*These notes refer to the Mental Capacity Act 2005 (c.9) which received Royal Assent on 7 April 2005*

# MENTAL CAPACITY ACT 2005

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## EXPLANATORY NOTES

### COMMENTARY ON SECTIONS

### Part 1: Persons Who Lack Capacity

### The principles

#### *Section 1: The principles*

20. This sets out key principles applying to decisions and actions taken under the Act. The starting point is a presumption of capacity. A person must be assumed to have capacity until it is proved otherwise. A person must also be supported to make his own decision, as far it is practicable to do so. The Act requires "all practicable steps" to be taken to help the person. This could include, for example, making sure that the person is in an environment in which he is comfortable or involving an expert in helping him express his views. It is expressly provided that a person is not to be treated as lacking capacity to make a decision simply because he makes an unwise decision. This means that a person who has the necessary ability to make the decision has the right to make irrational or eccentric decisions that others may not judge to be in his best interests (see *section 3*). Everything done, or decision made, under the Act for a person who lacks capacity must be done in that person's best interests. This principle is expanded upon in *section 4*. In addition, the "least restrictive option" principle must always be considered. The person making the decision or acting must think whether it is possible to decide or act in a way that would interfere less with the rights and freedom of action of the person who lacks capacity.

### Preliminary

#### *Section 2: People who lack capacity*

21. This sets out the Act's definition of a person who lacks capacity. It focuses on the particular time when a decision has to be made and on the particular matter to which the decision relates, not on any theoretical ability to make decisions generally. It follows that a person can lack capacity for the purposes of the Act even if the loss of capacity is partial or temporary or if his capacity fluctuates. It also follows that a person may lack capacity in relation to one matter but not in relation to another matter.

22. The inability to make a decision must be caused by an impairment of or disturbance in the functioning of the mind or brain. This is the so-called "diagnostic test". This could cover a range of problems, such as psychiatric illness, learning disability, dementia, brain damage or even a toxic confusional state, as long as it has the necessary effect on the functioning of the mind or brain, causing the person to be unable to make the decision.

23. *Subsection (3)* introduces a principle of equal consideration in relation to determinations of a person's capacity. It makes it clear that such determinations should not merely be made on the basis of a person's age, appearance or unjustified assumptions about

capacity based on the person's condition or behaviour. Any preconceptions and prejudicial assumptions held by a person making the assessment of capacity must therefore have no input into the assessment of capacity. The reference to "condition" captures a range of factors, including any physical disability a person may have. So, in making an assessment of capacity, the fact that the person in question has a learning difficulty should not in itself lead the person making the assessment to assume that the person with the learning difficulty would lack capacity to decide, for example, where to live. The reference to "appearance" would also include skin colour.

24. *Subsection (5)* makes it clear that powers under the Act generally only arise where the person lacking capacity is 16 or over (although powers in relation to property might be exercised in relation to a younger person who has disabilities which will cause the incapacity to last into adulthood: see *section 18(3)*). Any overlap with the jurisdiction under the Children Act 1989 can be dealt with by orders about the transfer of proceedings to the more appropriate court (see *section 21*).

25. *Subsection (5)* has the first use of the capital letter "D" to refer to a person exercising powers in relation to a person who lacks capacity. The use of capital letters sometimes makes complex provisions easier to follow (particularly where a number of different people are being referred to), and is a technique often adopted in recent legislation. In this Act, the fact that lack of capacity is specific to particular decisions and that there are many reasons why a person may lack capacity makes it necessary to use a neutral, rather than descriptive, label for the person concerned.

### *Section 3: Inability to make decisions*

26. This sets out the test for assessing whether a person is unable to make a decision about a matter and therefore lacks capacity in relation to that matter. It is a "functional" test, looking at the decision-making process itself. Four reasons are given why a person may be unable to make a decision. The first three (*subsection (1)(a)* to *(c)*) will cover the vast majority of cases. To make a decision, a person must first be able to comprehend the information relevant to the decision (further defined in *subsection (4)*). *Subsection (2)* makes clear that a determination of incapacity may not be reached without the relevant information having been presented to the person in a way that is appropriate to his circumstances. Secondly, the person must be able to retain this information (for long enough to make the decision, as explained in *subsection (3)*). And thirdly, he must be able to use and weigh it to arrive at a choice. If the person cannot undertake one of these three aspects of the decision-making process then he is unable to make the decision.

27. *Subsection (1)(d)* provides for the fourth situation where someone is unable to make a decision namely where he cannot communicate it in any way. This is intended to be a residual category and will only affect a small number of persons, in particular some of those with the very rare condition of "locked-in syndrome". It seems likely that people suffering from this condition can in fact still understand, retain and use information and so would not be regarded as lacking capacity under subsection (1)(a) to (c). Some people who suffer from this condition can communicate by blinking an eye, but it seems that others cannot communicate at all. *Subsection (1)(d)* treats those who are completely unable to communicate their decisions as unable to make a decision. Any residual ability to communicate (such as blinking an eye to indicate "yes" or "no" in answer to a question) would exclude a person from this category.

### *Section 4: Best interests*

28. It is a key principle of the Act that all steps and decisions taken for someone who lacks capacity must be taken in the person's best interests. The best interests principle is an essential aspect of the Act and builds on the common law while offering further guidance. Given the wide range of acts, decisions and circumstances that the Act will cover, the notion of "best interests" is not defined in the Act. Rather, *subsection (2)* makes clear that determining what is in a person's best interests requires a

consideration of all relevant circumstances (defined in *subsection (11)*). *Subsection (1)* makes clear that best interests determinations must not be based merely on a person's age, appearance, or unjustified assumptions about what might be in a person's best interests based on the person's condition or behaviour. Best interests determinations must not therefore be made on the basis of any unjustified and prejudicial assumptions. For example, in making a best interests determination for a person who has a physical disability it would not be acceptable to assume that, because of this disability, they will not have a good quality of life and should therefore not receive treatment. As with *section 2(3)* the references to "condition" and "appearance" capture a range of factors. The section goes on to list particular steps that must be taken. Best interests is not a test of "substituted judgement" (what the person would have wanted), but rather it requires a determination to be made by applying an objective test as to what would be in the person's best interests. All the relevant circumstances, including the factors mentioned in the section must be considered, but none carries any more weight or priority than another. They must all be balanced in order to determine what would be in the best interests of the person concerned. The factors in this section do not provide a definition of best interests and are not exhaustive.

29. The decision-maker must consider whether the individual concerned is likely to have capacity at some future date (*subsection (3)*). This is in case the decision can be put off, until the person can make it himself. Even if the decision cannot be put off, the decision is likely to be influenced by whether the person will always lack capacity or is likely to regain capacity.

30. *Subsection (4)* provides that the person concerned must so far as possible be involved in the process. Even where a person lacks capacity he should not be excluded from the decision-making process.

31. *Subsection (5)* applies to determinations as to whether treatment that is necessary to sustain life is in the best interests of the person concerned. It provides that the decision-maker must not be motivated by a desire to bring about the person's death. This means that whatever a decision-maker personally feels about, or wants for, the person concerned this must not affect his assessment of whether a particular treatment is in the person's best interests. This subsection does not change the previously understood common law on best interests. It does not mean that doctors are under an obligation to provide, or to continue to provide, life-sustaining treatment where that treatment is not in the best interests of the person.

32. The decision-maker must also consider, as far as is reasonably ascertainable, the "past and present wishes and feelings" of the person concerned (*subsection (6)*). Such wishes and feelings would include any relevant written statement. Even where people cannot make their own decisions, they can express preferences and feelings which should be taken seriously. For those who have lost capacity (for example because of progressive dementia) it may be particularly important to consider past wishes and feelings as well as current ones. In particular, there must be consideration of written statements made by the person whilst he had capacity. Such statements may be about what sort of care or treatment the person would wish to have in the case of future illness. Where written statements are well-thought out and considered, they are likely to carry particular weight for the purposes of best interests determinations. There must also be consideration of the person's beliefs and values – religious beliefs, cultural values and lifestyle choices are obvious aspects of this. There may also be other factors that the person would have been likely to consider if able to do so. For example, a person with capacity will often consider emotional bonds or family obligations when deciding how to spend his money or where to live.

33. *Subsection (7)* specifies who should be consulted when making a best interests determination, recognising that they will often have important information and views as to what would be in the person's best interests. They will also often have information about the past and present wishes and feelings of the person concerned, his beliefs and

values and other factors he would be likely to consider were he able to do so. The decision-maker should consult anyone the person concerned has named as someone to consult and anyone who has a caring role or is interested in his welfare. This will include informal carers, family and friends and others who care for the person in a professional or voluntary capacity, including any kind of existing advocate. Anyone appointed under an LPA and any deputy appointed by the court (dealt with later in Part 1) should also be consulted. Consultation is required where it is "practicable and appropriate". For example, no consultation may be possible in an emergency situation and it might not be appropriate for every day-to-day decision (such as whether to watch television). For significant, non-urgent, decisions, including where there is a series of minor decisions that cumulatively become significant, consultation will be required, as being both practicable and appropriate.

34. *Subsection (8)* applies the best interests principle to situations where the person concerned may not lack capacity. A donee may be acting under a lasting power of attorney while the donor still has capacity. The subsection makes clear that the obligation also applies where the person concerned does not in fact lack capacity but where the other person reasonably believes that he does lack capacity. There would otherwise be a lacuna in the applicability of the best interests test.

35. *Subsection (9)* offers appropriate protection to those who act in the reasonable belief that they are doing so in the other person's best interests. It should be remembered that "reasonable belief" is an objective test. Where the court makes a decision it must of course be satisfied that its decision is indeed in the person's best interests.

36. *Subsection (11)* explains what relevant circumstances means in the context of considering a person's best interests. The person making the determination must consider those circumstances of which he is aware and which it would be reasonable to regard as relevant. This strikes a balance by acknowledging that the decision-maker cannot be expected to be aware of everything whilst stipulating that he must take into account factors that it is reasonable to regard as relevant.

### *Section 5: Acts in connection with care or treatment*

37. This provides statutory protection against liability for certain acts done in connection with the care or treatment of another person. If an act qualifies as a "section 5 act" then a carer can be confident that he will not face civil liability or criminal prosecution. Civil liability could involve being sued for committing a tort such as battery, false imprisonment or breach of confidence. Criminal prosecution might be for an offence against the person (assault or causing actual bodily harm) or for an offence against property (theft).

38. A qualifying "section 5 act" may be performed by a range of people on any one day. The key requirements are that the person ("D") acts in connection with the care or treatment of another person ("P") and that D has formed a reasonable belief as to P's lack of capacity and best interests.

39. D will not incur any liability which would not have arisen if P, with capacity to do so, had in fact consented to D's act. Consent is a complete defence to a wide range of torts (battery, false imprisonment, trespass to land or goods, breach of confidence) and to many offences against the person or against property. Many people who are fully capable will regularly consent (expressly or impliedly) to others touching them, locking the doors of a car or dealing with their property. If a person takes someone else's unwanted clothes to a charity shop he could, in the absence of the owner's consent, in principle face civil liability for trespass to goods or criminal prosecution for theft. This section offers protection against liability where the owner is unable to give a valid consent, as long as the step is taken in connection with caring for him and is in his best interests.

40. Consent is not a defence to a claim in the tort of negligence. There are some offences which depend on a finding of negligence as defined in civil law (most notably, manslaughter where the element of unlawful killing may be made out by grossly negligent behaviour, whether an act or an omission to act in breach of duty). Consent might be relevant to issues of contributory negligence. *Subsection (3)* therefore makes it clear that liability for negligence is unaffected by the section.

41. This section does not affect the operation of advance decisions to refuse treatment, as covered by *sections 24* to *26*. If a person has made a valid and applicable advance decision then that takes priority over the rules in this section.

### *Section 6: Section 5 acts: limitations*

42. This sets two limitations to "section 5 acts". *Subsections (1)* to *(4)* deal with restraint, which is defined as the use or threat of force where P is resisting and any restriction of liberty of movement, whether or not P resists. This will include actions such as pulling someone away from the road, putting a seat belt on someone in a car or administering sedatives in order to undertake treatment. Restraint is permitted only when the person using it reasonably believes it is necessary to prevent harm to P. The restraint used must be proportionate both to the likelihood of the harm and the seriousness of the harm. It follows that the minimum level of restraint must be used; if the risk of harm diminishes, the restraint used must be reduced. It should be remembered that the principles in *section 1* also apply when restraint is proposed. The principle of the "least restrictive option" in *section 1(6)* is likely to be particularly significant here.

43. Decisions of the European Court of Human Rights draw a clear distinction between acts which restrict a person's liberty of movement and those which deprive a person of his liberty within the meaning of Article 5 of the ECHR. *Subsection (4)(b)* refers only to restriction of the person's liberty of movement. *Subsection (5)* makes clear that for *section 6* a deprivation of liberty, within the ECHR meaning, amounts to more than mere restraint. *Section 6* will therefore not provide protection for an action that amounts to a deprivation of liberty for the purposes of Article 5.

44. The second limitation is in *subsection (6)* which makes it clear that a valid decision by an attorney or a deputy takes priority over any action which might be taken under section 5. However, there is a limitation on the authority of an attorney or deputy. There could be a dispute or difficulty over a decision made by an attorney or deputy. For example, a doctor might be concerned that the attorney is not acting in P's best interests. *Subsection (7)* makes it clear that action can be taken to sustain life or prevent serious deterioration while any such dispute is referred to the court.

### *Section 7: Payment for necessary goods and services*

45. This revises and extends the statutory rule in section 3(2) of the Sale of Goods Act 1979 insofar as it applies to people who lack capacity to contract. In general, a contract entered into by a person who lacks capacity to contract is voidable if the other person knew or must be taken to have known of the lack of capacity. This does not apply if "necessaries" are supplied. In those circumstances, the person lacking capacity must still pay a reasonable price. The rule in section 3(2) of the 1979 Act only applies to "necessary" goods, but there is a matching common law rule about "necessary" services. This section combines these rules to set out a single statutory rule to cover "necessary" goods and services. *Subsection (2)* repeats the established legal definition of what is 'necessary'. Thus, for example, if the milkman carries on delivering milk to the house of someone who has a progressive dementia, he can expect to be paid. If, however, a roofer puts a completely unnecessary new roof on to that person's house, when all that was required was a minor repair, then the rule will operate to prevent the roofer from being able to recover his charges.

### *Section 8: Expenditure*

46. This is to be read with *sections 5* and *7*. It allows a person who is acting under *section 5* and who arranges something for P's care or treatment that costs money to do certain things. He can promise that P will pay, use money which P has in his possession and pay himself back from P's money in his possession or consider himself owed by P. This restates existing common law rules which provide that a person acting as an "agent of necessity" for another person should not be out of pocket as a result. A carer might, acting in P's best interests, arrange the delivery of disability aids or household items. Nothing in this section allows a carer to gain access to P's funds where they are held by a third party such as a bank or building society. The bank or building society would remain bound by contractual obligations to P until formal steps were taken (for example, registering a relevant power of attorney, or obtaining a court order).

47. *Subsection (3)* recognises that some people may have control over P's money or property by other routes, for example under the Social Security (Claims and Payments) Regulations 1987 (SI 1987/1968) or by way of banking arrangements.

## Lasting powers of attorney

### *Section 9: Lasting powers of attorney*

48. *Sections 9* to *14* create a new statutory form of power of attorney, the "lasting power of attorney" (or LPA). This replaces the "enduring power of attorney" (or EPA) provided for by the Enduring Powers of Attorney Act 1985. The 1985 Act is repealed by section 66(1)(b), but the legal effect of an EPA already made under the current law is preserved and integrated into the scheme of the Act by *section 66(3)* and *Schedule 4*.

49. *Section 9* sets out the key aspects of an LPA. Unlike an EPA, it can extend to personal welfare matters (*(subsection (1)(a)*) as well as to property and affairs. By making an LPA, an individual (the donor) confers on another individual or individuals (donee/s) authority to make decisions about the donor's personal welfare and/or property and affairs or specified matters concerning those areas. Power to make decisions includes, by virtue of *section 64(2)*, acting on decisions made where appropriate.

50. *Subsection (1)* also makes clear that to be valid an LPA must include authority to make decisions when the donor no longer has capacity to make those decisions himself. An LPA can, in certain circumstances, operate as an 'ordinary' power of attorney when the donor has full mental capacity but it will also continue to operate after the donor has lost capacity.

51. *Subsection (2)* deals with the creation of an LPA. The donor must be aged 18 or over and have capacity to execute an LPA. The rules in section 10 about who can be a donee must be complied with. Detailed provisions about the making and registration of the instrument, as set out in *Schedule 1*, must be complied with. If the rules are not complied with the document created will not be a valid LPA and cannot be lawfully used to make decisions on behalf of the donor (*subsection (3)*).

52. *Subsection (4)* reiterates that any donee must apply the principles set out in *section 1* and act in the donor's best interests. A donee's authority is also subject to any conditions or restrictions that the donor may choose to put in the LPA document itself.

### *Section 10: Appointment of donees*

53. This sets out certain requirements relating to donees and how they should act. A donee must be aged 18 or over. Someone who is bankrupt cannot be appointed as the donee of an LPA relating to property and affairs. If the LPA relates only to property and affairs, the donee can be either an individual or a trust corporation (defined 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).

54. *Subsection (4)* provides that where two or more people are appointed as donees, they may be appointed either to act jointly (so that they must all join together in any decision) or to act jointly and severally (which means they can act all together or each of them can act independently). The donor may also appoint two or more persons to act jointly in respect of some matters and jointly and severally in respect of others. To the extent that the donor does not specify in the instrument whether donees are to act jointly or jointly and severally, it will be assumed from the instrument that they are appointed to act jointly (*subsection (5)*).

55. For joint attorneys, any breach of the relevant rules about how lasting powers of attorney are made will prevent a valid LPA being created (*subsection (6)*). For "joint and several" attorneys, a breach only affects the attorney who is in breach; a valid LPA is still created in respect of the other donee(s) (*subsection (7)*).

56. *Subsection (8)* allows a donor to provide for the replacement of the donee(s) on the occurrence of a specified event which would normally terminate a donee's powers. The specified events are: the donee renouncing his appointment, the donee's death or insolvency, the dissolution or annulment of a marriage or civil partnership between the donor and the donee or the lack of capacity of the donee. For example, an older donor might wish to appoint his spouse, but nominate a son or daughter as a replacement donee. A donee cannot be given power to choose a successor (*subsection (8)(a)*) as this would be inconsistent with the core principle that the donor is giving authority to a chosen attorney. A civil partnership is a registered relationship between two people of the same sex which ends only on death, dissolution or annulment, as provided for in the Civil Partnership Act 2004.

### *Section 11: Lasting powers of attorney: restrictions*

57. *Subsections (1)* to *(4)* place restrictions on the use of restraint by attorneys, matching those applying in relation to "section 5 acts" (*see section 6*) and deputies (*see section 20*). Restraint can only be used to prevent harm, and must be proportionate. *Subsection (6)* makes clear that for *section 11* a deprivation of liberty within the ECHR meaning amounts to more than mere restraint.

58. Further restrictions are set out in *subsection (7)*. An attorney cannot act where the donor has capacity, or where the donor has made a qualifying advance decision (*see sections 24* to *26*). *Subsection 7(c)* has to be read with *subsection (8)*. Thus, although an attorney may give or refuse consent to the carrying out or continuation of health care, this would not extend to refusing life-sustaining treatment unless the LPA expressly said so, and is subject to any conditions or restrictions in the LPA.

### *Section 12: Scope of lasting powers of attorney: gifts*

59. This is similar to section 3(5) of the Enduring Powers of Attorney Act 1985 and deals with an attorney's power to make gifts of the donor's property. The attorney can only do something that is in the donor's best interests but this section operates as a specific restriction in relation to gifts. It allows modest gifts proportionate to the donor's assets to people related or connected to the donor (including himself) on "customary occasions", as defined; and to charities (subject to any conditions or restrictions in the LPA itself). The court has power to authorise more substantial gifts (see *section 23(4)*) if satisfied this would be in the donor's best interests. For example, if an older person has substantial assets then tax planning might be a reason for the making of gifts.

### *Section 13: Revocation of lasting powers of attorney*

60. This deals with the ways in which LPAs may cease to be effective, whether before or after registration. A donor may revoke an LPA at any time while he has capacity to do so (*subsection (2)*). Other events will automatically terminate an LPA.

61. The bankruptcy of either the donor or the attorney will terminate any financial powers granted. *Section 64(3)* provides that all references to the bankruptcy of an individual include a case where a bankruptcy restrictions order is in force in respect of him. Bankruptcy restrictions orders are provided for in Schedule 4A to the Insolvency Act 1986. Interim bankruptcy restrictions orders do not bring a power of attorney to an end; they just have a suspensive effect (*subsections (4)* and *(9)*).

62. An LPA also comes to an end if the donee disclaims, dies or loses capacity. The dissolution or annulment of a marriage or civil partnership between the donee and the donor will terminate the donee's powers unless the donor has specified that it should not (*subsection (11)*).

63. *Subsections (7)* and *(10)* provide for situations where there is a replacement or a "joint and several" attorney (in respect of any matter) who can continue to act.

### *Section 14: Protection of donee and others if no power created or power revoked*

64. This sets out the legal consequences when a registered LPA turns out to be invalid. There is similar provision in relation to EPAs in section 9 of the 1985 Act. Broadly, both attorneys and third parties are given protection from liability if they were unaware that the LPA was invalid or had come to an end.

## General powers of the court and appointment of deputies

### *Section 15: Power to make declarations*

65. This gives the court power to make declarations, if necessary, about whether an individual has capacity, either in relation to a specific decision that needs to be made, or in relation to decisions on such matters as are described in the declaration. It also gives the court power to make declarations about whether an act or proposed act was or would be lawful. The Court of Protection would have this latter power as a superior court of record which, under *section 47*, has the same powers, rights, privileges and authority as the High Court, but it is considered helpful to spell this out. *Subsection (2)* confirms that the court can be asked to adjudicate on omissions to act (for example, the withholding or withdrawing of medical treatment) and a course of conduct.

### *Section 16: Powers to make decisions and appoint deputies: general*

66. This sets out the core jurisdiction of the court, which is to make decisions about personal welfare or property and affairs for persons lacking capacity or to appoint a deputy to do so.

67. *Subsection (3)* confirms that the principles in *section 1* and the best interests checklist will govern the court's exercise of its powers.

68. *Subsection (4)* requires the court to consider two additional principles, further emphasising the "least restrictive intervention" principle mentioned in *section 1(6)*. The first additional principle is that a decision of the court is preferable to the appointment of a deputy and the second is that, if a deputy is appointed, the appointment should be as limited in scope and duration as is reasonably practicable in the circumstances. In welfare (including health care) matters a deputy is never required in order for care or treatment to be given to a person because *section 5* provides sufficient scope for carers and professionals to act. Nevertheless, a deputy may be particularly helpful in cases of dispute. For matters concerning property and affairs, a deputy may be needed in order to provide the authority to deal with contractual matters and where there is an on-going

need for such decisions to be taken. *Subsection (5)* enables the court to grant the deputy powers or impose duties on him as it thinks necessary to avoid repeated applications to the court. However, it also enables the court to require the deputy to seek consent before taking certain actions. *Subsection (6)* gives the court an "own motion" power to make whatever order is in the person's best interests.

69. The court can always vary or discharge its orders and *subsection (8)* provides that it has power to take away or alter a deputy's powers if the deputy is overstepping his powers or not adhering to his best interests obligations.

### *Section 17: Section 16 powers: personal welfare*

70. The powers created by *section 16* in relation to making orders and appointing deputies will extend to a wide range of personal welfare issues. Particular mention is made in this section of issues which have arisen in the past and been dealt with by the High Court in the exercise of its inherent jurisdiction and may be most likely to arise in future. This is not an exhaustive, merely an indicative, list. It is not a list of decisions that must always go to court, rather it provides examples of where the court can act if it would be appropriate, and beneficial to the person, for the court to do so. There are restrictions on what may be delegated to a deputy, set out in *section 20(2)*.

### *Section 18: Section 16 powers: property and affairs*

71. *Subsection (1)* indicates the extent of the court's powers with regard to property and affairs. Again it provides a non-exhaustive, indicative list of the matters within the powers relating to property and affairs. This largely reproduces the list which applies to the original Court of Protection in section 96 of the Mental Health Act 1983. Again, this is not a list of matters which must always go to the new Court of Protection but rather an indication of the types of order the court might make if an application were made. Where property and financial matters are concerned the effect of the general law relating to contract and property will often be to create a need for formal powers. So if the person concerned has lost capacity to enter into a contract for the sale of his house no purchaser is going to accept a contract or Land Registry transfer document signed by someone who is not the registered owner, unless the proposed purchaser sees a document proving that someone else has formal authority to contract to sell and transfer the property on his behalf. Equally, the person's bank will be bound by the terms of its contract with him not to hand his money over to someone else. If he can no longer give a valid instruction or valid receipt to the bank then his money will have to be held by the bank until formal authority is provided. If a valid power of attorney exists then this would probably remove any need for the Court of Protection to make orders. Again, not all of the powers can be given to deputies (see *section 20(3)*). These correspond to matters which, under the current law, always have to be dealt with by the court itself.

### *Section 19: Appointment of deputies*

72. This deals with deputies appointed by the court. The general rule is that a deputy must be at least 18 years of age. If a trust corporation is appointed deputy it can only act in respect of property and affairs. The court may appoint the holder of a specified office as deputy (this is different to LPAs where the attorney must be an individual). Before being appointed deputy, a person must consent to being appointed. The court will be able to appoint more than one deputy to act on behalf of an individual who lacks capacity and these deputies can act jointly, jointly and severally, or jointly for some matters and jointly and severally for other matters. That is, the court can specify that they must all act together, that each can act independently of the other or that they can act either way, depending on the matter in question. When appointing a deputy, the court will also have the power to appoint a successor or successors to the original appointees. The court will specify the circumstances under which this could occur.

73. *Subsection (6)* provides that a deputy will be treated as an "agent" of the adult who lacks capacity. The law of agency imposes a range of duties on those who act as agents for someone else. For example, an agent must act with "due care and skill" and is bound by fiduciary duties amongst other duties. Case law has established that receivers appointed by the original Court of Protection under Part 7 of the Mental Health Act 1983 are agents but it is considered helpful to make statutory provision to that effect in relation to deputies.

74. All deputies will be able to claim reasonable expenses from the estate of the adult lacking capacity and if the court directs, the deputy can be paid for his services from the estate. The court will be able to give a deputy the power to deal with all matters concerning the control and management of any property belonging to the adult lacking capacity, including being able to invest. The court will also be able to require a deputy to give the Public Guardian security against misbehaviour (that is, either a deposit of money or a guarantee bond) and to direct the deputy to file with the Public Guardian reports and accounts as it sees fit. These provisions are broadly in line with arrangements in the original Court of Protection (Mental Health Act 1983, Part 7).

### *Section 20: Restrictions on deputies*

75. This sets a number of limitations on the powers of deputies. *Subsection (1)* specifies that a deputy cannot act where the person concerned is able to act for himself. In some cases the person may have fluctuating capacity, for example as a result of mental health problems, and it is not acceptable for a deputy to carry on making substitute decisions when the person concerned has in fact recovered. *Subsection (6)* reiterates that a deputy must act in accordance with *section 1* (principles) and *section 4* (best interests).

76. *Subsections (2) and (3)* relate back to *sections 16* to *17* and list certain matters which must always be dealt with by the court, not a deputy. The powers to prohibit a person from having contact with an adult lacking capacity or to direct a person responsible for his health care to allow a different person to take over are, of course, powers which have to be exercised by the court itself. As under the current law, deputies will also be restricted from making certain financial decisions in connection with wills and trusts.

77. *Subsection (4)* makes it clear that a deputy cannot be given power to "trump" an attorney (who will have been chosen by the donor himself, at a time when he had capacity). If there is a concern or a dispute about the way an attorney is behaving the court must use its powers in *sections 22* and*23*, rather than seeking to appoint a deputy.

*Subsection (5)* restricts deputies from refusing consent to the carrying out or continuation of treatment that is necessary to sustain life. *Subsection (6)* clarifies that the principles in *section 1* and the considerations as to best interests as set out in *section 4* apply to deputies.

78. *Subsections (7)* to *(11)* impose limitations on deputies in relation to restraint, matching those imposed in relation to "section 5 acts" by *section 6* and on attorneys by *section 11*. A deputy will have to be acting within the scope of an authority expressly conferred on him by the court. Restraint can only be used to prevent harm and must be proportionate. *Subsection (13)* makes clear that for *section 20* a deprivation of liberty within the ECHR meaning amounts to more than mere restraint.

### *Section 21: Transfer of proceedings relating to people under 18*

79. The Act deals with people aged 16 and over (and with the property of younger children – see *section 18(3)*), while the Children Act 1989 deals with people under the age of 18. There will be some overlap between the jurisdictions and the Lord Chancellor is therefore given power by this section to make transfer of proceedings orders. It is intended that the order will indicate that a case should be transferred to the court most suitable to deal with the issues. One factor is likely to be the prospect of a person under 18 who is the subject of a dispute still lacking capacity when an adult. 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 made under the Children Act 1989 would expire on the child's 18th birthday at the latest.

## Powers of the court in relation to lasting powers of attorney

### *Section 22: Powers of court in relation to validity of lasting powers of attorney*

80. This section and *section 23* set out what the Court of Protection can do in relation to LPAs. The powers are similar to those in section 8 of the Enduring Powers of Attorney Act 1985, except that administrative functions connected with registration will be performed by the Public Guardian.

81. The court can determine questions about validity and revocation (*subsection (2)*). It can direct that an instrument should not be registered or (if it is unregistered) revoke it on the grounds set out in *subsection (3)* (fraud or undue pressure, or misbehaviour by the attorney).

82. *Subsection (5)* provides that where there is more than one donee the court may revoke the instrument or the LPA so far as it relates to any of them.

### *Section 23: Powers of court in relation to operation of lasting powers of attorney*

83. This allows the court to decide questions about the meaning or effect of an LPA (or an instrument purporting to create an LPA) and to give directions to attorneys where the donor lacks capacity. The court may also give the attorney directions about producing reports, accounts, records and information and about his remuneration and expenses. The court has power to relieve a donee from some or all of the liabilities arising from a breach of duty (cf Enduring Powers of Attorney Act 1985, section 8(2)(f)). It may also authorise gifts beyond the scope of what is permitted by *section 12(2)* (for example, for tax planning purposes).

## Advance decisions to refuse treatment

### *Section 24: Advance decisions to refuse treatment: general*

84. *Sections 24* to *26*deal with advance decisions to refuse treatment. Some people already choose to make such decisions and their legal effect has been analysed in a number of judicial decisions. It has been confirmed by the High Court that a competent adult patient's anticipatory refusal of consent remains binding and effective notwithstanding that he has subsequently become incompetent (*HE v NHS Trust A and AE* [2003] EWHC 1017 (Fam), a case concerning a refusal of blood transfusion). Broadly, the sections seek to codify and clarify the current common law rules, integrating them into the broader scheme of the Act. There would otherwise be a lacuna in the scheme of the Act and the powers of the new court. Many general forms of advance statement or "living will" will be important and relevant as "past wishes" of the person for the purposes of the best interests checklist in *section 4*. An "advance decision" as defined in these sections is a special type of advance statement that represents an actual decision to refuse treatment, albeit at an earlier date. As now, it will therefore be decisive in certain circumstances.

85. The key characteristics of an "advance decision" for the purposes of the Act are set out in *subsection (1)* of this section. It must be made by a person who is 18 or over and at a time when the person has capacity to make it. A qualifying advance decision must specify the treatment that is being refused, although this can be in lay terms (for example using "tummy" instead of stomach). It may specify particular circumstances, again in lay terms, in which the refusal will apply. A person can change or completely withdraw the advance decision if he has capacity to do so (*subsection (3)*). *Subsection (4)* confirms that the withdrawal, including a partial withdrawal, of an advance decision does not need to be in writing and can be by any means. *Subsection (5)* confirms that

an alteration of an advance decision does not need to be in writing, unless it applies to an advance decision refusing life-sustaining treatment, in which case formalities will need to be satisfied in order for it to apply.

### *Section 25: Validity and applicability of advance decisions*

86. This introduces the two important safeguards of validity and applicability in relation to advance decisions to refuse treatment.

87. To be valid the advance decision must not have been withdrawn or overridden by a subsequent LPA giving a donee the authority to consent or refuse consent to the treatment (other LPAs will not override – see *subsection ((7)*). Also, if the person has acted in a way that is clearly inconsistent with the advance decision remaining his fixed decision, then the advance decision is invalid. An example of an inconsistent action might be a former Jehovah's Witness converting to Islam and marrying a Muslim man. Even if she had forgotten to destroy a written advance decision refusing blood transfusion, her actions could be taken into account in determining whether that earlier refusal remained her fixed decision.

88. An advance decision will not be applicable if the person actually has capacity to make the decision when the treatment concerned is proposed. It will also not be applicable to treatments, or in circumstances, not specified in the decision. Furthermore the decision will not be applicable if there are reasonable grounds for believing that the current circumstances were not anticipated by the person and, if they had been anticipated by him, would have affected his decision. For example, there may be new medications available that radically change the outlook for a particular condition and make treatment much less burdensome than was previously the case.

89. *Subsection (5)* introduces further rules about the applicability of advance decisions to refuse treatment that is necessary to sustain life. An advance decision will not apply to life-sustaining treatment unless it is verified by a statement confirming that the decision is to apply to that treatment even if life is at risk. The reference to "life" includes the life of an unborn child. Both the decision and the statement verifying it must be in writing and be signed and the signature must be witnessed. It is important to note that a person does not physically need to write his advance decision himself. This means that advance decisions recorded in medical notes are considered to be in writing. Writing can also include electronic records.

90. If the maker of the advance decision cannot sign then another person can sign for him at his direction and in his presence (*section 25(6)(b)*). As with a signature by the person himself, the witness must be present when the third party signs.

### *Section 26: Effect of advance decisions*

91. This deals with the legal effect of a qualifying advance decision. If it is both valid and applicable it has the same effect as a contemporaneous refusal of treatment by a person with capacity. That is, the treatment cannot lawfully be given. If given, the person refusing would be able to claim damages for the tort of battery and the treatment-provider might face criminal liability for assault. *Subsections (2)* and *(3)* clarify the rules about liability. A treatment-provider may safely treat unless satisfied that there is a valid and applicable qualifying advance refusal; and a treatment-provider may safely withhold or withdraw treatment as long as he has reasonable grounds for believing that there is a valid and applicable qualifying advance decision.

92. If there is doubt or a dispute about the existence, validity or applicability of an advance decision then the Court of Protection can determine the issue. There is an important proviso to the general rule that an advance refusal is legally effective. There may be a doubt or dispute about whether a particular refusal is in fact one which meets all the tests (existence, validity and applicability). As with decisions by donees or deputies in *section 6(7)*, action may be taken to prevent the death of the person concerned, or a

serious deterioration in his condition, whilst any such doubt or dispute is referred to the court.

## Excluded decisions

### *Section 27: Family relationships etc.*

93. This lists certain decisions that can never be made under the Act on behalf of a person who lacks capacity. For example, in relation to adoption, if a birth parent lacks capacity to consent to an adoption order the rules as to dispensing with consent in the adoption legislation will apply. There will be no question of an attorney consenting or of the Court of Protection making an order or appointing a deputy to provide the requisite consent.

### *Section 28: Mental Health Act matters*

94. This deals with the question of people who are detained for psychiatric treatment pursuant to the Mental Health Act 1983. The section ensures that the Mental Capacity Act does not apply to any treatment for mental disorder which is being given in accordance with the rules about compulsory treatment set out in Part 4 of the 1983 Act. The specific statutory safeguards which the 1983 Act gives in relation to compulsory psychiatric treatment must always be afforded to those patients to whom that Act applies.

### *Section 29: Voting rights*

95. This provides that the Act does not apply to decisions on voting.

## Research

### *Section 30: Research*

96. This section and *sections 31* to *33*allow intrusive research to be lawfully carried out on, or in relation to, a person who lacks capacity, where the research is part of a research project approved by an appropriate body and it is carried out in accordance with the conditions set out in *sections 32* and *33*. The provisions are based on long-standing international standards, for example, those laid down by the World Medical Association and the Council of Europe Convention on Human Rights and Biomedicine.

97. This section relates to intrusive research, which means research that would normally need consent if it involved an adult with capacity. Clinical trials that are currently regulated under the Medicines for Human Use (Clinical Trials) Regulations 2004 (SI 2004/1031) (or regulations succeeding or amending them) are excluded from the Act because those Regulations already make provision for trials involving participants who lack capacity. Research on anonymised medical data or tissue is also not included, but may be subject to controls under the Data Protection Act 1998 or the Human Tissue Act 2004.

98. The appropriate authority (the Secretary of State in relation to research in England and the National Assembly for Wales in relation to research in Wales) must specify an appropriate body for approving research projects, such as a Research Ethics Committee (REC).

### *Section 31: Requirements for approval*

99. This section sets out the matters of which the appropriate body – such as an REC— must satisfy itself before approving a research project involving a person who lacks capacity.

100. Subsection *(2)* requires that the research must be connected with an impairing condition that affects the person participating in the research or with the treatment of the condition.

Impairing condition means one that is, or may be, attributable to or causes or contributes to the impairment of or disturbance in the functioning of the person's mind or brain. This limits the sort of research projects that the person may be involved in but will include research into the effects of the impairment on his health and day-to-day life as well as into the causes or possible causes of the impairment and its treatment. *Subsection (4)* requires that there are reasonable grounds for believing that there is no alternative to the involvement of the person in the research, that is, it cannot be carried out as effectively if it only involves people who have capacity.

101. *Subsections (5)* and *(6)* 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.

### *Section 32: Consulting carers etc*

102. Before any decision is taken to involve a particular person in approved research, the researcher must take reasonable steps to identify a person close to the person (this could include an attorney or deputy but not someone acting in a professional capacity or for payment, such as a paid carer) who is prepared to be consulted about the person's involvement in the research (*subsection (2)*). If there is no such person, then the researcher must nominate a person independent of the research in accordance with guidance issued by the appropriate authority (see paragraph 99).

103. *Subsection (4)* requires the researcher to give the consultee information about the research and to ask him or her for advice as to whether the person should take part in the research and what, in his opinion, the consultee's wishes and feelings would be about taking part in the research. If at any time the person consulted advises the researcher that in his opinion the person's wishes and feelings would be likely to lead him to decline to take part in the project then the researcher must ensure that the person does not take part in the project, or if it is already underway must ensure that the person is withdrawn from it. But the person may still receive treatment he was receiving during the research if withdrawal would create a significant risk to his health *(subsection (6)*).

104. *Subsections (8)* and *(9)* allow for action to be taken in relation to the research where treatment is to be provided to the person urgently and there is insufficient opportunity to consult. The researcher may proceed if he has the agreement of a doctor who is not connected to the project or in accordance with a procedure agreed by the appropriate body at the time of approval. However *subsection (10)* makes it clear that the researcher may only rely on *subsection (9)* while there is an urgent need to treat. Examples of this type of research may involve action by a paramedic or doctor to make measurements in the first few minutes following a serious head injury or stroke. These arrangements are similar to those provided for in the Clinical Trials Regulations.

### *Section 33: Additional safeguards*

105. The purpose of *section 33* is to provide additional safeguards for the person participating in the research once the research has begun. It requires the researcher to respect any signs of resistance from the person (except where this would conflict with

procedures designed to protect him from harm or injury), and not to involve the person in research that would be contrary to an advance decision or any other form of statement. The person's interests must be assumed to outweigh those of science and society *(subsection (3)*).

106. The person must be withdrawn from the project without delay if he indicates that he wishes to be withdrawn from it or if the researcher has reasonable grounds for believing that any of the requirements for approval of the project as set out at in *section 31(2)* to *(7)* are no longer met. As in *section 32*, the person may still receive treatment he was receiving during the research if withdrawal would create a significant risk to his health *(subsection (6)*).

### *Section 34: Loss of capacity during research project*

107. This section provides for a transitional regulation-making power to cover research started before *section 30* comes into force and which involves people who had capacity when enrolled but who lose capacity before the end of the project. The regulations will lay down the conditions on which such research may continue; the research must meet prescribed requirements, the information or material used in the research must have been obtained before the loss of capacity and certain steps must be taken to protect the person participating *(subsection (2)*).

108. The regulations will set out these requirements and steps and may include safeguards similar to those provided for in *sections 31* to *33* but with any necessary alterations to the requirements for approval by an appropriate body, consultation with carers or the additional safeguards *(subsection (3)*). Regulations made by the Secretary of State will be subject to the affirmative procedure in Parliament (see *section 65*).

## Independent mental capacity advocate service

### *Section 35: Appointment of independent mental capacity advocates*

109. *Sections 35* to *41* create a new scheme designed to provide the input of an independent mental capacity advocate ("IMCA") where certain decisions need to be taken for particularly vulnerable people who lack capacity. This may include older people with dementia who have lost contact with all friends and family, or people with severe learning disabilities or long term mental health problems who have been in residential institutions for long periods and lack outside contacts. Such people will be represented and provided with support when decisions are to be made about serious medical treatment or significant changes of residence provided by public bodies.

110. *Subsection (1)* places a duty on the appropriate authority to make arrangements for the provision of a new independent mental capacity advocacy service. The appropriate authority is, in relation to England, the Secretary of State and, in relation to Wales, the National Assembly for Wales.

111. *Subsection (2)* allows the appropriate authority to make regulations setting out how the IMCA will be appointed. This will ensure that an individual will need to meet common standards in order to be approved as an IMCA. *Subsection (4)* provides that, as far as practicable, the IMCA should be independent of the person who is making the decision concerned. *Subsection (5)* provides that the arrangements may include provision for payments to be made to, or in relation to, the IMCA. *Subsection (6)* stipulates that an IMCA must be able to meet the person concerned in private and see relevant health, social services and care home records. This is to enable the IMCA to be able to perform properly his function of representing and supporting the person who lacks capacity.

### *Section 36: Functions of independent mental capacity advocates*

112. This section allows the appropriate authority to make regulations setting out the functions of IMCAs. *Subsection (2)* provides that those regulations may set out the

steps which an IMCA needs to take in fulfilling those functions. These steps should ensure that the IMCA supports the person to participate as fully as possible in the decision; obtains and evaluates relevant information; ascertains and represents the person's wishes, feelings, beliefs and values; finds out about all the available options; and seeks a second medical opinion if necessary. *Subsection (3)* provides that the regulations may also set out the circumstances in which the IMCA may challenge the decision-maker on behalf of the person, if appropriate.

### *Section 37: Provision of serious medical treatment by NHS body*

113. This section applies where "serious medical treatment" is to be provided or arranged by the NHS for a person who lacks capacity, and there is no one for the treatment-provider to discuss it with. If there is neither a person from the list in *section 40* (such as an attorney under an LPA or deputy) nor a non-professional carer or friend whom it is appropriate to consult, then an IMCA is to be instructed.

114. The role of the IMCA will be both to represent and to support the person in accordance with the regulations made under *section 36*. The information and submissions provided by the IMCA must be taken into account by the decision-maker.

115. *Subsection (2)* provides that where the person's treatment is regulated under Part 4 of the Mental Health Act 1983, the IMCA does not need to be instructed under *section 37(3)*. That Act already contains its own safeguards.

116. *Subsection (4)* makes provision in relation to urgent treatment. *Subsection (6)* provides that the types of "serious medical treatment" to be covered will be set out in regulations. *Subsection (7)* provides that regulations will also define the particular NHS bodies who will become subject to the duties. The intention is that this will cover the bodies responsible for direct provision or funding of treatment as appropriate.

### *Section 38: Provision of accommodation by NHS body*

117. This section applies to long-stay accommodation in a hospital or a care home, or a move between such accommodation, where this accommodation is provided or arranged by the NHS. *Subsection (9)* clarifies that this section only applies when the accommodation is to be provided for more than 28 days in relation to accommodation in hospital or more than 8 weeks in relation to accommodation in a care home. The IMCA is to be instructed where such accommodation is being proposed and a person lacks capacity to agree to the arrangements and there is no other person to discuss it with. Again the role of the IMCA is both to support and to represent the person concerned. Any information or submissions from the IMCA must be taken into account by the NHS body.

118. *Subsection (2)* provides that where the person concerned is to be detained in hospital or otherwise required to live in the accommodation in question under the Mental Health Act 1983, the IMCA does not need to be consulted, as that Act already contains its own safeguards.*Subsection (3)* makes provision in relation to urgent placements.

119. *Subsection (4)* is intended to ensure that an IMCA is involved in relation to people whose residence is initially intended to be less than 28 days/8 weeks (see paragraph 118) if the period is later extended beyond the applicable period.

120. *Subsections (6)* and *(7)* define the types of care homes and hospitals which are covered under by this section. *Subsection (8)* provides that regulations will also define the particular NHS bodies who will become subject to the duties.

### *Section 39: Provision of accommodation by local authority*

121. This section applies to long-stay accommodation (8 weeks or more) arranged by a local authority or a change in such accommodation. It applies to residential accommodation provided in accordance with*section 21* or *29* of the National Assistance Act 1948. This may be accommodation in a care home, nursing home, ordinary and sheltered

housing, housing association or other registered social housing, or in private sector housing provided by a local authority or in hostel accommodation. The IMCA safeguard will also apply to people accommodated following discharge under section 117 of the Mental Health Act 1983.

122. The IMCA is to be instructed where a person lacks capacity to agree to the arrangements and there is no other person to discuss it with. Again the role of the IMCA is both to support and to represent the person concerned. Any information or submissions from the IMCA must be taken into account by the local authority.

123. *Subsection (3)* provides that the IMCA does not need to be instructed where the person is to be required under the Mental Health Act 1983 to live in the accommodation in question (for example, as a requirement of conditional discharge).*Subsection (4)* makes provision in relation to urgent placements.

124. *Subsection (5)* is intended to ensure that an IMCA is involved in relation to people whose residence is initially intended to be less than 8 weeks if the period is later extended.

### *Section 40: Exceptions*

125. This section provides that the independent mental capacity advocacy service does not have a role when the person concerned already has somebody who can speak with the provider of treatment or accommodation (e.g. a person chosen in advance, an attorney under an EPA or LPA, or a deputy). This overrides *sections 37(3)*, *38(3)* and *(4)* and *39(4*) and *(5)*, which generally trigger the involvement of an IMCA when there is no one appropriate to consult about the person's interests, other than a paid or professional carer.

### *Section 41: Power to adjust role of independent mental capacity advocate*

126. This section provides that the scope of the independent mental capacity advocacy service can be extended, by regulations made for England by the Secretary of State or for Wales by the National Assembly for Wales, to other sets of circumstances. Such regulations would follow consultation about where the involvement of an IMCA might prove useful. Regulations made by the Secretary of State will be subject to the affirmative procedure in Parliament (see *section 65*).

Miscellaneous and supplementary

### *Section 42: Codes of practice*

127. This section provides for the Lord Chancellor to make and revise a code or codes of practice to supplement the Act. Attorneys, deputies, professionals, paid workers, researchers and IMCAs acting on behalf of adults who lack capacity will be under an obligation to have regard to any relevant code. Any codes of practice issued will be allowed to be used as evidence in court or tribunal proceedings.

### *Section 43: Codes of practice: procedure*

128. This section sets out the procedure for issuing and revising any codes of practice. The Lord Chancellor will have to consult the National Assembly for Wales and other appropriate persons before preparing or revising a code. Draft codes will have to be laid before both Houses of Parliament for 40 days. They may then be issued, provided that neither House has resolved to reject the draft. The Lord Chancellor must arrange for the code to be brought to the attention of people who may need to know about it.

### *Section 44: Ill-treatment or neglect*

129. This section creates an offence of ill-treatment or wilful neglect of a person lacking capacity by anyone responsible for that person's care, donees of LPAs or EPAs, or deputies appointed by the court.