



Bar Council response to the Ministry of Justice's Revising the Mental Capacity Act 2005 Code of Practice: Call for evidence consultation paper

1. This is the response of the General Council of the Bar of England and Wales (the Bar Council) to Ministry of Justice's consultation paper on the Mental Capacity Act 2005 Code of Practice: Call for evidence.¹
2. The Bar Council represents over 16,000 barristers in England and Wales. It promotes the Bar's high-quality specialist advocacy and advisory services; fair access to justice for all; the highest standards of ethics, equality and diversity across the profession; and the development of business opportunities for barristers at home and abroad.
3. A strong and independent Bar exists to serve the public and is crucial to the administration of justice. As specialist, independent advocates, barristers enable people to uphold their legal rights and duties, often acting on behalf of the most vulnerable members of society. The Bar makes a vital contribution to the efficient operation of criminal and civil courts. It provides a pool of talented men and women from increasingly diverse backgrounds from which a significant proportion of the judiciary is drawn, on whose independence the Rule of Law and our democratic way of life depend. The Bar Council is the Approved Regulator for the Bar of England and Wales. It discharges its regulatory functions through the independent Bar Standards Board (BSB).

Overview

4. We are pleased to have had the opportunity to contribute to this important undertaking. We have commented on all of the Chapters, apart from Chapter 11 on research where we considered we had little to add. We have, where appropriate, separated our response into "General" and "Specific" comments. We have commented on the Key Words and Phrases, but not on Annex A.

¹ <https://www.gov.uk/government/consultations/revising-the-mental-capacity-act-2005-code-of-practice-call-for-evidence>

5. We have generally adopted the terminology of the Code in referring to the person who may lack capacity as “the person”. We have also used the term “P”, particularly where this is the term used in caselaw.

Question 1: Do you feel the current format of the Code of Practice is coherent?

6. Yes

Please explain your answer:

7. The Code of Practice is, in general, very impressive in its clear, user-friendly language. It is overdue an update, and we have a number of suggestions for improvement. It is very important that it retains its accessible tone. One of the group working on this response had the experience of advising the aunt of a young woman with learning disabilities, who lacked capacity on a range of issues and who had moved in with the aunt due to a crisis in her supported living placement. The aunt wanted guidance about how she should make decisions when her niece could not, and was referred to the Code of Practice and the next day, told her lawyer “I’ve been reading this all night- now I understand!” The challenge, therefore is to bring the Code up to date with significant developments through caselaw, without it becoming a legal treatise and losing its special quality.

8. We find the use of scenarios helpful. We have suggested ways in which they should be updated. When the Code was originally consulted on, it was suggested that some of the scenarios were over-simplistic. Where we consider that a scenario would be more effective and realistic if it were a little more nuanced, we have said so.

Chapter 1 – What is the Mental Capacity Act 2005?

Question 2: Do you feel this chapter provides an up to date explanation of what the Mental Capacity Act 2005 is?

9. No

Please explain your answer. Where possible kindly provide clear reference to specific sections of the Code of Practice you are commenting on:

10. This is, in general, a helpful introduction to the structure and ethos of the MCA. Some of it is now outdated: the Court of Protection no longer needs to be referred to as “new”. Para1.12 should no longer refer to the NHS and Community Care Act 1990

but should refer to the NHS Act 2006, Equality Act 2010, Health and Social Care Act 2012 and Care Act 2014.

11. Those tasked with updating the Code should consider including a chapter on Human Rights and may wish to look at Chapter 3 of the 2015 Code of Practice to the Mental Health Act 1983 (“the MHA Code”) for an example. It contains a useful table of relevant Human Rights obligations, and a summary of obligations under the Human Rights Act 1998 and Equality Act 2010, through the prism of the MHA Code’s guiding principles.

12. This chapter should in particular introduce the United Nations Convention on the Rights of Persons with Disabilities (“UNCRPD”), which has been referred to in a number of significant Court of Protection judgments, including *P (by his litigation friend the Official Solicitor) v Cheshire West and Others* [2014] UKSC 19.

Chapter 2 – What are the statutory principles and how should they be applied?

Question 3: Does this chapter provide an up to date view of the five statutory principles?

13. No

Please explain your answer. Where possible kindly provide clear reference to specific sections of the Code of Practice you are commenting on:

General points:

14. The statutory principles are clearly and helpfully explained. We note – and we would agree with- the findings of the House of Lords Select Committee in its post-legislative scrutiny of the MCA in 2014 (<https://publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/139.pdf>) that;

“The empowering ethos of the Act has not been widely implemented. Our evidence suggests that capacity is not always assumed when it should be. Capacity assessments are not often carried out; when they are, the quality is often poor. Supported decision-making, and the adjustments required to enable it, are not well embedded. The concept of unwise decision-making faces institutional obstruction due to prevailing cultures of risk-aversion and paternalism. Best interests decision-making is often not undertaken in the way set out in the Act: the wishes, thoughts and feelings of P are not routinely prioritised. Instead, clinical judgments or resource-led decision-making

predominate. The least restrictive option is not routinely or adequately considered. This lack of empowerment for those affected by the Act is underlined by the fact that many responsible for its implementation continue to consider it as part of the safeguarding agenda. (paragraph 104)

The presumption of capacity, in particular, is widely misunderstood by those involved in care. It is sometimes used to support non-intervention or poor care, leaving vulnerable adults exposed to risk of harm. In some cases this is because professionals struggle to understand how to apply the principle in practice. In other cases, the evidence suggests the principle has been deliberately misappropriated to avoid taking responsibility for a vulnerable adult. (paragraph 105).”

15. To ensure that the Code plays its full part in improving compliance with the MCA, we think it may be important to emphasise (perhaps in the introduction to this chapter) that failure to comply with the MCA, including failure to observe its guiding principles, may open up individuals and organisations to legal challenges. A relatively recent and graphic example can be found in *CH v A Metropolitan Council [2017] EWCOP 12*. A local authority had failed to provide sex education to a married man, found to lack capacity to consent to sexual relations, over a prolonged period during which his wife had been warned that the couple could not lawfully have sexual intercourse. The provision of sex education, as recommended by a psychologist was in line with the principle set out in s1(3) MCA. The court approved a damages award for violation of CH’s rights under Article 8.

Specific points:

16. Para 2.2- Add “Additionally, failure to follow the statutory principles could lead to legal challenges”.

17. Paras 2.2-2.5- Clarify that the presumption of capacity does not obviate the need to investigate capacity, and perhaps refer to the finding of the Select Committee on this point.

18. Paras 2.6-2.7- Please see comments on the scenarios about the need to provide an example of a longer term piece of work to help a person attain capacity. It would be useful to refer to the UNCRPD in this section, which we appreciate will be expanded upon in chapter 3.

19. Paras 2.8- 2.9 The section on undue influence should be updated and should include a reference to the possible use of the inherent jurisdiction following *DL v A Local Authority [2012] EWCA Civ 253*.

20. Paras 2.10-2.11- Perhaps refer to some of the many judgments which emphasise the importance of autonomy, such as *PC v City of York Council [2013] EWCA Civ 478* at [54].

21. Para 2.12-This paragraph should be updated to reflect post-MCA decisions on best interests and could perhaps refer to Lady Hale's judgment in *Aintree University Hospitals NHS Foundation Trust v James [2013] UKSC Civ 67*: "The purpose of the best interests test is to consider matters from the patient's point of view. That is not to say that his wishes must prevail, any more than those of a fully capable patient must prevail. We cannot always have what we want. Nor will it always be possible to ascertain what an incapable patient's wishes are. Even if it is possible to determine what his views were in the past, they might well have changed in the light of the stresses and strains of his current predicament. In this case, the highest it could be put was, as counsel had agreed, that "It was likely that Mr James would want treatment up to the point where it became hopeless". But insofar as it is possible to ascertain the patient's wishes and feelings, his beliefs and values or the things which were important to him, it is those which should be taken into account because they are a component in making the choice which is right for him as an individual human being."

22. Paras 2.14-2.16- We appreciate that this will be considered in further detail in chapter 5. We agree that these paragraphs are accurate. It may be useful to refer to the decision of the Court of Appeal in *K v LBX [2012] Civ 79*.

Question 4: Do you feel the scenarios in this chapter are both relevant and effective?

23. No

Please explain your answer, and if relevant please share a more suitable scenario.

24. It would be useful to add a scenario in support of section 1(3) which provides an example of longer-term support to a person to enable them to gain capacity. An example is providing sex education to an adult with learning disabilities.

Chapter 3 – How should people be helped to make their own decisions?

Question 5: Does this chapter provide an up to date view of how people should be helped to make their own decisions?

25. No

General points:

26. It is important not to conflate supporting someone to make a decision, with a capacity assessment under sections 2 and 3 MCA, or to confine support to eliciting wishes and feelings for the purposes of a best interests decision. Modes of supporting a decision should in the first instance form part of a capacity assessment, and if the assessment concludes that the person cannot make the decision even if supported to do so, support is still important to elicit wishes and feelings to feed into a best interests decision. This sequence is not clear in this chapter. Preserving legal capacity through supported decision making is at the heart of article 12 of the UNCRPD.

Specific points

27. Para 3.6 add: The UNCRPD promotes this form of supported decision-making.

28. Para 3.7 add more examples:

- Circle of support to assist a person with a learning disability or cognitive disability understand options, make decisions, and take actions to give effect to that person's will and preferences
- Education on relationships and sex to help people with learning disabilities to understand information about the act, about sexually transmitted infections and about pregnancy
- Provision of an advocate in mental health settings

29. Page 30, last bullet point above para 3.1: consider adding the following: because CRPD is all about providing support to people, and not viewing (as the MCA does) the person as an individual needing to take decisions alone:

Supporting the person

- Can anyone else help or support the person to understand available options, help use and weigh those options, make choices or express a view?

30. Para 3.7 add something like "The person needs to be able to understand the salient details, not the minutiae of every option."

31. See comments on the Jane scenario below.

Question 6: Do you feel the scenarios in this chapter are both relevant and effective?

32. No

Please explain your answer, and if relevant please share a more suitable scenario.

33. Mrs Thomas scenario: This is helpful and demonstrates that even a simple set of choices needs thought, planning and a creative approach to explanations. For Mrs Thomas this is an important decision which will enhance her quality of life. The importance to the person of any decision, even a simple one, should be emphasised. This scenario could be more expansive in relation to how to explain the choices. Explaining a DVD may be supported with a picture of the room, and people sitting and watching a film. It may require repeating over time, hours or even days. Patience is important. Also it is necessary to factor in that Mrs Thomas really may not want to do either of the activities on offer. She should not be forced to make a choice on every occasion. If she keeps refusing, differing approaches to her decision making should be considered.

34. Jane scenario: The staff should conduct a full capacity assessment. The advocate should be used during that process to see if Jane can be assisted to use, weigh, retain and understand the relevant information. If not, then the advocate can support Jane to express her wishes and feelings. Once suitable places are found and Jane is taken to visit them, a fresh capacity assessment is probably warranted as the level of information, and or her understanding may have changed. With support she may now be able to make this decision.

Chapter 4 – How does the Act define a person’s capacity to make a decision and how should capacity be assessed?

Question 7: Does this chapter provide an up to date view of how does the Act define a person’s capacity to make a decision and how should capacity be assessed?

35. No.

36. We consider this chapter requires some updating:

(a) Re fluctuating capacity: There has been slightly inconsistent case law on the question of decision-making in respect of those with fluctuating capacity. The case of *Royal Borough of Greenwich v CDM [2018] EWCOP 15* is subject to appeal and it is hoped that the Court of Appeal’s judgment will be available before the new Code is published. Other cases of relevance include *MB v Surrey County Council [2017] EWCOP B 27* (Bailli citation) and *Re G [2004] EWHC 2222 (Fam)*;

(b) See below, in response to question 9.

Question 8: Do you feel the scenarios in this chapter are both relevant and effective?

37. No

Please explain your answer, and if relevant please share a more suitable scenario.

38. The scenarios are relevant but could be made more effective in the following ways:

39. Scenario after 4.9 (Tom): It would be helpful to explain, by reference to the application of the use of the s.3(1) questions, how the ambulance crew determined that Tom was capable of making healthcare decisions for himself.

Question 9: With reference to section s 4.11- 4.13 (p.44), we intend to reorder the two stages of the capacity test to reflect the need for capacity assessors to show that the inability to decide must be caused by an impairment of or a disturbance of the mind or brain as reflected in the Court of Appeal judgment. Do you agree with this change?

40. Yes

Please explain your answer:

41. We agree with this proposal. This change accords with the decision of the Court of Appeal in *PC v CYC [2014] 2 WLR 1. [2014] 2 W.L.R.* It would be helpful therefore for the section entitled "Stage 2..." (4.13-4.15) to come before the section entitled "Stage 1..." (4.11-4.12).

42. It may be worth noting, however, that the issue the court was concerned with was not primarily the question of the order in which the questions were posed, but rather that there was a danger that the conclusion that there is a mental impairment could lead assessors to the conclusion that the mental impairment was enough, on its own, to satisfy the test in s.2(1): See *NCC v PB [2014] EWCOP 14* at paragraphs 89-90.

43. It would perhaps be helpful to stress that both stages of the test must be complied with. This imperative is not underscored in the current Code.

44. The other addition that may be helpful would be for the precise causative relationship required to exist between the "inability to make a decision" and the

“Impairment of, or disturbance in the functioning of the mind or brain” to be set out and explained. It would be useful to refer to:

(a) The fact that the inability must be “because of” the impairment/disturbance. Current paragraph 4.13 suggests that the impairment or disturbance must “affect their ability”. It would be clearer to refer to the judgment of the Court of Appeal in *PC v CYC* where the court specifically indicated that “because” of cannot be taken to mean “referable to” or “significantly relates to”;

(b) The fact that “because of” does not mean “is the sole cause of”, but rather means “an effective cause: *NCC v PB [2014] EWCOP 14* at paragraphs 83-84.

(c) The fact that if there is considered to be undue influence by another/other circumstances (the sort of influence that would cause the High Court to take steps to protect a vulnerable adult whose ability to make the decision was “overborne” by another or by other circumstances under its inherent jurisdiction), should not lead the assessor to conclude that the assessment of capacity for the purposes of s.2(1) should not be undertaken. Influence can operate to make a person unable to make a decision for the purposes of s.2(1): *In Re A (Capacity: A Refusal of Contraception) [2011] Fam 61* at paragraph 73.

Chapter 5 – What does the Act mean when it talks about ‘best interests’?

Question 10: Does this chapter provide an up to date description of what is meant by ‘best interests’?

45. No

Please explain your answer. Where possible kindly provide clear reference to specific sub-sections of the Code of Practice you are commenting on:

46. On the whole, this chapter provides an accurate description of what is meant by ‘best interests’. However, it should be updated to take account of a number of more nuanced principles that have since developed in the case law. These are as follows.

47. Para 5.8: Who can be a decision-maker? It would be helpful if this could provide some examples from health and social care practice where care or treatment is commissioned by one body but provided by another.

48. Para 5.13 onwards_ (‘what must be taken into account when trying to work out someone’s best interests’):

- Further to *A Local Authority v WMA* [2013] EWHC 2580 (COP), it is clear that determining what is in the best interests for an incapacitated individual is not the same as deciding what is best for that person (“P”).
 - The best interests test is not a test of ‘substituted judgment’. If sufficiently reliable evidence exists, the answer to the question of whether P would have consented or refused is likely to be determinative of whether continuing such treatment is in their best interests (*Briggs v Briggs (No. 2)* [2016] EWCOP 53; *B v D* [2017] EWCOP 15).
 - ‘Best interests’ do not cease at the moment of death (*In re P (Statutory Will)* [2010] Ch 33, at [44]; approved in *ITW v Z and others*[2009] EWHC 2525, at [37].).
49. Paras 5.18 – 5.20_ (‘all relevant circumstances’):
- These include a consideration of P’s rights under Article 8 ECHR (*K v LBX* [2012] EWCA 79).
50. Para 5.37 onwards_ (‘wishes and feelings’):
- There is now case law to the effect that the best interests test is not an objective test. The purpose of the test is to consider matters from P’s point of view, which should be taken into account insofar as is possible. In particular, we make reference to the dicta of: Lady Hale at [45] in *Aintree University Hospitals v James and others*[2013] UKSC 67, Peter Jackson J at [38] in *Re M (Best Interests: Deprivation of Liberty)* [2013] EWHC 3456 (COP), and Charles J at [59] in *Briggs v Briggs (No. 2)* [2016] EWCOP 53.
 - It is also now clear that there is no ‘hierarchy’ in the factors which must be borne in mind when making a decision on behalf of a person who lacks capacity. The weight of those factors will differ depending on the individual circumstances of the particular case. The incapacitated individual’s wishes and feelings will always be a significant factor to which regard must be paid but the weight attached to them will be fact-specific. On this, see the case of *ITW v Z and others* [2009] EWHC 2525, confirming *Re M*[2009] EWHC 2525 (Fam). The authors may wish to list examples of factors which assist in determining weight. A very useful non-exhaustive list was provided at [35] of *ITW v Z and others* [2009] EWHC 2525.
 - A person lacking capacity is entitled to the same protection of his rights under the European Convention as any other individual (*P v Cheshire West* [2014] UKSC 19). In considering the wishes and feelings of such individuals, one

should not consider the individual to be a person in good health who has been afflicted by illness. It is more real and respectful to recognise the individual for who he is (*Wye Valley Hospital v Mr B* [2015] EWCOP 60, at [10] – [13]), though it should be noted that, respecting individual autonomy “does not always require P’s wishes to be afforded predominant weight”; the matter depends on factors such as how invasive the treatment might be and the likely outcome of that treatment for the patient in question (*M v Mrs N* [2015] EWCOP 76, at [28]).

- The case law also suggests that particular weight is to be given to P’s past written statements (*Re Treadwell* [2013] EWHC 2409 (COP) at [88]; *Re BM; JB v AG* [2014] EWCOP B20 at [58]).

51. 5.29 onwards_('life-sustaining treatment'):

52. The section needs to be updated to reflect the case of *Aintree University Hospitals v James and others*[2013] UKSC 67, in which the following clarifications were made:

- The starting point in a case of life-sustaining treatment is a strong presumption that it is in a person’s best interests to stay alive.
- Decision-makers should look at P’s welfare in the widest sense and try to put themselves in the place of P and ask what his attitude to the treatment is likely to be (Lady Hale, at [39]).
- The Court defined the terms ‘futility’ and ‘no prospect of recovery’ in the context of life-sustaining treatment, as used in the Code at paras. 5.31 – 5.33.
- ‘Futility’ was to be considered as treatment which is “ineffective” or “of no benefit to the patient” (at [40]) and not merely because it had “no real prospect of curing or palliating the life-threatening condition from which the patient was suffering”.
- In the phrase ‘prospect of recovery’, the word ‘recovery’ did not mean a “return to full health” but “resumption of a quality of life [which the individual] would regard as worthwhile” (at [40]). Treatment offering no prospect of recovering to a good state of health can therefore be in the patient’s best interests if it may enable him to resume a quality of life which he would regard as worthwhile.

53. The following principles also arise from the post-2007 case law:

- In the case of an individual in a vegetative state, it is necessary for there to be standardised testing before an application to the court (*St George’s Healthcare NHS Trust v P* [2015] EWCOP 42, at [49]).

- Sanctity of life is important but should not be pursued “to the point where life has become empty of real content or to a degree where the principle eclipses or overwhelms other competing rights of the patient” (Re O [2016] EWCOP 24, at [17]). Quality of life “should be judged not by the values of others but from the particular perspective of the patient” (St George’s Healthcare NHS Trust v P [2015] EWCOP 42, per Newton J, at [38]).
- Where the provisions of the MCA 2005 have been followed, the relevant guidance has been observed, and there is agreement between those close to the patient and clinical professionals about what would be in the best interests of the patient, life-sustaining treatment (whether clinically assisted nutrition and hydration or another form of such treatment) can be withdrawn without the need to make an application to the court (*An NHS Trust and others v Y and another* [2018] UKSC 46). However, if the way forward is finely balanced or there is a difference of opinion, a court application should be made (per Lady Black at [125]).

54. 5.65 – 5.67_ (‘individuals consulted’):

55. At 5.66: it should be added that it may be appropriate to consult with former carers and to take into account oral statements made to them by the person who lacks capacity (*Re M (ITW v Z)* [2009] EWHC 2525 (Fam), at [36]).

56. At 5.67: This should be updated to add that the weight to be given to the views expressed by consultees will depend on factors such as the extent of their knowledge of P, the amount of contact that they have with P, whether they have a vested interest in the decision to be taken and their relationship with P.

57. At 5.68_ (‘disputes about best interests’):

58. It should be clarified that in the event of a dispute, the MCA 2005 does not give a special status to the opinions of health or social care professionals as above those of family members. Any dispute must ultimately be settled by the Court of Protection. This could usefully cross-refer to Chapters 8 and 15.

Other

59. The issue of covert medication is not currently discussed in the Code but has recently been addressed by the courts. It has been clarified that covert medication is a serious interference with an individual’s right to respect for private life under Article 8. Even when a patient is incapacitated, s/he “*should not be subjected to anaesthesia or invasive surgery without, as a minimum, being informed in sensitive and appropriate language*

as to what is about to be done to them before it is done" (*An NHS Trust v The Patient* [2014] EWCOP 54, at [22]). The authors should also have regard to the guidance given by District Judge Bellamy at [43] of *AG v BMBC & Anor* [2016] EWCOP 37.

60. It should however be noted that administration of medication by deception tends to be allowed where an individual, when capacitous, voluntarily sought and engaged fully with treatment prior to losing capacity (*Re AB* [2016] EWCOP 16).

Question 11: Do you feel the scenarios in this chapter are both relevant and effective?

61. No

Please explain your answer, and if relevant please share a more suitable scenario.

62. Page 69 (Pedro): This situation is a little problematic given the dicta on covert medication at para. 8 above. There is no suggestion in the scenario that Pedro has been informed about the prospect of a general anaesthetic being used; only that he would be "involved in the decision" (to clean his teeth; not to do so via an anaesthetic). The covert element of the scenario should therefore be reviewed. The scenario is otherwise a fair 'introductory' scenario to this chapter.

63. Page 71 (Jack): This should be amended to reflect the possibility of conflict between the opinions of Jack's parents and the professionals this and the appropriate course of events in the case of conflict.

64. Page 74 (Martina): The scenario is acceptable though it does not really add much to the chapter. All it reiterates is that the checklist must be followed. The contents of that checklist have already been outlined in paragraphs 5.13 – 5.15. It could instead be used to reflect the absence of a 'hierarchy' between relevant factors and the way in which the weight of each of those respective factors may change in different situations.

65. Page 76 (Amy): The scenario does not address the possibility of the advocate being unable to discern Amy's wishes and feelings. A more realistic scenario is that a number of different individuals are involved in assisting with the determinations of the wishes and feelings of the incapacitated individual.

66. Page 78 (Mr Fowler): This is a reasonable scenario.

67. Page 81 (Andre): This is a somewhat simplistic scenario which does not really tackle the issue of wishes and feelings head-on. If anything, it suggests that they can be ignored. It should be amended to a) outline the kinds of factors which may reveal

information about Andre's wishes and interests in this scenario; b) explain how these have been factored into the decision-making process; and c) justify why the decision was ultimately to give Andre the vaccination.

68. Page 83 (Anita): It would be valuable to ask how Anita's father would or should have reacted if advised that the ethical investments carried a lower rate of return, and would barely meet the cost of Anita's car and equipment. Those preparing the Code may also wish to outline a separate scenario relating to religious belief having regard to the way in which the Court reasoned the case of *Re IH* [2017] EW COP 9. This addressed whether it was in the best interests of a Muslim individual (1) to fast during daylight hours of Ramadan; and (2) for his axillary (i.e. underarm) and pubic hair to be trimmed, in accordance with Islamic cultural and religious practice insofar as it was safe and reasonable to do so.

69. Page 85 (Lucia): This is, again, somewhat simplistic. Again, what would happen if there were conflict between the views of Lucia's parents and the professionals? It is also difficult to see what this scenario adds to that outlined on page 7.

70. Page 87 (Mrs Prior): This is a fair scenario and continues to be supported by the case law.

71. Page 89 (Mr Graham): No reasoning process is outlined. Why do the attorneys agree what they agree?

72. Page 90 (Robert): The scenario should also address the possibility of disagreement between the views of family members and professionals and the wishes and feelings of the incapacitated individuals.

Chapter 6 – What protection does the Act offer for people providing care or treatment?

Question 12: Does this chapter provide an up to date understanding of the protection the Act offers for people providing care or treatment?

73. No

Please explain your answer. Where possible kindly provide clear reference to specific sub-sections of the Code of Practice you are commenting on:

74. Change of residence: The provisions of the Code which state that a change of residence may involve a deprivation of liberty (6.13) may be interpreted as suggesting that the circumstances in which a proposed change may amount to a deprivation are

rare. This is no longer the case, following the judgment in *P v Cheshire West and others* [2014] UKSC 22. This section of the MCA Code was, as is known, drafted before Schedule A1 was enacted/in force. It is believed to be necessary (and this reflects the volume of applications made pursuant to s.21A MCA since Schedule A1 has been in force) to stress that in many cases it is highly likely that a proposed change of residence in defiance of P's wishes, or those of her family or appropriate consultees, will amount to a deprivation of liberty. Very careful consideration will need to be given to this issue and an authorisation of the deprivation of liberty (either via Re X procedure, Schedule A1, or the Liberty Protection Safeguards when enacted) will need to be sought).

75. In light of the decision in *Re MM (Mental Capacity: Contact)* [2011] 1 FLR 712 it may be necessary to stress that carers, relatives etc must have a "reasonable belief" in a lack of capacity when deciding whether to act against P's wishes; and where there is a significant disagreement as to either capacity or best interests in these circumstances of which a statutory authority becomes aware, it ought to give careful consideration to placing the matter before the Court of Protection. Whether it is necessary to place the matter before the Court of Protection will largely depend upon the gravity/importance of the decision for P. In any event, a reliable capacity assessment should be undertaken.

76. Paragraph 6.50: It could be noted that restraint to preventing P from attacking others has not been found to amount to a deprivation of liberty (and is therefore permissible under s.6 MCA (*Re RK* [2010] EWHC 3355, reaffirmed on appeal in *RK v BCC* [2011] EWCA Civ 1305);

77. The revisions to this chapter referred to at 6.53 in light of the enactment of Schedule A1 MCA need to be undertaken.

Question 13: Do you feel the scenarios in this chapter are both relevant and effective?

78. No

Please explain your answer, and if relevant please share a more suitable scenario.

79. All scenarios require revision to take account of the fact that the Code was not amended to take account of the impact of Schedule A1 and the associated case law on the meaning of a deprivation of liberty and the circumstances, and manner, in which authorisation must be sought.

Chapter 7 – What does the Act say about Lasting Powers of Attorney?

Question 14: Does this chapter provide an up to date explanation about what the Act says about Lasting Powers of Attorney?

80. Yes

Please explain your answer. Where possible kindly provide clear reference to specific sub-sections of the Code of Practice you are commenting on:

General points

81. We consider that the importance of the Code being user-friendly is particularly pertinent in the context of Lasting Powers of Attorney (LPAs), as attorneys are required to have regard to the Code of Practice when acting. The 'quick summary' introducing this chapter is considered helpful in this regard.

82. Given that LPAs are no longer new and that no new EPAs have been made since the MCA came into force, it is suggested that the comparison between EPAs and LPAs could be moved further back in the chapter. Whilst it may still be useful to include the comparison, it may now be appropriate to give EPAs less prominence.

Specific points

- Footnote 26 – forms are also available online, as is a gov.uk guide to making and registering an LPA - <https://www.gov.uk/government/publications/make-a-lasting-power-of-attorney/lp12-make-and-register-your-lasting-power-of-attorney-a-guide-web-version>. There is also an online LPA tool - <https://www.lastingpowerofattorney.service.gov.uk/home>.
- Footnote 27 – who may and may not be a certificate provider is now provided for by regulation 8 of the Lasting Powers of Attorney, Enduring Powers of Attorney and Public Guardian Regulations 2007. The OPG guidance is available at:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/245569/LPA112_Property_financial_affairs_guidance.pdf.
- Footnote 28 – the banking guidance has been updated.

83. Para 7.73- This should be updated to refer to the safeguarding duties imposed on local authorities by the Care Act 2014- see comments on chapter 14.

Question 15: Do you feel the scenarios in this chapter are both relevant and effective?

84. No

Please explain your answer, and if relevant please share a more suitable scenario.

85. The scenarios are relevant and effective for addressing the issues they seek to cover. However, they do not address many of the more complex issues that can arise in the context of LPAs, which it is considered would be far more useful. For example, it would be useful to have a scenario (or potentially several different scenarios) addressing when an LPA may be revoked due to an attorney acting in a manner inconsistent with the donor's best interests.

Chapter 8 – What is the role of the Court of Protection and court-appointed deputies?

Question 16: Do you feel this chapter provides an up to date explanation of what the Mental Capacity Act 2005 is?

86. No

Please explain your answer. Where possible kindly provide clear reference to specific sections of the Code of Practice you are commenting on:

General points

87. We wonder whether it would be helpful to separate this into 2 chapters, one dealing with deputies and the other with the Court of Protection. Once again, the language of the chapter is clear and accessible which is helpful. In relation to the Court of Protection sections, these require an update to align with caselaw. Care will need to be taken to ensure that these are consistent with other references to the Court of Protection in the Code, such as Chapters 5 and 10. The powers of the Court in relation to section 21A MCA 2005 (clause 21AA in the Mental Capacity Amendment Bill) will also need to be included. It may be helpful to mention that the Court of Protection will usually sit in public with reporting restrictions. If legal aid matters continue to be covered in chapter 15, this chapter should cross-refer to Chapter 15.

Specific points

88. Para 8.3- It may be helpful to add a reference to Practice Direction 3B and the requirements of the "pre-issue stage" in relation to welfare decisions.

89. Para 8.6- We agree that this should "signpost" the reader to Chapter 12 rather than provide detailed information here.

90. Para 8.7-8.10 need to be updated to provide clarity about the responsibility of statutory bodies to bring significant welfare disputes which cannot be resolved by discussion to the Court (following *London Borough of Hillingdon v Neary* [2011] 4 AER 584, [2011] EWHC 1377 COP) and the requirements on RPRs and in some cases local authorities to bring challenges under section 21A MCA 2005, following in *AJ v A Local Authority* [2015] EWCOP 5. It is important for the Code to make it clear that a failure to bring an appropriate case to the Court of Protection may result in a violation of the relevant person's rights under Articles 5 or 8.

91. Para 8.10 requires revision to reflect the range of options for the representation of the person lacking capacity now provided for in the Court of Protection Rules 2017 (COPR r1.2).

92. Para 8.11 needs to be updated to reflect section 21A MCA 2005.

93. Para 8.16 Whilst it is reasonable to expect those disagreeing over capacity to attempt to resolve the issue without litigation, we are not sure that it is right to say that such applications are rare. In addition the challenges by the person who is asserted to lack capacity and disputes between family members, health bodies may need to ask the court to resolve a question as to a person's capacity to consent to treatment. Local authorities may find themselves needing to ask the Court to resolve issues such as capacity to consent to sexual relations.

94. Para 8.18-8.24- This section needs to be overhauled in response to the Supreme Court's decision in *An NHS Trust v Y (by his litigation friend the Official Solicitor) and others* [2018] UKSC 46. Care should be taken to ensure that it is consistent with any practice guidance given by the Court. The Code as it was originally drafted, for example, was found to be inconsistent with what was then Practice Direction 9E (see *Director of Legal Aid Casework and others v Briggs* [2017] EWCA Civ 1169). Practice Direction 9E has been withdrawn and it is understood that there will be replacement guidance issued in the relatively near future.

95. Para 8.25-8.26- It may be helpful here to mention *N v ACCG* [2017] UKSC 22, to make clear the limitation of the powers of the Court of Protection.

Question 17: Do you feel the scenarios in this chapter are both relevant and effective?

96. No

Please explain your answer, and if relevant please share a more suitable scenario.

97. Case study- Sunita: We can see the point that this case study is attempting to make. However, if a vulnerable adult was being withheld contact from someone he is close to, when there was no evidence that this was in the brother's best interests, this would constitute a restriction in his care arrangements that does not appear to be justified. Many advisers would suggest inviting the relevant local authority to make the application.

98. Scenario 2- Mrs Worrall: It might be sensible to amend this so that the solicitor has been appointed under an LPA (for property and affairs) rather than an EPA.

Chapter 9 – What does the Act say about advance decisions to refuse treatment?

Question 18: Does this chapter provide an up to date explanation about what the Act says about advance decisions to refuse treatment?

99. Yes, with some updates needed.

General points

100. The contents of this chapter remain accurate. The principles on advance decisions have not departed from the original statutory principles outlined in sections 24 – 26 of the Mental Capacity Act 2005. However, the courts have provided a number of clarifications in the case law and the chapter should be updated to reflect these. These are outlined below.

Specific points

101. 9.7 – 9.9('capacity to make an advance decision'):

102. The paragraphs accurately summarise the basic principle that an individual who has made an advance decision should be assumed to have capacity unless there are reasonable grounds to doubt that the person had the capacity to make the advance decision at the time they made it. However, it does not do much more than this, referring readers back to chapter 3. It is clear that there may be a number of factors which may be specific to an individual's capacity to make an advance decision, as opposed to capacity generally. These are helpfully outlined by Alex Ruck Keene in his 2012 paper 'Advance Decisions: getting it right?' and include, in his terms:

- a. "The nature of the treatment(s) that is/are to be covered by the advance decision, including, if various forms of intervention are necessary to support a particular purpose, that there is more than one intervention, and the core elements of those forms of intervention which are to be covered (e.g. *A Local Authority v E* [2012] EWHC 1639 (COP));

- b. the circumstances (if such are specified) under which the treatment(s) are not to be started or continued;
- c. the consequences of refusing the start or the continuation of that treatment (and, in the case of life-sustaining treatment, that such may result in death);
- d. that the decision can be withdrawn or changed at any time whilst the person still has capacity to do so; but that
- e. if the decision is not withdrawn or changed, and the person loses capacity to consent to the carrying out or continuation of treatment, that decision will bind the medical professionals and may do so even if – at the time – the individual is indicating that they do not wish it to.”

103. 9.11 (‘what should people include in an advance decision?’)

104. The Code states that “*specific rules apply to life-sustaining treatment*”. It would be helpful to cross-refer readers to paragraph 9.24.

105. 9.24 (‘what rules apply to advance decisions to refuse life-sustaining treatment?’):

106. We would recommend adding an introductory paragraph to this section to outline the clear message of the case law that notwithstanding the serious consequences of decisions to refuse life-sustaining treatment, such decisions embody the right to self-determination, and are to be respected provided that such decisions meet the requirements of sections 25(5) and (6). In particular, the authors are directed to the dicta of Lady Hale at [45] of *Aintree University Hospitals v James and others*[2013] UKSC 67) and Charles J at [28] of *Briggs v Briggs* [2016] EWCOP 53, as well as to the decision in *Nottinghamshire Healthcare NHS Trust v RC* [2014] EWHC 1317 (COP), where Mostyn J held that the provisions of the Mental Health Act 1983 could not be used to override P’s capacitous wishes.

107. It should however be highlighted that cases where implementation of an advance decision would lead to P’s death require “a full, reasoned and contemporaneous assessment evidencing mental capacity to make such a momentous decision” (*A Local Authority v E* [2012] EWHC 1639 (COP), at para. [65] per Peter Jackson J).

108. 9.40 (‘deciding whether an advance decision is valid’):

109. There should be an additional paragraph after the list of requirements to clarify that the validity requirements are not intended to impose a high threshold. The judgment of Charles J from *Briggs v Briggs* [2016] EWCOP 53 assists here. There, it was made clear at [22] that setting a low threshold “*would run counter to the enabling intention of ss.24 to 26 MCA 2005*”. It should, however, be noted that the requirement

for a witness does appear to be a strict one. In *An NHS Trust v D* [2012] EWHC 885 (COP) (at [16]), the Court found that the absence of a witness rendered invalid an advance decision refusing life-sustaining treatment.

110. The following practical advice was given by Theis J at [33] – [35] of *X Primary Care Trust v XB* [2012] EWHC 1390 (Fam):

- In the event that there is an issue raised about an advance decision, it is important it is investigated by the relevant health authorities or relevant bodies as a matter of urgency.
- There is no set form for advance decisions.
- It is in everybody's interest for there to be clarity in relation to what the terms of the advance decision are.

111. On section 25(2)(c) specifically (i.e. invalidity where the individual "*has done anything else clearly inconsistent with the advance decision remaining his fixed decision*"), the following points of clarification should be noted:

- A 'fleeting' change of mind does not appear to be sufficient. Note the following dictum of Keehan J in *Re QQ* [2016] EWCOP 22: "*I do not accept that when QQ made an advance decision in August 2015 in relation to her treatment that she was capacitous and therefore that it is a valid or lawful advance decision. If I were to be wrong on that issue, I accept Mr Wenban-Smith's submission that the contrary views that QQ has recently and fleetingly expressed from time to time, namely that she would accept treatment, would not of themselves invalidate, pursuant to s 25 (2) (c) of the Mental Capacity Act 2005, what would otherwise have been a valid advance decision. Sustained indications are necessary."*
- Peter Jackson J in *A Local Authority v E* [2012] EWHC 1639 (COP) found at [63] that an instruction in an advance decision that "if I exhibit behaviour seemingly contrary to this advance directive this should not be viewed as a change of decision" should not be binding.
- A good example of an accepted change of opinion can be found in *HE v A Hospital NHS Trust* [2003] EWHC 1017 (Fam). The patient, when a Jehovah's Witness, had made an advance directive refusing blood. Subsequent to this she had become betrothed to a Muslim man upon condition that she would revert to being a Muslim, and had ceased attending Jehovah's Witness meetings. The judge held that the advance directive was founded entirely on the patient's faith and could not survive the abandonment of that faith. There had therefore been a withdrawal of the advance decision.

112. Paras 9.38 – 9.44 ('deciding whether an advance decision exists'):

113. It should be noted that the test of whether an advance decision relating to life-sustaining treatment is valid and applicable is on the balance of probabilities (*A Local Authority v E* [2012] EWHC 1639 (COP), Peter Jackson J, at [55]).

114. Paras 9.67 – 9.69_('when can somebody apply to the Court of Protection?):

115. Any doubt about validity and/or applicability of an advance decision to refuse life-sustaining treatment should be resolved by the court in favour of preserving life (*HE v A Hospital NHS Trust* [2003] WHC 1017 (Fam)).

116. We would recommend that the authors highlight the importance of bringing any disputes about the existence, validity, and/or applicability of an advance decision to Court as quickly as possible. This was emphasised in *A Local Authority v E* [2012] EWHC 1639 (COP) (at [40]) and *X Primary Care Trust v XB* [2012] EWHC 1390 (Fam) (at [54]).

Question 19: Do you feel the scenarios in this chapter are both relevant and effective?

117. Mostly, with a few exceptions.

Please explain your answer, and if relevant please share a more suitable scenario.

118. Page 162 (Mrs Long): This is appropriate as an introductory scenario to the topic.

119. Page 170 (Angus): The scenario has juxtaposed the existence of a written advance decision against conflicting evidence in Angus's actions immediately before losing capacity, but has not provided any indication of a) the factors that would be weighed against one another in such a scenario or b) the ultimate answer, depending on these factors.

120. Page 172 (Mr Moss): This is a reasonable scenario, though there should also be a short paragraph addressing the alternative (and more realistic) situation where the 'guinea pig' aspect is only one of a number of reasons for which Mr Moss had previously refused retro-viral treatments. Another good scenario could be that of an individual changing religion (as in *HE v A Hospital NHS Trust* [2003] EWHC 1017 (Fam) above).

121. Other: There should be a scenario relating to situations in which healthcare professionals will be protected from liability (at or subsequent to paragraphs 9.57 – 9.60).

Chapter 10 – What is the new Independent Mental Capacity Advocate service and how does it work?

Question 20: Does this chapter provide an up to date explanation about what the new Independent Mental Capacity Advocate service is and how it works?

122. No

Please explain your answer. Where possible kindly provide clear reference to specific sections of the Code of Practice you are commenting on:

123. Much of this chapter of the Code is still valuable and applicable. As with the majority of the Code the language is clear and user-friendly.

General points:

124. We would suggest that as the use of IMCAs is now relatively well-established, there is no need to refer to it as a new service. If there is to be a new Code to support the Liberty Protection Safeguards (LPS), then this chapter of the Code should cross-refer to the duties arising under revised sections 39A-D MCA 2005.

125. The revised Code should refer to the other types of statutory advocacy services such as Independent Mental Health Advocates (for example at 10.49) and Care Act advocates. A person lacking capacity to make decisions about care and treatment whose Care Act needs are being assessed must have an advocate as of right (section 67 Care Act 2014) if there is no one appropriate to “represent and support the individual” (s67(2) Care Act 2014). 10.62-10.65 will need to be updated accordingly.

126. The Care Act 2014 has put adult safeguarding on a statutory footing and 10.66-10.68 will need to be updated to reflect this.

127. The references to medical treatment and to when the Court of Protection should be approached require significant updating.

Specific suggestions

128. Para 10.2- update to reflect impact of the Care Act 2014

129. Para 10.5- perhaps include a reference to other statutory advocates

130. Paras 10.7-10.11- consider updating to terminology to reflect the Health and Social Care Act 2012 and the Care Act 2014 and check that there are no inconsistencies.

131. Paras 10.15 and 10.16- see comments on 10.34-10.39.

132. Paras 10.20- Given the importance of the IMCA role and the importance on the participation of the person lacking capacity (particularly having regard to the UNCRPD), we suggest that cases where the IMCA does not meet or interview the person lacking capacity upon whom the IMCA is reporting will be exceptional. The second bullet point should read “will meet and interview the person who lacks capacity, unless exceptional circumstances prevent this. Where possible the meeting or interview will take place in private”.

133. Para 10.22- could refer to experience of the IMCA scheme since the MCA, rather than pilot schemes.

134. Para 10.34- consider including a reference to the Local Government Ombudsman.

135. Para 10.37. The suggestion that only “particularly serious or urgent cases” would require an IMCA to apply to the Court of Protection (or to ensure that the relevant statutory body makes an application) does not reflect the guidance given in caselaw. It would be useful to adopt the formulation used by Peter Jackson J (as he then was) in *London Borough of Hillingdon v Neary* [2011] 4 AER 584, [2011] EWHC 1377 COP: “Significant welfare issues that cannot be resolved by discussion should be placed before the Court of Protection, where decisions can be taken as a matter of urgency where necessary.”

136. Para 10.38. This is out of date, and indeed did not reflect the Official Solicitor’s practice at the time of the MCA. It may be useful to refer to the Practice Direction 3B, which deals with the steps that should usually be taken before an application to the Court of Protection is made.

137. Para 10.39. This should be amended to reflect the basis on which the Administrative Court might interfere with a public law decision, rather than the current description which seems designed to put IMCAs off this course of action without providing much useful information.

138. Para 10.42-10.48- This section should be updated having regard to the decision in *An NHS Trust v Y (by his litigation friend the Official Solicitor) and others* [2018] UKSC 46.

139. Para 10.49- Add a reference to the availability of IMHAs.

140. Para 10.53, 10.56- update to refer to the Care Act 2014

141. Paras 10.59-10.10.68- update to reflect changes in the Care Act 2014.

Question 21: Do you feel the scenarios in this chapter are both relevant and effective?

142. The first two could usefully be updated.

Please explain your answer, and if relevant please share a more suitable scenario.

143. Scenario 1: Using an IMCA- This would be more informative if it included the outcome of the local authority's decision, and the options available to the IMCA.

144. Scenario 2: Using an IMCA for serious medical treatment- It may be useful to be clearer about who the decision-maker is in this context.

Chapter 11 – How does the Act affect research projects involving a person who lacks capacity?

Question 22: Does this chapter provide an up to date explanation about how the Act affects research projects involving a person who lacks capacity?

Please explain your answer. Where possible kindly provide clear reference to specific sections of the Code of Practice you are commenting on:

145. We have no comments to make on this chapter

Question 23: Do you feel the scenarios in this chapter are both relevant and effective?

Please explain your answer, and if relevant please share a more suitable scenario.

146. No comment.

Chapter 12 – How does the Act apply to children and young people?

Question 24: Does this chapter provide an up to date explanation about how the Act applies to children and young people?

147. No

Please explain your answer. Where possible kindly provide clear reference to specific sections of the Code of Practice you are commenting on:

148. Understandably, the current Chapter 12 gives insufficient guidance in relation to the deprivation of the liberty of children.

149. In particular, the guidance will require updating to take account of the important cases of:

(a) *RE D [2017] EWCA Civ 1695*: In this case the Court of Appeal concluded that parents could, in principle consent to the confinement of their incapacitated child. It is understood that Charles J made an order authorising the deprivation of liberty of a 16-year-old notwithstanding parental consent. *Re D* has been appealed to the Supreme Court and that decision will also require detailed consideration.

(b) *RE A-F (Children) [2018] EWHC 138 (Fam)*: In this case Sir James Munby set out what the autonomous convention term “confinement” means in relation to children of a variety of age ranges and, in addition, gave guidance on the process to be followed where parental consent is either not available or would not amount to appropriate authority for a deprivation of liberty in the particular circumstances.

(c) It would be useful to provide further guidance on transfers to and from the Court of Protection in cases of 16-17 year olds, in particular as set out in *B v RM and ors [2010] EWHC 3802 (Fam)*.

(d) This chapter will need to reflect the inclusion of 16-17-year olds in the proposed Liberty Protection Scheme.

Question 25: Do you feel the scenarios in this chapter are both relevant and effective?

150. Partly.

Please explain your answer, and if relevant please share a more suitable scenario.

151. Scenarios: The final scenario could be improved by ensuring that the guidance on *B v RM* is included.

Chapter 13 – What is the relationship between the Mental Capacity Act and the Mental Health Act 1983?

Although it has been announced that there will be new Mental Health Legislation we would still appreciate your comments on this chapter.

Question 26: Does this chapter provide an up to date explanation about the relationship between the Mental Capacity Act and the Mental Health Act 1983?

152. No

Please explain your answer. Where possible kindly provide clear reference to specific sections of the Code of Practice you are commenting on:

153. This chapter was out of date at the time of publication. It was written prior to the inclusion of deprivation of liberty powers into the MCA through s 4A, 16A, schedules A1 and 1A. There is no reference to the interface between the MHA and MCA provided by schedule 1A which has variously been described as 'fiendish' and 'impenetrable'.

154. Schedule 1A comprises 5 case scenarios A-E. It stipulates 'conditions' for the application of each including an 'objection' criterion which has caused difficulties on the ground. There is case law under these provisions attempting to elucidate their proper application.

155. 13.22 refers to after-care under supervision under the MHA which was repealed by the MHA 2007, and replaced by community treatment orders under s 17A MHA.

Question 27: Do you feel the scenarios in this chapter are both relevant and effective?

156. No

157. For the reasons above the scenarios need reconsideration. They are neither relevant nor effective in elaborating the issues arising under schedule 1A.

Chapter 14 – What means of protection exist for people who lack capacity to make decisions for themselves?

Question 28: Does this chapter provide an up to date explanation about the means of protection that exist for people who lack capacity to make decisions for themselves?

158. No

Please explain your answer. Where possible kindly provide clear reference to specific sections of the Code of Practice you are commenting on:

159. This chapter is now out of date.

160. There has been a significant wholesale reform of social care legislation since the Code was drafted. The Code needs to reference the relevant provisions of the Care Act 2014 and Social Services and Well-being (Wales) Act 2014. There is now for the first time a statutory framework for adult safeguarding.

161. Section 4(2) (e) Care Act 2014 places a duty on a local authority to establish and maintain a service for providing people in its area with information and advice about how to raise concerns about the safety or wellbeing of an adult who has needs for care and support.

162. Section 9 imposes a duty on an authority to assess whether an adult has needs for care and support in cases where it appears that they may have such needs.

163. Section 11(2) requires the authority to carry out a needs assessment even where the adult refuses where the adult is experiencing or is at risk of abuse or neglect.

164. Section 18 imposes a duty on an authority to meet eligible needs and section 19 gives it a power to meet assessed needs even where there is no duty.

165. Sections 42-47 Care Act 2014 deal with safeguarding adults at risk of abuse and neglect.

166. Section 42 imposes a duty of inquiry on a local authority to make inquiry where it has reasonable cause to suspect that an adult in its area has needs for care and support, is experiencing, or is at risk of, abuse or neglect, and as a result of those needs is unable to protect himself/herself against the abuse or the risk of it. Abuse includes financial abuse.

167. Section 43 requires a local authority to establish a Safeguarding Adults Board for its area whose objective is to help and protect adults in its area.

168. Section 44 explains the circumstances in which a SAB must arrange for a review of a case involving an adult in its area with needs for care and support - this includes where there is a reasonable cause for concern about how agencies/persons worked together to safeguard the adult and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

169. Section 47 provides for the protection of property of adults being cared for away from home and imposes a duty on a local authority to take reasonable steps to prevent or mitigate loss/damage where an adult is having needs for care and support

in a way that involves provision of accommodation / hospitalisation; the adult is unable to protect or deal with the property and no suitable arrangements have been / are being made. The performance of the duty allows the authority to enter premises on reasonable notice and at a reasonable time and deal with the property as is reasonably necessary provided that it has the consent of the person authorised under the MCA 2005 to give consent on P's behalf or where there is no such person, the local authority is satisfied that exercising the power to enter would be in P's best interests. Obstruction of the exercise of the power without reasonable cause is a criminal offence which can be punished by a fine.

170. The Act is to be read with statutory guidance which deals with safeguarding at Chapter 14. This provides examples of what amounts to abuse and neglect and sets out relevant scenarios.

171. Health and social care providers in England are now regulated by the Care Quality Commission which has enforcement powers against the providers. The Welsh Regulators are Care Inspectorate Wales and Healthcare Inspectorate Wales.

172. Para 14.4 - No Secrets guidance has been replaced by the statutory guidance under the Care Act 2014.

173. Para 14.5 - Age Concern is now Age UK. Community Legal Service Direct is now known as Civil Legal Advice - <https://www.gov.uk/civil-legal-advice>

174. Para 14.7. The Fraud Act 2006 is in force. The offences should not be described a new. It should be pointed out that secrecy is not an element of the offence.

175. 14.10 Court of Protection visitors – refer to OPG Practice Note 6 which explains who Court of Protection visitors are.

176. 14.26 Explain that applies to acts and omissions and that wilful neglect is more than neglect/carelessness. Put in a reference to *R v Nursing* [2012] EWCA Crim 2521 which explains the purpose of s. 44 MCA 2005. The CPS has published guidance on prosecuting crimes against older people - <https://www.cps.gov.uk/legal-guidance/older-people-prosecuting-crimes-against>

177. 14.27 - Needs wholesale revision and to refer to the Safeguarding Adults Boards regime established by section 43 Care Act 2014 – see above.

178. 14.29 - The Safeguarding Vulnerable Groups Act 2006 was amended by Protection of Freedoms Act 2012 which established the Disclosure and Barring Service and carries out the functions previously undertaken by the Criminal Records Bureau (CRB) and the Independent Safeguarding Authority (ISA). It is responsible for:

- Processing requests for, and issuing, DBS checks for England, Wales, the Channel Islands and the Isle of Man
- Making considered decisions regarding whether an individual should be barred from engaging in regulated activity with children, adults or both, in England, Wales and Northern Ireland
- Maintaining the children's and adults' barred lists

179. An enhanced DBS check is suitable for people working with children or adults in certain circumstances such as those in receipt of healthcare or personal care. An enhanced check is also suitable for a small number of other roles such as taxi licence applications or people working in the Gambling Commission.

180. An individual cannot apply for an enhanced check by themselves. There must be a recruiting organisation who needs the applicant to get the check. This is then sent to DBS through a [registered body](#).²

181. The service is free for [volunteers](#).³

14.32 - The regulator in England is the Care Quality Commission. In Wales the Regulation and Inspection of Social Care (Wales) Act 2016 came into force in April 2018 and required care homes previously registered under the Care Standards Act 2000 to register under the 2016 Act. In 2017, the social care workforce regulator Care Council for Wales became Social Care Wales.

Question 29 - Do you feel the scenarios in this chapter are both relevant and effective?

182. No

Please explain your answer, and if relevant please share a more suitable scenario.

183. These should be revised in light of the changes set out above.

Chapter 15 – What are the best ways to settle disagreements and disputes about issues covered in the Act?

Question 30: Does this chapter provide an up to date explanation about the best ways to settle disagreements and disputes about issues covered in the Act?

² <https://www.gov.uk/government/organisations/disclosure-and-barring-service/about>

³ <https://www.gov.uk/government/publications/disclosure-application-process-for-volunteers>

184. No

Please explain your answer. Where possible kindly provide clear reference to specific sections of the Code of Practice you are commenting on:

General points:

185. We agree with the philosophy in this chapter as to the value of settling disputes without litigation. It is important to strike the right balance with ensuring that appropriate cases are brought to court in a timely fashion. It may be useful to refer to the Office of the Public Guardian's mediation pilot (see for example <https://publicguardian.blog.gov.uk/2019/02/18/testing-how-an-opg-mediation-service-might-help-protect-vulnerable-people/>). We think it is essential to emphasise the importance in mediation and ADR of the person lacking capacity having a voice within the ADR process. As the Code notes at 5.64, an agreement may not in itself be in the person's best interests. The sections on legal aid are significantly out of date and require revision in light of the changes brought about by the Legal Aid Sentencing and Punishment of Offenders Act 2012 (LASPOA 2012).

186. Advocacy is often suggested in this chapter. It is important to make it clear firstly that advocates are not mediators. Secondly, there are significant pressures on advocacy services and their availability is likely to be contingent on the contracting arrangements between local authorities and advocacy services in a given area.

Specific points

187. Para 15.3- The CLS no longer exists

188. Para 15.4- We are concerned that this may present an unrealistic picture of the availability of advocacy services.

189. Para 15.6- This make an important point about the importance of a person lacking capacity being represented in mediation and ADR. Advocacy is not the only method of achieving this- an alternative may be for the person lacking capacity having legal representation.

190. Para 15.11- It is our understanding that the National Mediation Helpline has been closed and replaced by an online service. Family mediation is geared more specifically to separating couples and will not always be a useful source for disputes arising under the MCA. It may be worth mentioning that mediation can take place during the course of proceedings in the Court of Protection so can be deployed at a later stage of a dispute.

191. Para 15.14-15.32- This section will require updating to ensure it is still accurate following the NHS Act 2006, the Health and Social Care Act 2012 and the Care Act 2014. Some of the references are out of date for example the Mental Health Act Commission no longer exists and its functions have been assumed by the Care Quality Commission.

192. Para 15.35-15.36. It is always preferable to resolve disputes without litigation where possible. However as Peter Jackson J as he then was observed in *London Borough of Hillingdon v Neary* [2011] 4 AER 584, [2011] EWHC 1377 COP, Court of Protection proceedings need not be adversarial; they are inquisitorial in nature and judges take seriously their responsibility in COPR r1.3 to encourage parties to make use of ADR where this is appropriate. Contentious property and affairs cases will always be referred to a Dispute Resolution Hearing (Practice Direction 3B, paragraph 3.4).

193. Para 15.36- This needs to be updated in light of *An NHS Trust v Y (by his litigation friend the Official Solicitor) and others* [2018] UKSC 46, and to be consistent with other references in the Code.

194. Para 15.37-15.44- This section is out of date and should be re-written following LASPOA 2012.

Question 31. Do you feel the scenarios in this chapter are both relevant and effective?

195. Yes

Please explain your answer, and if relevant please share a more suitable scenario.

196. No comment

Chapter 16 – What rules govern access to information about a person who lacks capacity?

Question 32: Does this chapter provide an up to date explanation about the rules that govern access to information about a person who lacks capacity?

197. No

Please explain your answer. Where possible kindly provide clear reference to specific sections of the Code of Practice you are commenting on:

198. This chapter requires updating to take account of the General Data Protection Regulation.

Question 33: Do you feel the scenarios in this chapter are both relevant and effective?

199. No comment

Please explain your answer, and if relevant please share a more suitable scenario.

200. No comment

Key words and phrases used in the Code

Question 34: Are the key words and phrases up to date?

201. No

Please explain your answer. If relevant, please also provide suggestions of additional key words or phrases that should be included.

202. Adult Protection Procedures- replace with Adult Safeguarding Procedures

203. Aftercare under supervision- this has been abolished. Consider adding Community Treatment Order

204. Approved Social Worker- replace with Approved Mental Health Practitioner

205. Bournemouth Provisions- replace with Deprivation of Liberty Safeguards (and/or Liberty Protection Safeguards)

206. Mental Health Review Tribunal – only relevant to Wales and replaced in England with First Tier Tribunal (Mental Health). Consider using “Mental Health Tribunal” for both.

Annex A

Question 35: Is the Annex up to date?

207. No comment.

Please explain your answer, and if relevant please provide any other items you would find useful in the Annex:

208. No comment.

Bar Council
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