care Act. The second and third seminars in the series will be on "New" categories of abuse and neglect' (20 May) and 'Safeguarding and devolution – UK perspectives' (22 September). For more details, see here.

Professorial Lecture

Jill will be delivering her inaugural professorial lecture entitled "Paradigm Shift or Paradigm Paralysis: Law, rights and mental health" on 2 June at Edinburgh Napier University. For more details, and to book, see here.

The Use of Physical Intervention and Restraint: Helpful or Harmful?

Tor will be speaking at this free afternoon seminar jointly arranged by 39 Essex Chambers and Leigh Day on 13 June. For more details, and to book, see here.

Mental Health Lawyers Association 3rd Annual COP Conference

Charles J will be the keynote speaker, and Alex will be speaking at, the MHLA annual CoP conference on 24 June, in Manchester. For more details, and to book, see here.

Advertising conferences and training events

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

Chambers Details

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

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Alex is recommended as a 'star junior' in Chambers & Partners 2016 for his Court of Protection work. He has been in cases involving the MCA 2005 at all levels up to and including the Supreme Court. He also writes extensively, has numerous academic affiliations and is the creator of the website www.mentalcapacitylawandpolicy.org.uk. He is on secondment for 2016 to the Law Commission working on the replacement for DOLS. To view full CV click here.

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

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

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

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Anna regularly appears in the Court of Protection in cases concerning welfare issues and property and financial affairs. She acts on behalf of local authorities, family members and the Official Solicitor. Anna also provides training in COP related matters. Anna also practices in the fields of education and employment where she has particular expertise in discrimination/human rights issues. To view full CV click here.

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

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

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Professor Jill Stavert is Reader in Law within the School of Accounting, Financial Services and Law at Edinburgh Napier University and Director of its Centre for Mental Health and Incapacity Law Rights and Policy. Jill is also a member of the Law Society for Scotland's Mental Health and Disability Sub-Committee, Alzheimer Scotland's Human Rights and Public Policy Committee, the South East Scotland Research Ethics Committee 1, and the Scottish Human Rights Commission Research Advisory Group. She has undertaken work for the Mental Welfare Commission for Scotland (including its 2015 updated guidance on Deprivation of Liberty). To view full CV click here.