

IN THE MATTER OF THE MENTAL CAPACITY BILL

OPINION

Pt 1: OVERVIEW

1. I am further instructed on behalf of ALERT in respect of the latest version of the Mental Capacity Bill ('MCB') and the draft Code of Practice ('the Code') to be issued by virtue of clause 40. I am asked to review this version and to advise whether, in the light of recent case-law, MCB and/or the Code is/are compatible in all respects with the requirements of the European Convention on Human Rights ('ECHR').¹
2. The remainder of this Opinion is structured as follows. Pts 2 and 3 outline (respectively) the salient features of MCB and the Code that arise in the present context. Pt 4 sets out the essential points in the recent decision of the High Court in *R (Burke) v. GMC* (unrep, July 30th 2004) and the cases there referred to against which both MCB and the Code fall to be reviewed. Pt 5 contains my analysis and my Conclusions.

Pt 2: MCB – SALIENT FEATURES

3. The latest version of MCB differs in several respects from the predecessor version on which I advised previously.² I do not intend to consider the differences since what matters is, of course, the legality of the *current* version in terms of ECHR requirements.

¹ I have also been sent details of concerns expressed over the adequacy of the powers of the Court of Protection. However, these concerns raise issues of practice and are not referred to in my instructions. If the concerns were well founded and were to arise in due course they may raise questions of Convention compliance in particular cases. However, they do not affect the proper interpretation of MCB and are entirely outside the scope of my instructions.

² See Opinion dated August 2nd 2003.

4. In my view – taking into account ECHR requirements and the *Burke* case which I address below – I consider that the main features of MCB that require consideration are as set out in the succeeding paragraphs of this Pt.
5. Clause 1 contains a new formulation of the principles governing the exercise of powers under MCB. There are six principles. Four relate to the ascertainment of whether or not a person has the requisite capacity to make decisions for himself or herself. They are unobjectionable and reflect existing case-law. Importantly, clause 1(3) imposes the requirement that *‘[a] person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.’*
6. The remaining two principles relate to ‘best interests.’ Clause 1(5) stipulates that *‘[a]n act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.’* Clause 1(6) provides that: *‘[b]efore the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.’*
7. These principles are very general and, as will be seen, there is little elaboration of what is or is not in a person’s best interests. It is, of course, true that the content of ‘best interests’ will differ from case to case. However, the fundamental rights aspects of ‘best interests’ – in particular, dignity – are nowhere referred to. The reasoning of Munby J in *Burke* (see below) suggests that this is an important omission. It is one to which I will return.
8. Clauses 2-3 follow the pattern of the general principles in clause 1 and refer back to capacity.

9. Clause 4 is pivotal and is at the heart of the obligations under MCB. It is a general set of duties lying on anyone exercising powers under MCB. Clause 4(1) provides thus:

‘In determining for the purposes of this Act what is in a person’s best interests, the person making the determination must consider all the circumstances appearing to him to be relevant.’

10. There follow, in clauses 4(2)-4(6) a series of indicative ‘steps’ that must ‘*in particular*’ be taken. These include (see clause 4(6)) requirements – where practicable and appropriate – of consultation and, where ‘*reasonably ascertainable*’ (see clause 4(5)), the incapacitated person’s past and present wishes and feelings and beliefs and values must be ‘*considered*.’

11. So, it can be seen that under the MCB regime, the core values of a person – such as his religious convictions – are, albeit important, merely factors that must be considered by the person exercising statutory powers under the Act. This aspect of MCB is, I consider, at odds with the judgment in *Burke* and (for that reason) incompatible with Article 8 ECHR (see below). Clause 4(8) further provides that in the case of a person other than the Court, there is sufficient compliance with clause 4 provided that ‘... *he reasonably believes that what he does or decides is in the best interests of the person concerned.*’

12. Clause 5 is also important. That concerns acts in connection with ‘*care or treatment.*’ I highlight the word ‘*care*’ because, under that provision, a person providing (or ceasing to provide) *care* – as well as *treatment* – is immunised from civil liability provided that (see clause 5(1)) he – having made the requisite inquiry – ‘*reasonably believes*’ that the affected person lacks capacity and that it will be in the best interests of the person for the act to be done. Materially, although clause 5(4) makes it clear that an advance decision (for which separate provision is made in clauses 24-26) prevents the exercise of contrary power under clause 4, advance

decisions appear to relate only to *'treatment'* and do not obviously extend to *'care.'* This is another material omission and, in my view, is clearly contrary to the ECHR. I develop this reasoning below.

13. Clause 6 sets out two further restrictions on the exercise of statutory power under MCB where it is sought to *restrain* the incapacitated person. Sensibly, MCB requires the restraint to be believed to be necessary; it must also be objectively proportionate.
14. However, clause 6(5) (which is separately concerned with the operation of clause 5) provides that nothing in clause 5 authorises a person to do an act that conflicts with a decision made within the scope of his authority and in accordance with the Act by a donee of a lasting power of attorney or by a deputy appointed by the Court. There is an exception (see clause 6(6)) for the provision of life-saving treatment whilst a decision is sought from the Court. This severe restriction on what (say) a carer or doctor can do in a person's best interests means that the carer or doctor will, in many instances, be powerless to act in what they reasonably consider to be the patient's best interests. Thus, (short of providing life-saving treatment) a doctor who considered that the donee of a lasting power of attorney was acting unreasonably and contrary to the patient's best interests would be acting unlawfully under clause 6(5) if (s)he did anything to conflict with what the donee had decided. I consider that this is potentially contrary to Article 8 ECHR (see below).
15. Clauses 9-14 deal with lasting powers of attorney. I have addressed these powers in other Opinions and will not dwell on them here. Lasting powers of attorney are (see clause 9(4)) subject to clause 4 as well as to any restrictions or conditions specified in the instrument of appointment. As has been well publicised, the lasting power of attorney includes – at least where the instrument of appointment so specifies – the giving or refusing consent to the carrying out or continuation of treatment by a person providing health care to the patient (see clause 11(6)(c)).

16. The powers of the Court of Protection (the designated ‘court’ for the purposes of MCB) are outlined in clauses 15-23 and clauses 43-54. Again, I have addressed these in earlier Opinions. The essential machinery of the Court has not changed in the different versions of MCB. The important point to note, for present purposes, is that there is no mechanism for ensuring that the Court considers the position of a patient at any particular stage. There is no *requirement* to seek the Court’s approval.³ There is provision for the Court to appoint a deputy (see clauses 16-20). However, the relationship between powers exercised by a deputy on the one hand and the donee of a lasting power of attorney on the other are unclear. I consider, for reasons developed below, that the absence of a mechanism for bringing a patient’s case before the Court is in violation of Article 8 ECHR as is, potentially, the statutory elevation given to the donee of a lasting power of attorney over anyone else providing care and/or treatment and possible even over a deputy appointed by the Court.

17. Advance decisions are covered by clauses 24-26. I have considered these powers extensively in other Opinions. There are two short points to make about the MCB regime. First, advance decisions only extend to ‘*treatment.*’ Treatment, though widely defined (see clause 60) is defined in terms of health care. The concept of ‘treatment’ appears to differ from that of (say) personal care (see, e.g. clause 5 which expressly distinguishes between ‘care’ and ‘treatment’). MCB is, in my view, defective in not expressly legislating for advance decisions in the context of care as well as treatment. Whilst a Court would probably interpret clauses 24-26 as embracing personal care it is by no means obvious that it would do so and the position should be clarified. Plainly, if personal care were excluded from the ambit of clauses 24-26 that would be in breach of Article 8 as infringing the principle of autonomy (see below).

18. The second point to make about advance decisions is that there is no safeguard in MCB (though the Code attempts to address the difficulties) for ensuring that advance decisions are properly scrutinised and that true effect is given to the then competent

³ Note, too, the restrictions on being apply to apply to the Court without permission (clause 48).

patient's wishes. I have already addressed this point at length in my August 2003 Opinion (see paragraphs 17-20 and 68).

19. Finally (for present purposes) there are the 'research' clauses (see clauses 30-33). These allows for 'intrusive research' to be carried out on incapacitated patients subject to what are termed 'safeguards.' There is provision, as one would expect, for consultation (where practicable) with carers and similar persons (clause 32). The research (clause 31) must have the potential to benefit the patient and must not impose a disproportionate burden on him. It must be research that would not be as effective if carried out with respect only to those with the capacity to consent to it (clause 31). If the incapacitated patient 'objects' (see clause 33) it must be stopped. It must also not be proceeded with without a Court application if a person consulted advises that the patient would be likely to have declined to proceed with the project (clause 32). However, in those circumstances the Court – on application – may still declare that it is lawful for the research to be undertaken if it considers that the research has the potential to benefit the patient and will not impose a disproportionate burden (clause 32(8)). For reasons developed below, I consider that this provision is contrary (at least) to Article 8 ECHR and, perhaps also, contrary to Article 3 ECHR.
20. These are, to my mind, the main provisions of the latest version of MCB that require review in the light of the decision in *Burke* and of the case-law referred to therein.⁴

Pt 3: THE CODE – SALIENT FEATURES

21. The Code is issued under clause 40. In fairness to its drafters it recognises that it may well require revision in the light of the decision in *Burke*. The difficulty (see below) is that the structure of MCB also requires revision in the light of that

⁴ There are many other important provisions in MCB such as the appointment of independent consultees and the public guardian. However, these are not germane to my present instructions which are to review my former Opinion in the light of *Burke*.

judgment. The profound implications of *Burke* cannot, in my judgment, be left to the Code which is, in any event, largely advisory.⁵

22. In general terms the Code is extremely helpful with many practical examples designed to amplify the somewhat skeletal nature of the primary legislation. Nothing, however, in the Code can replace the structural defects of MCB to which I have already made reference.

23. I regard the following four features of the Code as material in the present context.

24. First, there is no reference whatever to the core values of dignity or the reflection that must be given to autonomy as a facet of Article 8: see *Burke*, below. This is unsurprising given that, so far as I can see, the ECHR and its principles do not surface in the Code at all. This is a serious omission. Even if individual carers or donees of a lasting power of attorney are not a '*public authority*' within the meaning of s. 8 of the Human Rights Act 1998, the State is under a positive obligation to ensure that a patient's fundamental rights are observed. In my opinion, the State is – when issuing a Code of Practice – under a correlative positive obligation to ensure that all persons exercising powers in respect of an incapacitated person are fully aware of the need to protect that patient's fundamental rights under the ECHR.

25. Secondly, I have considerable concern over the content of paragraph 4.22 of the Code. The last sentence reads as follows:

' ... While neither past nor present wishes can determine the decision which is now to be made, both are important and must be weighed against each other and considered alongside other factors in the checklist.'

⁵ Though the Court must take account of it when deciding whether action has been taken in a patient's best interests.

26. The implication of this is that no matter what the incapacitated person's values and wishes (even when fully competent) they are merely one factor in a general balancing exercise to be conducted (on the basis of reasonable belief in what is the patient's best interests) to be conducted by the person exercising the statutory power. In my opinion this is entirely at odds with the principle of autonomy as explained in *Burke* and with the imperatives of Article 8 (see below). In that context, the example given at p. 38 is, at least ostensibly, internally inconsistent with the advice given in paragraph 4.22.
27. Thirdly, paragraph 5.17 seems deliberately to limit the scope of advance decisions to the purely *medical*. I have already indicated that I consider this to be contrary to Article 8 ECHR and that all forms of care and treatment must be capable of being the subject of an advance decision. The Code should state this in express terms. In this respect, other provisions of the Code require revision: see, especially, paragraphs 8.3-8.5 which refer only to *medical* treatment.
28. Finally, paragraph 6.11 of the Code (donees of a lasting power of attorney cannot require treatment) plainly requires revision in the light of *Burke*. As that case demonstrates, there are now circumstances in which a competent patient *can* require treatment. The same principle must, logically, apply equally to those acting on behalf of incapacitated patients.
29. I should emphasise that the above are not the only features of the Code that are, in my view, incompatible with the ECHR since, in many areas, the Code seeks to explain aspects of MCB that are, if my analysis is right, also incompatible with the ECHR. However, the above features are to my mind additional features of (or omissions in) the Code that would require rectification in any event.

Pt 4: BURKE AND THE ATTENDANT CASE-LAW

30. It is clear that the decision in *Burke* is extremely important and has enormous implications both for MCB and the Code. In that case Munby J engaged in an extensive analysis that is, for the most part, as relevant to the incapacitated patient as it is to the competent patient (see paragraph 40 of the judgment). The paragraphs of the judgment and/or passages set out hereunder are particularly relevant in the present context.

31. At paragraph 45 the Judge observes that the legal classification of ‘competent’ as opposed to ‘incompetent’ patient *‘tends to cut across the underlying medical realities.’*

32. At paragraph 57, Munby J cites his own observations in the earlier case of *R (A,B,X and Y) v. East Sussex CC and the Disability Rights Commission (No 2) (2003) 6 CCLR 194* at paragraph 86. The first sentence gives the flavour:

‘The recognition and protection of human dignity is one of the core values – in truth the core value – of our society and, indeed, of all the societies which are part of the European family of nations and which have embraced the principles of the Convention ...’.

33. As the Judge then observes in the next paragraph (58) of his judgment in *Burke*: ‘... it is not just the sentient or self-conscious who have dignity interests protected by the law.’⁶ So, patients who have dignity interests protected by the law include the incapacitated just as much as those possessing legal capacity to make decisions for themselves. An important source of this obligation is Article 8 ECHR. As Munby J explains,⁷ the European Court of Human Rights in *Pretty v. United Kingdom (2002) 35 EHRR 1* said this (at paragraph 61):

⁶ To similar effect, see *Airedale NHS Trust v. Bland [1993] A.C. 789, 829* per Lord Hoffmann.

⁷ See paragraph 59.

‘ ... the concept of “private life” is a broad term not susceptible to exhaustive definition. It covers the physical and psychological integrity of a person. It can sometimes embrace aspects of an individual’s physical and social identity... Article 8 also protects a right to personal development, and the right to establish and develop relationships with other human beings and the outside world. Though no previous case has established as such any right to self-determination as being contained in Article 8 of the Convention, the Court considers that the notion of personal autonomy is an important principle underlying the interpretation of its guarantees.’

34. This passage is very important.. Crucially, it seems to follow that the right to self-determination is one that must be respected as much in the incompetent as the competent *to such extent as is possible*. Thus, the known values and wishes of a person should, *prima facie*, be complied with and should certainly be complied with if reached at a time when the patient was competent (even though that person is no longer competent). That is why the known values of the incapacitated are not merely one of a number of indicia to be balanced by (say) the donee of a lasting power of attorney. It is also why intrusive research should not be imposed on an incapacitated patient by the Court (as under the current regime it may be) even though it is known that the patient would have declined to permit such research.
35. Munby J also explains in *Burke* (see paragraph 63) that the requirement to protect dignity is also encompassed in Article 3 ECHR. He points out that the disabled (and, logically, the incapacitated) may require *enhanced* protection to give effect to that requirement (see paragraphs 67-72).
36. In considering the question of ‘best interests’ Munby J emphasises the important point that best interests are not confined to best *medical* interests (see, especially, paragraphs 88-94). Ultimately, ‘best interests’ in the context of an incapacitated patient is a matter for the Court (paragraphs 93 and 116) and goes well beyond the purely medical. In deciding whether life prolonging treatment is in such a patient’s

best interests there is a **very strong presumption** in favour of the preservation of life. At paragraph 111, Munby J crystallises his reasoning in this respect to two essential points. First, the assessment of best interests has to be made from ‘*the point of view or perspective of the particular patient*’. Secondly, the touchstone of best interests in the context of preserving life is whether to preserve life would be ‘intolerable’ for the patient (see paragraph 111 but also the careful analysis by reference to the case-law at paragraphs 98-110).

37. This is very far from the notion of a mere balancing exercise conducted against a backcloth of general reasonableness. In the light of *Burke* and the cases there referred to the whole process of ascertaining the best interests of an incapacitated patient is one that is founded almost entirely on what the patient would have chosen in the light of his or her personal values. If life-prolonging treatment is providing even *some* benefit it should be provided unless the patient’s life if thus prolonged would from the patient’s point of view be **intolerable** (paragraph 116).
38. Munby J next observes at paragraph 120 of his judgment in *Burke* that Articles 2, 3 and 8 can impose positive obligations on the State. The scope and content of the obligations under these provisions are reached by looking at the Convention as a whole (see paragraphs 123-125). That is why analysis of the State’s duties under Article 2 are, to an extent, conditioned by Articles 3 and 8. In particular, there is no obligation under Article 2 to provide life prolonging treatment where, to do so, would violate Article 3 (see paragraph 129).
39. Importantly, Munby J makes it clear that the fact that a person may not be sentient is no indicator of the fact that he or she cannot be the subject of inhuman or degrading treatment under Article 3. In that respect he differs from the President of the Family Division who had reached the opposite conclusion (see, especially, Munby J’s analysis at paragraphs 144-151).

40. The central *ratio* of *Burke* is that a competent patient is entitled to *require* treatment (at least where there are no resource constraints) even where that treatment is not considered by the clinicians to be in his or her best interests. Whilst clinicians cannot be compelled to treat, a hospital trust must – in such circumstances – make the necessary arrangements to ensure that a clinician is made available to provide the treatment in question (see paragraphs 163-177 and 191-194). In practical terms, the Judge makes it clear that in the context of basic life prolonging treatment, the withdrawal of such treatment – save where it would be intolerable from the patient’s point of view – is likely to be unlawful whether the patient is competent or incompetent (see paragraph 172).

41. Finally, and highly relevant to one aspect of MCB, Munby J holds – by reference to Article 8 imperatives – that where it is proposed to withhold or withdraw life prolonging artificial nutrition and hydration prior judicial authorisation must be obtained in most circumstances (see paragraph 202). The *requirement* that the Court be involved in such issues stems from the common law (paragraph 203) but it is **enhanced** by the advent of the Human Rights Act 1998 and the right to respect for private and family life under Article 8(1). In view of the very recent decision of the European Court of Human Rights in *Glass v. United Kingdom* (decided after the argument in *Burke* had been completed) this is now a legal requirement. As Munby J observes at paragraph 210:

‘ ... The primary significance of there being the obligation under Article 8 identified in Glass II is that what was previously only a matter of good practice is now, by reason of the Human Rights Act 1998, a matter of legal requirement. That, it seems to me, is a significant and potentially very important change.’

42. *Burke* – as it seems to me – illuminates a number of defects in the current version of MCB and the Code. I will endeavour to draw the strands together in the next Pt of this Opinion. I should emphasise that I have already advised in respect of many aspects of MCB especially in respect of advance decisions and the lasting power of

attorney. The matters set out below are additional to that advice and arise as a consequence of the decision in *Burke*.

Pt 5: ANALYSIS AND CONCLUSIONS

43. First, Munby J's analysis in *Burke* demonstrates that MCB clause 4 is at least potentially incompatible, as it stands, with Article 8 ECHR. This is because clause 4 would enable a person determining 'best interests' to treat the past and present wishes, beliefs and values of an incapacitated person as mere considerations (albeit important ones since expressly referred to in the statute) and to decide the question of best interests in the light of 'all the circumstances appearing to him to be relevant.' Further, there is no statutory requirement on the part of the donee of a lasting power of attorney to apply any different or special criteria when it comes to deciding whether to consent to, or to refuse, life-sustaining treatment. There is no underlying statutory requirement that a decision as to 'best interests' must, in order to be reasonable, be taken entirely from the perspective of the patient rather than by reference to external factors in the subjective appreciation of the person exercising the power.

44. Secondly, clause 6(5) has the likely effect, in practice, of permitting the donee of a lasting power of attorney in at least some instances to act towards an incapacitated patient in a way that a carer or doctor or other health or social care professional may perceive as wholly unreasonable but be powerless in law to do anything about. If they were to make any contrary decision that would, according to MCB, be unlawful. This is, to my mind, also in breach of Article 8 on *Burke* lines since – coupled with the lack of any machinery for bringing the matter before a Court - such a consequence means that the State has provided no effective mechanism for protecting the patient's private life under Article 8. Put starkly, even though professionals can clearly see that a patient's private life is not being respected or that, to say the least, his best interests are not being protected they can – in most cases – do nothing.

45. Thirdly, there is no statutory or other machinery requiring cases to be brought before, or reviewed by, the Court of Protection. As explained above, this is a violation of Article 8 at least in cases where decisions are being made as to the withdrawal of life prolonging treatment. As MCB stands at present, the donee of a lasting power of attorney may make such a decision with no obligation on him or anyone else to bring the matter before the Court. In previous Opinions I have stated that I considered this to be a breach of Article 6 ECHR. *Burke* and *Glass II* clarify that it is, in fact, a breach of Article 8 as opposed to Article 6.
46. Fourthly, the statutory regime and Code appear to envisage that advance decisions relate only to medical treatment. In view of *Burke* this cannot be so. An incapacitated patient who, when competent, made an advance decision as to the provision or non-provision of particular types of care must be entitled to have those wishes respected as a facet of his right to self-determination. The Code, in particular, needs radical revision in that respect. But so, too, does MCB.
47. Fifthly, the research clauses are clearly in breach of Article 8 ECHR having regard to the reasoning in *Burke*. The plain consequence of them is that whilst a competent patient may refuse to be subjected to intrusive research, MCB envisages that an incapacitated patient may be so subjected even those his or her carers (for example) have clearly advised that the patient would have declined to take part. The Court may take a decision to impose intrusive research on such a patient. That is, in my opinion, both potentially discriminatory under Article 14 ECHR (in conjunction with Article 8). But it is also an infringement under Article 8 alone – on *Burke* reasoning – of the incapacitated patient’s right to self-determination in so far as that is practicable.
48. So far as the Code is concerned, I consider that it is defective for the reasons specified in paragraphs 24-28 above. There is, in particular, no reference whatever to the importance of protecting an incapacitated patient’s core right to dignity under Article 8 and, hence, of needing to make ‘best interest’ decisions entirely from the

perspective of the individual patient's viewpoint. There is virtually no reference to fundamental rights or to the ECHR which is a serious deficiency given the State's positive obligations under Article 8 as adumbrated in *Burke*.

49. This Opinion is intended as a review in the light of the *Burke* decision of advice previously given. It is not intended as independent advice and it needs, therefore, to be read in conjunction with those earlier Opinions. In one respect, at least, (mechanism of bringing cases before the Court) I have, as indicated above, modified my view as to the source of ECHR obligation for there to be a requirement to bring life prolonging treatment issues before the Court. The ECHR provenance is Article 8 and not, as I had previously considered, Article 6 ECHR.

50. The only other matter that I should add is that judgment in the *Bournewood* case to which I made reference in my last Opinion is to be published by the European Court of Human Rights on October 5th 2004. That decision, too, may have some relevance to MCB and the attendant Code.

51. For the present, no further points arise.

RICHARD GORDON Q.C.

Brick Court Chambers,
7-8 Essex Street,
London WC2.

October 1st 2004.