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

Section 5 of the Act allows carers, healthcare and social care staff to carry out certain tasks without fear of liability. These tasks involve the personal care, healthcare or treatment of people who lack capacity to consent to them. The aim is to give legal backing for acts that need to be carried out in the best interests of the person who lacks capacity to consent.19

This chapter explains:

• how the Act provides protection from liability
• how that protection works in practice
• where protection is restricted or limited, and
• when a carer can use a person’s money to buy goods or services without formal permission.

In this chapter, as throughout the Code, a person’s capacity (or lack of capacity) refers specifically to their capacity to make a particular decision at the time it needs to be made.

Quick summary

The following steps list all the things that people providing care or treatment should bear in mind to ensure they are protected by the Act.

**Acting in connection with the care or treatment of someone who lacks capacity to consent**

• Is the action to be carried out in connection with the care or treatment of a person who lacks capacity to give consent to that act?
• Does it involve major life changes for the person concerned? If so, it will need special consideration.
• Who is carrying out the action? Is it appropriate for that person to do so at the relevant time?

**Checking whether the person has capacity to consent**

• Have all possible steps been taken to try to help the person make a decision for themselves about the action?
• Has the two-stage test of capacity been applied?
• Are there reasonable grounds for believing the person lacks capacity to give permission?

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19 The provisions of section 5 are based on the common law ‘doctrine of necessity’ as set out in *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1
Acting in the person’s best interests

- Has the best interests checklist been applied and all relevant circumstances considered?
- Is a less restrictive option available?
- Is it reasonable to believe that the proposed act is in the person’s best interests?

Understanding possible limitations on protection from liability

- If restraint is being considered, is it necessary to prevent harm to the person who lacks capacity, and is it a proportionate response to the likelihood of the person suffering harm – and to the seriousness of that harm?
- Could the restraint be classed as a ‘deprivation of the person’s liberty’?
- Does the action conflict with a decision that has been made by an attorney or deputy under their powers?

Paying for necessary goods and services

- If someone wishes to use the person’s money to buy goods or pay for services for someone who lacks capacity to do so themselves, are those goods or services necessary and in the person’s best interests?
- Is it necessary to take money from the person’s bank or building society account or to sell the person’s property to pay for goods or services? If so, formal authority will be required.

What protection do people have when caring for those who lack capacity to consent?

6.1 Every day, millions of acts are done to and for people who lack capacity either to:

- take decisions about their own care or treatment, or
- consent to someone else caring for them.

Such acts range from everyday tasks of caring (for example, helping someone to wash) to life-changing events (for example, serious medical treatment or arranging for someone to go into a care home).

In theory, many of these actions could be against the law. Legally, people have the right to stop others from interfering with their body or property unless they give permission. But what happens if someone lacks capacity to give permission? Carers who dress people who cannot dress themselves are potentially interfering with someone’s body without their consent, so could theoretically be prosecuted for assault. A neighbour who enters and cleans the house of a person who lacks capacity could be trespassing on the person’s property.

6.2 Section 5 of the Act provides ‘protection from liability’. In other words, it protects people who carry out these actions. It stops them being prosecuted for acts that could otherwise be classed as civil wrongs or crimes. By
protecting family and other carers from liability, the Act allows necessary caring acts or treatment to take place as if a person who lacks capacity to consent had consented to them. People providing care of this sort do not therefore need to get formal authority to act.

6.3 Importantly, section 5 does not give people caring for or treating someone the power to make any other decisions on behalf of those who lack capacity to make their own decisions. Instead, it offers protection from liability so that they can act in connection with the person’s care or treatment. The power to make decisions on behalf of someone who lacks capacity can be granted through other parts of the Act (such as the powers granted to attorneys and deputies, which are explained in chapters 7 and 8).

What type of actions might have protection from liability?

6.4 Section 5(1) provides possible protection for actions carried out in connection with care or treatment. The action may be carried out on behalf of someone who is believed to lack capacity to give permission for the action, so long as it is in that person’s best interests (see chapter 5). The Act does not define ‘care’ or ‘treatment’. They should be given their normal meaning. However, section 64(1) makes clear that treatment includes diagnostic or other procedures.

6.5 Actions that might be covered by section 5 include:

**Personal care**

- helping with washing, dressing or personal hygiene
- helping with eating and drinking
- helping with communication
- helping with mobility (moving around)
- helping someone take part in education, social or leisure activities
- going into a person’s home to drop off shopping or to see if they are alright
- doing the shopping or buying necessary goods with the person’s money
- arranging household services (for example, arranging repairs or maintenance for gas and electricity supplies)
- providing services that help around the home (such as homecare or meals on wheels)
- undertaking actions related to community care services (for example, day care, residential accommodation or nursing care) – but see also paragraphs 6.7–6.14 below
- helping someone to move home (including moving property and clearing the former home).

**Healthcare and treatment**
• carrying out diagnostic examinations and tests (to identify an illness, condition or other problem)
• providing professional medical, dental and similar treatment
• giving medication
• taking someone to hospital for assessment or treatment
• providing nursing care (whether in hospital or in the community)
• carrying out any other necessary medical procedures (for example, taking a blood sample) or therapies (for example, physiotherapy or chiropody)
• providing care in an emergency.

6.6 These actions only receive protection from liability if the person is reasonably believed to lack capacity to give permission for the action. The action must also be in the person’s best interests and follow the Act’s principles (see paragraph 6.26 onwards).

6.7 Some acts in connection with care or treatment may cause major life changes with significant consequences for the person concerned. Those requiring particularly careful consideration include a change of residence, perhaps into a care home or nursing home, or major decisions about healthcare and medical treatment. These are described in the following paragraphs.

A change of residence
6.8 Sometimes a person cannot get sufficient or appropriate care in their own home, and they may have to move – perhaps to live with relatives or to go into a care home or nursing home. If the person lacks capacity to consent to a move, the decision-maker(s) must consider whether the move is in the person’s best interests (by referring to the best interests checklist in chapter 5 and in particular the person’s past and present wishes and feelings, as well as the views of other relevant people). The decision-maker(s) must also consider whether there is a less restrictive option (see chapter 2, principle 5).

This may involve speaking to:
• anyone currently involved in the person’s care
• family carers and other family members close to the person and interested in their welfare
• others who have an interest in the person’s welfare
• anyone the person has previously named as someone to be consulted, and
• an attorney or deputy who has been legally appointed to make particular decisions on their behalf.

6.9 Some cases will require an Independent Mental Capacity Advocate (IMCA). The IMCA represents and supports the person who lacks capacity and they will provide information to make sure the final decision is in the person’s best interests (see chapter 10). An IMCA is needed when there is no-one close to the person who lacks capacity to give an opinion about what is best for them, and:
• an NHS body is proposing to provide serious medical treatment or
• an NHS body or local authority is proposing to arrange accommodation in a hospital or a care home or other longer-term accommodation and
  – the person will stay in hospital longer than 28 days, or
  – they will stay in a care home for more than eight weeks.

There are also some circumstances where an IMCA may be appointed on a discretionary basis. More guidance is available in chapter 10.

6.10 Sometimes the final outcome may not be what the person who lacks capacity wanted. For example, they might want to stay at home, but those caring for them might decide a move is in their best interests. In all cases, those making the decision must first consider other options that might restrict the person’s rights and freedom of action less (see chapter 2, principle 5).

6.11 In some cases, there may be no alternative but to move the person. Such a move would normally require the person’s formal consent if they had capacity to give, or refuse, it. In cases where a person lacks capacity to consent, section 5 of the Act allows carers to carry out actions relating to the move – as long as the Act’s principles and the requirements for working out best interests have been followed. This applies even if the person continues to object to the move.

However, section 6 places clear limits on the use of force or restraint by only permitting restraint to be used (for example, to transport the person to their new home) where this is necessary to protect the person from harm and is a proportionate response to the risk of harm (see paragraphs 6.40–6.53). Any action taken to move the person concerned or their property could incur liability unless protected under section 5.

6.12 If there is a serious disagreement about the need to move the person that cannot be settled in any other way, the Court of Protection can be asked to decide what the person’s best interests are and where they should live. For example, this could happen if members of a family disagree over what is best for a relative who lacks capacity to give or deny permission for a move.

6.13 In some circumstances, being placed in a hospital or care home may deprive the person of their liberty (see paragraphs 6.49–6.53). If this is the case, there is no protection from liability – even if the placement was considered to be in the best interests of the person (section 6(5)). It is up to the decision-maker to first look at a range of alternative and less restrictive options to see if there is any way of avoiding taking away the person’s liberty.

6.14 If there is no alternative way of caring for the person, specific authority will be required to keep the person in a situation which deprives them of their liberty. For instance, sometimes the Court of Protection might be prepared to grant an order of which a consequence is the deprivation of a person’s liberty – if it is satisfied that this is in the person’s best interests. In other cases, if the person needs treatment for a mental disorder and meets the criteria for detention under the Mental Health Act 1983, this may be used to admit or keep the person in hospital (see chapter 13).
Healthcare and treatment decisions

6.15 Section 5 also allows actions to be taken to ensure a person who lacks capacity to consent receives necessary medical treatment. This could involve taking the person to hospital for out-patient treatment or arranging for admission to hospital. Even if a person who lacks capacity to consent objects to the proposed treatment or admission to hospital, the action might still be allowed under section 5 (but see paragraphs 6.20 and 6.22 below). But there are limits about whether force or restraint can be used to impose treatment (see paragraphs 6.40–6.53).

6.16 Major healthcare and treatment decisions – for example, major surgery or a decision that no attempt is to be made to resuscitate the patient (known as ‘DNR’ decisions) – will also need special consideration. Unless there is a valid and applicable advance decision to refuse the specific treatment, healthcare staff must carefully work out what would be in the person’s best interests (see chapter 5). As part of the process of working this out, they will need to consider (where practical and appropriate):

- the past and present wishes and feelings, beliefs and values of the person who lacks capacity to make the treatment decision, including any advance statement the person wrote setting out their wishes when they had capacity
- the views of anyone previously named by the person as someone to be consulted
- the views of anyone engaged in caring for the person
- the views of anyone interested in their welfare, and
- the views of any attorney or deputy appointed for the person.

In specific cases where there is no-one else available to consult about the person’s best interests, an IMCA must be appointed to support and represent the person (see paragraph 6.9 above and chapter 10).

Healthcare staff must also consider whether there are alternative treatment options that might be less intrusive or restrictive (see chapter 2, principle 5). When deciding about the provision or withdrawal of life-sustaining treatment, anyone working out what is in the best interests of a person who lacks capacity must not be motivated by a desire to bring about the person’s death (see chapter 5).

6.17 Multi-disciplinary meetings are often the best way to decide on a person’s best interests. They bring together healthcare and social care staff with different skills to discuss the person’s options and may involve those who are closest to the person concerned. But final responsibility for deciding what is in a person’s best interest lies with the member of healthcare staff responsible for the person’s treatment. They should record their decision, how they reached it and the reasons for it in the person’s clinical notes. As long as they have recorded objective reasons to show that the decision is in the person’s best interests, and the other requirements of section 5 of the Act are met, all healthcare staff taking actions in connection with the particular treatment will be protected from liability.
Some treatment decisions are so serious that the court has to make them – unless the person has previously made a Lasting Power of Attorney appointing an attorney to make such healthcare decisions for them (see chapter 7) or they have made a valid advance decision to refuse the proposed treatment (see chapter 9). The Court of Protection must be asked to make decisions relating to:

- the proposed withholding or withdrawal of artificial nutrition and hydration (ANH) from a patient in a permanent vegetative state (PVS)
- cases where it is proposed that a person who lacks capacity to consent should donate an organ or bone marrow to another person
- the proposed non-therapeutic sterilisation of a person who lacks capacity to consent (for example, for contraceptive purposes)
- cases where there is a dispute about whether a particular treatment will be in a person’s best interests.

See paragraphs 8.18–8.24 for more details on these types of cases.

This last category may include cases that introduce ethical dilemmas concerning untested or innovative treatments (for example, new treatments for variant Creutzfeldt-Jakob Disease (CDJ)) where it is not known if the treatment will be effective, or certain cases involving a termination of pregnancy. It may also include cases where there is conflict between professionals or between professionals and family members which cannot be resolved in any other way.

Where there is conflict, it is advisable for parties to get legal advice, though they may not necessarily be able to get legal aid to pay for this advice. Chapter 8 gives more information about the need to refer cases to court for a decision.

Who is protected from liability by section 5?

Section 5 of the Act is most likely to affect:

- family carers and other kinds of carers
- care workers
- healthcare and social care staff, and
- others who may occasionally be involved in the care or treatment of a person who lacks capacity to consent (for example, ambulance staff, housing workers, police officers and volunteer support workers).

At any time, it is likely that several people will be carrying out tasks that are covered by section 5 of the Act. Section 5 does not:

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20 The procedures resulting from those court judgements are set out in a Practice Note from the Official Solicitor (available at www.officialsolicitor.gov.uk) and will be set out in a Practice Direction from the new Court of Protection.
• give one person more rights than another to carry out tasks
• specify who has the authority to act in a specific instance
• allow somebody to make decisions relating to subjects other than the care or treatment of the person who lacks capacity, or
• allow somebody to give consent on behalf of a person who lacks capacity to do so.

6.22 To receive protection from liability under section 5, all actions must be related to the care or treatment of the person who lacks capacity to consent. Before taking action, carers must first reasonably believe that:

• the person lacks the capacity to make that particular decision at the time it needs to be made, and
• the action is in the person’s best interests.

This is explained further in paragraphs 6.26–6.34 below.

Scenario: Protecting multiple carers

Mr Rose, an older man with dementia, gets help from several people. His sister sometimes cooks meals for him. A district nurse visits him to change the dressing on a pressure sore, and a friend often takes Mr Rose to the park, guiding him when they cross the road. Each of these individuals would be protected from liability under section 5 of the Act – but only if they take reasonable steps to check that he lacks capacity to consent to the actions they take and hold a reasonable belief that the actions are in Mr Rose’s best interests.

6.23 Section 5 may also protect carers who need to use the person’s money to pay for goods or services that the person needs but lacks the capacity to purchase for themselves. However, there are strict controls over who may have access to another person’s money. See paragraphs 6.56–6.66 for more information.

6.24 Carers who provide personal care services must not carry out specialist procedures that are normally done by trained healthcare staff. If the action involves medical treatment, the doctor or other member of healthcare staff with responsibility for the patient will be the decision-maker who has to decide whether the proposed treatment is in the person’s best interests (see chapter 5). A doctor can delegate responsibility for giving the treatment to other people in the clinical team who have the appropriate skills or expertise. People who do more than their experience or qualifications allow may not be protected from liability.

Care planning

6.25 Decisions about a person’s care or treatment are often made by a multi-disciplinary team (a team of professionals with different skills that contribute to a person’s care), by drawing up a care plan for the person. The preparation of a care plan should always include an assessment of the person’s capacity to consent to the actions covered by the care plan, and confirm that those
actions are agreed to be in the person’s best interests. Healthcare and social care staff may then be able to assume that any actions they take under the care plan are in the person’s best interests, and therefore receive protection from liability under section 5. But a person’s capacity and best interests must still be reviewed regularly.

What steps should people take to be protected from liability?

6.26 As well as taking the following steps, somebody who wants to be protected from liability should bear in mind the statutory principles set out in section 1 of the Act (see chapter 2).

6.27 First, reasonable steps must be taken to find out whether a person has the capacity to make a decision about the proposed action (section 5(1)(a)). If the person has capacity, they must give their consent for anyone to take an action on their behalf, so that the person taking the action is protected from liability. For guidance on what is classed as ‘reasonable steps’, see paragraphs 6.29–6.34. But reasonable steps must always include:

- taking all practical and appropriate steps to help people to make a decision about an action themselves, and
- applying the two-stage test of capacity (see chapter 4).

The person who is going to take the action must have a ‘reasonable belief’ that the individual lacks capacity to give consent for the action at the time it needs to be taken.

6.28 Secondly, the person proposing to take action must have reasonable grounds for believing that the action is in the best interests of the person who lacks capacity. They should apply all elements of the best interests checklist (see chapter 5), and in particular

- consider whether the person is likely to regain capacity to make this decision in the future. Can the action wait until then?
- consider whether a less restrictive option is available (chapter 2, principle 5), and
- have objective reasons for thinking an action is in the best interests of the person who lacks capacity to consent to it.

What is ‘reasonable’?

6.29 As explained in chapter 4, anyone assessing a person’s capacity to make decisions for themselves or give consent must focus wholly on whether the person has capacity to make a specific decision at the time it needs to be made and not the person’s capacity to make decisions generally. For example, a carer helping a person to dress can assess a person’s capacity to agree to their help by explaining the different options (getting dressed or staying in nightclothes), and the consequences (being able to go out, or staying in all day).

6.30 Carers do not have to be experts in assessing capacity. But they must be able to show that they have taken reasonable steps to find out if the person has the capacity to make the specific decision. Only then will they have reasonable
grounds for believing the person lacks capacity in relation to that particular matter. See paragraphs 4.44–4.45 for guidance on what is classed as ‘reasonable’ – although this will vary, depending on circumstances.

6.31 For the majority of decisions, formal assessment processes are unlikely to be required. But in some circumstances, professional practice requires some formal procedures to be carried out (for example, where consent to medical treatment is required, the doctor will need to assess – and record the person’s capacity to consent). Under section 5, carers and professionals will be protected from liability as long as they are able to provide some objective reasons that explain why they believe that the person lacks capacity to consent to the action. If somebody challenges their belief, both carers and professionals will be protected from liability as long as they can show that they took steps to find out whether the person has capacity and that they have a reasonable belief that the person lacks capacity.

6.32 Similarly, carers, relatives and others involved in caring for someone who lacks capacity must have reasonable grounds for believing that their action is in the person’s best interests. They must not simply impose their own views. They must be able to show that they considered all relevant circumstances and applied the best interests checklist. This includes showing that they have tried to involve the person who lacks capacity, and find out their wishes and feelings, beliefs and values. They must also have asked other people’s opinions, where practical and appropriate. If somebody challenges their decision, they will be protected from liability if they can show that it was reasonable for them to believe that their action was in the person’s best interests – in all the circumstances of that particular case.

6.33 If healthcare and social care staff are involved, their skills and knowledge will affect what is classed as ‘reasonable’. For example, a doctor assessing somebody’s capacity to consent to treatment must demonstrate more skill than someone without medical training. They should also record in the person’s healthcare record the steps they took and the reasons for the finding. Healthcare and social care staff should apply normal clinical and professional standards when deciding what treatments to offer. They must then decide whether the proposed treatment is in the best interests of the person who lacks capacity to consent. This includes considering all relevant circumstances and applying the best interests checklist (see chapter 5).

6.34 Healthcare and social care staff can be said to have ‘reasonable grounds for believing’ that a person lacks capacity if:

- they are working to a person’s care plan, and
- the care planning process involved an assessment of the person’s capacity to make a decision about actions in the care plan.

It is also reasonable for them to assume that the care planning process assessed a person’s best interests. But they should still make every effort to communicate with the person to find out if they still lack capacity and the action is still in their best interests.

**Scenario: Working with a care plan**
Margaret, an elderly woman, has serious mental health and physical problems. She lives in a nursing home and a care plan has been prepared by the multi-disciplinary team, in consultation with her relatives in deciding what course of action would be in Margaret’s best interests. The care plan covers the medication she has been prescribed, the physiotherapy she needs, help with her personal care and other therapeutic activities such as art therapy.

Although attempts were made to involve Margaret in the care planning process, she has been assessed by the doctor responsible for her care as lacking capacity to consent to most aspects of her care plan. The care plan can be relied on by the nurse or care assistant who administers the medication, by the physiotherapist and art therapist, and also by the care assistant who helps with Margaret’s personal care, providing them with reasonable grounds for believing that they are acting in her best interests.

However, as each act is performed, they must all take reasonable steps to communicate with Margaret to explain what they are doing and to ascertain whether she has the capacity to consent to the act in question. If they think she does, they must stop the treatment unless or until Margaret agrees that it should continue.

What happens in emergency situations?

6.35 Sometimes people who lack capacity to consent will require emergency medical treatment to save their life or prevent them from serious harm. In these situations, what steps are ‘reasonable’ will differ to those in non-urgent cases. In emergencies, it will almost always be in the person’s best interests to give urgent treatment without delay. One exception to this is when the healthcare staff giving treatment are satisfied that an advance decision to refuse treatment exists (see paragraph 6.37).

What happens in cases of negligence?

6.36 Section 5 does not provide a defence in cases of negligence – either in carrying out a particular act or by failing to act where necessary. For example, a doctor may be protected against a claim of battery for carrying out an operation that is in a person’s best interests. But if they perform the operation negligently, they are not protected from a charge of negligence. So the person who lacks capacity has the same rights in cases of negligence as someone who has consented to the operation.

What is the effect of an advance decision to refuse treatment?

6.37 Sometimes people will make an advance decision to refuse treatment while they still have capacity to do so and before they need that particular treatment. Healthcare staff must respect this decision if it is valid and applies to the proposed treatment.

6.38 If healthcare staff are satisfied that an advance decision is valid and applies to the proposed treatment, they are not protected from liability if they give any treatment that goes against it. But they are protected from liability if they did not know about an advance decision or they are not satisfied that the advance decision is valid and applies in the current circumstances (section 26(2)). See chapter 9 for further guidance.
What limits are there on protection from liability?

6.39 Section 6 imposes some important limitations on acts which can be carried out with protection from liability under section 5 (as described in the first part of this chapter). The key areas where acts might not be protected from liability are where there is inappropriate use of restraint or where a person who lacks capacity is deprived of their liberty.

Using restraint

6.40 Section 6(4) of the Act states that someone is using restraint if they:

- use force – or threaten to use force – to make someone do something that they are resisting, or
- restrict a person’s freedom of movement, whether they are resisting or not.

6.41 Any action intended to restrain a person who lacks capacity will not attract protection from liability unless the following two conditions are met:

- the person taking action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity, and
- the amount or type of restraint used and the amount of time it lasts must be a proportionate response to the likelihood and seriousness of harm.

See paragraphs 6.44–6.48 for more explanation of the terms necessary, harm and a proportionate response.

6.42 Healthcare and social care staff should also refer to:

- professional and other guidance on restraint or physical intervention, such as that issued by the Department of Health or Welsh Assembly Government, and
- limitations imposed by regulations and standards, such as the national minimum standards for care services (see chapter 14).

6.43 In addition to the requirements of the Act, the common law imposes a duty of care on healthcare and social care staff in respect of all people to whom they provide services. Therefore if a person who lacks capacity to consent has challenging behaviour, or is in the acute stages of illness causing them to act in a way which may cause harm to others, staff may, under the common law,

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21 For guidance on using restraint with people with learning disabilities and autistic spectrum disorder, see Guidance for restrictive physical interventions (published by the Department of Health and Department for Education and Skills and available at www.dh.gov.uk/assetRoot/04/06/84/61/04068461.pdf).

22 In Wales, the relevant guidance is the Welsh Assembly Government’s Framework for restrictive physical intervention policy and practice (available at www.childrenfirst.wales.gov.uk/content/framework/phys-int-e.pdf).
take appropriate and necessary action to restrain or remove the person, in order to prevent harm, both to the person concerned and to anyone else.

However, within this context, the common law would not provide sufficient grounds for an action that would have the effect of depriving someone of their liberty (see paragraphs 6.49–6.53).

**When might restraint be ‘necessary’?**

6.44 Anybody considering using restraint must have objective reasons to justify that restraint is necessary. They must be able to show that the person being cared for is likely to suffer harm unless proportionate restraint is used. A carer or professional must not use restraint just so that they can do something more easily. If restraint is necessary to prevent harm to the person who lacks capacity, it must be the minimum amount of force for the shortest time possible.

**Scenario: Appropriate use of restraint**

Derek, a man with learning disabilities, has begun to behave in a challenging way. Staff at his care home think he might have a medical condition that is causing him distress. They take him to the doctor, who thinks that Derek might have a hormone imbalance. But the doctor needs to take a blood test to confirm this, and when he tries to take the test Derek attempts to fight him off.

The results might be negative – so the test might not be necessary. But the doctor decides that a test is in Derek’s best interests, because failing to treat a problem like a hormone imbalance might make it worse. It is therefore in Derek’s best interests to restrain him to take the blood test. The temporary restraint is in proportion to the likely harm caused by failing to treat a possible medical condition.

**What is ‘harm’?**

6.45 The Act does not define ‘harm’, because it will vary depending on the situation. For example,

- a person with learning disabilities might run into a busy road without warning, if they do not understand the dangers of cars
- a person with dementia may wander away from home and get lost, if they cannot remember where they live
- a person with manic depression might engage in excessive spending during a manic phase, causing them to get into debt
- a person may also be at risk of harm if they behave in a way that encourages others to assault or exploit them (for example, by behaving in a dangerously provocative way).

6.46 Common sense measures can often help remove the risk of harm (for example, by locking away poisonous chemicals or removing obstacles). Also, care planning should include risk assessments and set out appropriate actions to try to prevent possible risks. But it is impossible to remove all risk, and a proportionate response is needed when the risk of harm does arise.
What is a ‘proportionate response’?

6.47 A ‘proportionate response’ means using the least intrusive type and minimum amount of restraint to achieve a specific outcome in the best interests of the person who lacks capacity. On occasions when the use of force may be necessary, carers and healthcare and social care staff should use the minimum amount of force for the shortest possible time.

For example, a carer may need to hold a person’s arm while they cross the road, if the person does not understand the dangers of roads. But it would not be a proportionate response to stop the person going outdoors at all. It may be appropriate to have a secure lock on a door that faces a busy road, but it would not be a proportionate response to lock someone in a bedroom all the time to prevent them from attempting to cross the road.

6.48 Carers and healthcare and social care staff should consider less restrictive options before using restraint. Where possible, they should ask other people involved in the person’s care what action they think is necessary to protect the person from harm. For example, it may be appropriate to get an advocate to work with the person to see if they can avoid or minimise the need for restraint to be used.

Scenario: Avoiding restraint

Oscar has learning disabilities. People at the college he attends sometimes cannot understand him, and he gets frustrated. Sometimes he hits the wall and hurts himself.

Staff don’t want to take Oscar out of class, because he says he enjoys college and is learning new skills. They have allowed his support worker to sit with him, but he still gets upset. The support worker could try to hold Oscar back. But she thinks this is too forceful, even though it would stop him hurting himself.

Instead, she gets expert advice from members of the local community team. Observation helps them understand Oscar’s behaviour better. They come up with a support strategy that reduces the risk of harmful behaviour and is less restrictive of his freedom.

When are acts seen as depriving a person of their liberty?

6.49 Although section 5 of the Act permits the use of restraint where it is necessary under the above conditions, section 6(5) confirms that there is no protection under the Act for actions that result in someone being deprived of their liberty (as defined by Article 5(1) of the European Convention on Human Rights). This applies not only to public authorities covered by the Human Rights Act 1998 but to everyone who might otherwise get protection under section 5 of the Act. It also applies to attorneys or deputies – they cannot give permission for an action that takes away a person’s liberty.

6.50 Sometimes there is no alternative way to provide care or treatment other than depriving the person of their liberty. In this situation, some people may be detained in hospital under the Mental Health Act 1983 – but this only applies to people who require hospital treatment for a mental disorder (see chapter 13). Otherwise, actions that amount to
a deprivation of liberty will not be lawful unless formal authorisation is obtained.

6.51 In some cases, the Court of Protection might grant an order that permits the deprivation of a person’s liberty, if it is satisfied that this is in a person’s best interests.

6.52 It is difficult to define the difference between actions that amount to a restriction of someone’s liberty and those that result in a deprivation of liberty. In recent legal cases, the European Court of Human Rights said that the difference was ‘one of degree or intensity, not one of nature or substance’. There must therefore be particular factors in the specific situation of the person concerned which provide the ‘degree’ or ‘intensity’ to result in a deprivation of liberty. In practice, this can relate to:

- the type of care being provided
- how long the situation lasts
- its effects, or
- the way in a particular situation came about.

The European Court of Human Rights has identified the following as factors contributing to deprivation of liberty in its judgments on cases to date:

- restraint was used, including sedation, to admit a person who is resisting
- professionals exercised complete and effective control over care and movement for a significant period
- professionals exercised control over assessments, treatment, contacts and residence
- the person would be prevented from leaving if they made a meaningful attempt to do so
- a request by carers for the person to be discharged to their care was refused
- the person was unable to maintain social contacts because of restrictions placed on access to other people
- the person lost autonomy because they were under continuous supervision and control.

23 HL v The United Kingdom (Application no, 45508/99). Judgement 5 October 2004, paragraph 89

24 In HL v UK (also known as the ‘Bournewood’ case), the European Court said that “the key factor in the present case [is] that the health care professionals treating and managing the applicant exercised complete and effective control over his care and movements”. They found “the concrete situation was that the applicant was under continuous supervision and control and was not free to leave.”

25 These are listed in the Department of Health’s draft illustrative Code of Practice guidance about the proposed safeguards. www.dh.gov.uk/assetRoot/04/14/17/64/04141764.pdf
6.53 The Government has announced that it intends to amend the Act to introduce new procedures and provisions for people who lack capacity to make relevant decisions but who need to be deprived of their liberty, in their best interests, otherwise than under the Mental Health Act 1983 (the so-called ‘Bournewood provisions’). This chapter will be fully revised in due course to reflect those changes. Information about the Government’s current proposals in respect of the Bournewood safeguards is available on the Department of Health website. This information includes draft illustrative Code of Practice guidance about the proposed safeguards. See paragraphs 13.52–13.55 for more details.

**How does section 5 apply to attorneys and deputies?**

6.54 Section 5 does not provide protection for actions that go against the decision of someone who has been authorised to make decisions for a person who lacks capacity to make such decision for themselves. For instance, if someone goes against the decision of an attorney acting under a Lasting Power of Attorney (LPA) (see chapter 7) or a deputy appointed by the Court of Protection (see chapter 8), they will not be protected under section 5.

6.55 Attorneys and deputies must only make decisions within the scope of the authority of the LPA or court order. Sometimes carers or healthcare and social care staff might feel that an attorney or deputy is making decisions they should not be making, or that are not in a person’s best interests. If this is the case, and the disagreement cannot be settled any other way, either the carers, the staff or the attorney or deputy can apply to the Court of Protection. If the dispute concerns the provision of medical treatment, medical staff can still give life-sustaining treatment, or treatment which stops a person’s condition getting seriously worse, while the court is coming to a decision (section 6(6)).

**Who can pay for goods or services?**

6.56 Carers may have to spend money on behalf of someone who lacks capacity to purchase necessary goods or services. For example, they may need to pay for a milk delivery or for a chiropodist to provide a service at the person’s home. In some cases, they might have to pay for more costly arrangements such as house repairs or organising a holiday. Carers are likely to be protected from liability if their actions are properly taken under section 5, and in the best interests of the person who lacks capacity.

6.57 In general, a contract entered into by a person who lacks capacity to make the contract cannot be enforced if the other person knows, or must be taken to have known, of the lack of capacity. Section 7 of the Act modifies this rule and states that where the contract is for ‘necessary’ goods or services for a person who lacks capacity to make the arrangements for themselves, that person must pay a reasonable price for them.

**What are necessary goods and services?**

6.58 ‘Necessary’ means something that is suitable to the person’s condition in life (their place in society, rather than any mental or physical condition) and their actual requirements when the goods or services are provided (section 7(2)). The aim is to make sure that people can enjoy a similar standard of living and
way of life to those they had before lacking capacity. For example, if a person who now lacks capacity previously chose to buy expensive designer clothes, these are still necessary goods – as long as they can still afford them. But they would not be necessary for a person who always wore cheap clothes, no matter how wealthy they were.

6.59 Goods are not necessary if the person already has a sufficient supply of them. For example, buying one or two new pairs of shoes for a person who lacks capacity could be necessary. But a dozen pairs would probably not be necessary.

**How should payments be arranged?**

6.60 If a person lacks capacity to arrange for payment for necessary goods and services, sections 5 and 8 allow a carer to arrange payment on their behalf.

6.61 The carer must first take reasonable steps to check whether a person can arrange for payment themselves, or has the capacity to consent to the carer doing it for them. If the person lacks the capacity to consent or pay themselves, the carer must decide what goods or services would be necessary for the person and in their best interests. The carer can then lawfully deal with payment for those goods and services in one of three ways:

- If neither the carer nor the person who lacks capacity can produce the necessary funds, the carer may promise that the person who lacks capacity will pay. A supplier may not be happy with this, or the carer may be worried that they will be held responsible for any debt. In such cases, the carer must follow the formal steps in paragraphs 6.62–6.66 below.

- If the person who lacks capacity has cash, the carer may use that money to pay for goods or services (for example, to pay the milkman or the hairdresser).

- The carer may choose to pay for the goods or services with their own money. The person who lacks capacity must pay them back. This may involve using cash in the person's possession or running up an IOU. (This is not appropriate for paid care workers, whose contracts might stop them handling their clients' money.) The carer must follow formal steps to get money held in a bank or building society account (see paragraphs 6.63–6.66 below).

6.62 Carers should keep bills, receipts and other proof of payment when paying for goods and services. They will need these documents when asking to get money back. Keeping appropriate financial records and documentation is a requirement of the national minimum standards for care homes or domiciliary care agencies.

**Access to a person’s assets**

6.63 The Act does not give a carer or care worker access to a person’s income or assets. Nor does it allow them to sell the person’s property.

6.64 Anyone wanting access to money in a person’s bank or building society will need formal legal authority. They will also need legal authority to sell a person’s property. Such authority could be given
in a Lasting Power of Attorney (LPA) appointing an attorney to deal with property and affairs, or in an order of the Court of Protection (either a single decision of the court or an order appointing a deputy to make financial decisions for the person who lacks capacity to make such decisions).

Scenario: Being granted access to a person’s assets

A storm blew some tiles off the roof of a house owned by Gordon, a man with Alzheimer’s disease. He lacks capacity to arrange for repairs and claim on his insurance. The repairs are likely to be costly.

Gordon’s son decides to organise the repairs, and he agrees to pay because his father doesn't have enough cash available. The son could then apply to the Court of Protection for authority to claim insurance on his father’s behalf and for him to be reimbursed from his father’s bank account to cover the cost of the repairs once the insurance payment had been received.

6.65 Sometimes another person will already have legal control of the finances and property of a person who lacks capacity to manage their own affairs. This could be an attorney acting under a registered EPA or an appropriate LPA (see chapter 7) or a deputy appointed by the Court of Protection (see chapter 8). Or it could be someone (usually a carer) that has the right to act as an ‘appointee’ (under Social Security Regulations) and claim benefits for a person who lacks capacity to make their own claim and use the money on the person’s behalf. But an appointee cannot deal with other assets or savings from sources other than benefits.

6.66 Section 6(6) makes clear that a family carer or other carer cannot make arrangements for goods or services to be supplied to a person who lacks capacity if this conflicts with a decision made by someone who has formal powers over the person’s money and property, such as an attorney or deputy acting within the scope of their authority. Where there is no conflict and the carer has paid for necessary goods and services the carer may ask for money back from an attorney, a deputy or where relevant, an appointee.
7 What does the Act say about Lasting Powers of Attorney?

This chapter explains what Lasting Powers of Attorney (LPAs) are and how they should be used. It also sets out:

• how LPAs differ from Enduring Powers of Attorney (EPAs)
• the types of decisions that people can appoint attorneys to make (attorneys are also called ‘donees’ in the Act)
• situations in which an LPA can and cannot be used
• the duties and responsibilities of attorneys
• the standards required of attorneys, and
• measures for dealing with attorneys who don’t meet appropriate standards.

This chapter also explains what should happen to EPAs that were made before the Act comes into force.

In this chapter, as throughout the Code, a person’s capacity (or lack of capacity) refers specifically to their capacity to make a particular decision at the time it needs to be made.

Quick summary

Anyone asked to be an attorney should:

• consider whether they have the skills and ability to act as an attorney (especially if it is for a property and affairs LPA)
• ask themselves whether they actually want to be an attorney and take on the duties and responsibilities of the role.

Before acting under an LPA, attorneys must:

• make sure the LPA has been registered with the Public Guardian
• take all practical and appropriate steps to help the donor make the particular decision for themselves.

When acting under an LPA:

• make sure that the Act’s statutory principles are followed
• check whether the person has the capacity to make that particular decision for themselves. If they do:
  – a personal welfare LPA cannot be used – the person must make the decision
  – a property and affairs LPA can be used even if the person has capacity to make the decision, unless they have stated in the LPA that they should make decisions for themselves when they have capacity to do so.

At all times, remember:
• anything done under the authority of the LPA must be in the person’s best interests
• anyone acting as an attorney must have regard to guidance in this Code of Practice that is relevant to the decision that is to be made
• attorneys must fulfil their responsibilities and duties to the person who lacks capacity.

What is a Lasting Power of Attorney (LPA)?

7.1 Sometimes one person will want to give another person authority to make a decision on their behalf. A power of attorney is a legal document that allows them to do so. Under a power of attorney, the chosen person (the attorney or donee) can make decisions that are as valid as one made by the person (the donor).

7.2 Before the Enduring Powers of Attorney Act 1985, every power of attorney automatically became invalid as soon as the donor lacked the capacity to make their own decision. But that Act introduced the Enduring Power of Attorney (EPA). An EPA allows an attorney to make decisions about property and financial affairs even if the donor lacks capacity to manage their own affairs.

7.3 The Mental Capacity Act replaces the EPA with the Lasting Power of Attorney (LPA). It also increases the range of different types of decisions that people can authorise others to make on their behalf. As well as property and affairs (including financial matters), LPAs can also cover personal welfare (including healthcare and consent to medical treatment) for people who lack capacity to make such decisions for themselves.

7.4 The donor can choose one person or several to make different kinds of decisions. See paragraphs 7.21–7.31 for more information about personal welfare LPAs. See paragraphs 7.32–7.42 for more information about LPAs on property and affairs.

How do LPAs compare to EPAs?

7.5 There are a number of differences between LPAs and EPAs. These are summarised as follows:

• EPAs only cover property and affairs. LPAs can also cover personal welfare.
• Donors must use the relevant specific form (prescribed in regulations) to make EPAs and LPAs. There are different forms for EPAs, personal welfare LPAs and property and affairs LPAs.
• EPAs must be registered with the Public Guardian when the donor can no longer manage their own affairs (or when they start to lose capacity). But LPAs can be registered at any time before they are used – before or after the donor lacks capacity to make particular decisions that the LPA covers. If the LPA is not registered, it can’t be used.
• EPAs can be used while the donor still has capacity to manage their own property and affairs, as can property and affairs LPAs, so long as the donor
does not say otherwise in the LPA. But personal welfare LPAs can only be used once the donor lacks capacity to make the welfare decision in question.

- Once the Act comes into force, only LPAs can be made but existing EPAs will continue to be valid. There will be different laws and procedures for EPAs and LPAs.
- Attorneys making decisions under a registered EPA or LPA must follow the Act’s principles and act in the best interests of the donor.
- The duties under the law of agency apply to attorneys of both EPAs and LPAs (see paragraphs 7.58–7.68 below).
- Decisions that the courts have made about EPAs may also affect how people use LPAs.
- Attorneys acting under an LPA have a legal duty to have regard to the guidance in this Code of Practice. EPA attorneys do not. But the Code’s guidance will still be helpful to them.

How does a donor create an LPA?

7.6 The donor must also follow the right procedures for creating and registering an LPA, as set out below. Otherwise the LPA might not be valid. It is not always necessary to get legal advice. But it is a good idea for certain cases (for example, if the donor’s circumstances are complicated).

7.7 Only adults aged 18 or over can make an LPA, and they can only make an LPA if they have the capacity to do so. For an LPA to be valid:

- the LPA must be a written document set out in the statutory form prescribed by regulations
- the document must include prescribed information about the nature and effect of the LPA (as set out in the regulations)
- the donor must sign a statement saying that they have read the prescribed information (or somebody has read it to them) and that they want the LPA to apply when they no longer have capacity
- the document must name people (not any of the attorneys) who should be told about an application to register the LPA, or it should say that there is no-one they wish to be told
- the attorneys must sign a statement saying that they have read the prescribed information and that they understand their duties – in particular the duty to act in the donor’s best interests
- the document must include a certificate completed by an independent third party, confirming that:

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26 The prescribed forms will be available from the Office of the Public Guardian (OPG) or from legal stationers.

27 Details of who may and who may not be a certificate provider will be available in regulations. The OPG will produce guidance for certificate providers on their role.
– in their opinion, the donor understands the LPA’s purpose
– nobody used fraud or undue pressure to trick or force the donor into making the LPA and
– there is nothing to stop the LPA being created.

Who can be an attorney?

7.8 A donor should think carefully before choosing someone to be their attorney. An attorney should be someone who is trustworthy, competent and reliable. They should have the skills and ability to carry out the necessary tasks.

7.9 Attorneys must be at least 18 years of age. For property and affairs LPAs, the attorney could be either:

• an individual (as long as they are not bankrupt at the time the LPA is made), or
• a trust corporation (often parts of banks or other financial institutions).

If an attorney nominated under a property and affairs LPA becomes bankrupt at any point, they will no longer be allowed to act as an attorney for property and affairs. People who are bankrupt can still act as an attorney for personal welfare LPAs.

7.10 The donor must name an individual rather than a job title in a company or organisation, (for example, ‘The Director of Adult Services’ or ‘my solicitor’ would not be sufficient). A paid care worker (such as a care home manager) should not agree to act as an attorney, apart from in unusual circumstances (for example, if they are the only close relative of the donor).

7.11 Section 10(4) of the Act allows the donor to appoint two or more attorneys and to specify whether they should act ‘jointly’, ‘jointly and severally’, or ‘jointly in respect of some matters and jointly and severally in respect of others’.

• Joint attorneys must always act together. All attorneys must agree decisions and sign any relevant documents.
• Joint and several attorneys can act together but may also act independently if they wish. Any action taken by any attorney alone is as valid as if they were the only attorney.

7.12 The donor may want to appoint attorneys to act jointly in some matters but jointly and severally in others. For example, a donor could choose to appoint two or more financial attorneys jointly and severally. But they might say then when selling the donor’s house, the attorneys must act jointly. The donor may appoint welfare attorneys to act jointly and severally but specify that they must act jointly in relation to giving consent to surgery. If a donor who has appointed two or more attorneys does not specify how they should act, they must always act jointly (section 10(5)).

7.13 Section 10(8) says that donors may choose to name replacement attorneys to take over the duties in certain circumstances (for example, in the event of an
attorney’s death). The donor may name a specific attorney to be replaced, or
the replacements can take over from any attorney, if necessary. Donors
cannot give their attorneys the right to appoint a substitute or successor.

How should somebody register and use an LPA?

7.14 An LPA must be registered with the Office of the Public Guardian (OPG)
before it can be used. An unregistered LPA will not give the attorney any legal
powers to make a decision for the donor. The donor can register the LPA
while they are still capable, or the attorney can apply to register the LPA at
any time.

7.15 There are advantages in registering the LPA soon after the donor makes it (for
example, to ensure that there is no delay when the LPA needs to be used).
But if this has not been done, an LPA can be registered after the donor lacks
the capacity to make a decision covered by the LPA.

7.16 If an LPA is unregistered, attorneys must register it before making any
decisions under the LPA. If the LPA has been registered but not used for
some time, the attorney should tell the OPG when they begin to act under it –
so that the attorney can be sent relevant, up-to-date information about the
rules governing LPAs.

7.17 While they still have capacity, donors should let the OPG know of permanent
changes of address for the donor or the attorney or any other changes in
circumstances. If the donor no longer has capacity to do this, attorneys should
report any such changes to the OPG. Examples include an attorney of a
property and affairs LPA becoming bankrupt or the ending of a marriage
between the donor and their attorney. This will help keep OPG records up to
date, and will make sure that attorneys do not make decisions that they no
longer have the authority to make.

What guidance should an attorney follow?

7.18 Section 9(4) states that attorneys must meet the requirements set out in the
Act. Most importantly, they have to follow the statutory principles (section 1)
and make decisions in the best interests of the person who lacks capacity
(section 4). They must also respect any conditions or restrictions that the LPA
document contains. See chapter 2 for guidance on how to apply the Act’s
principles.

7.19 Chapter 3 gives suggestions of ways to help people make their own decisions
in accordance with the Act’s second principle. Attorneys should also refer to
the guidance in chapter 4 when assessing the donor’s capacity to make
particular decisions, and in particular, should follow the steps suggested for
establishing a ‘reasonable belief’ that the donor lacks capacity (see
paragraphs 4.44–4.45). Assessments of capacity or best interests must not be
based merely on:

• a donor’s age or appearance, or
• unjustified assumptions about any condition they might have or their
  behaviour.
7.20 When deciding what is in the donor’s best interests, attorneys should refer to the guidance in chapter 5. In particular, they must consider the donor’s past and present wishes and feelings, beliefs and values. Where practical and appropriate, they should consult with:

- anyone involved in caring for the donor
- close relatives and anyone else with an interest in their welfare
- other attorneys appointed by the donor.

See paragraphs 7.52–7.68 for a description of an attorney’s duties.

**Scenario: Making decisions in a donor’s best interests**

Mr Young has been a member of the Green Party for a long time. He has appointed his solicitor as his attorney under a property and affairs LPA. But Mr Young did not state in the LPA that investments made on his behalf must be ethical investments. When the attorney assesses his client’s best interests, however, the attorney considers the donor’s past wishes, values and beliefs. He makes sure that he only invests in companies that are socially and environmentally responsible.

**What decisions can an LPA attorney make?**

**Personal welfare LPAs**

7.21 LPAs can be used to appoint attorneys to make decisions about personal welfare, which can include healthcare and medical treatment decisions. Personal welfare LPAs might include decisions about:

- where the donor should live and who they should live with
- the donor’s day-to-day care, including diet and dress
- who the donor may have contact with
- consenting to or refusing medical examination and treatment on the donor’s behalf
- arrangements needed for the donor to be given medical, dental or optical treatment
- assessments for and provision of community care services
- whether the donor should take part in social activities, leisure activities, education or training
- the donor’s personal correspondence and papers
- rights of access to personal information about the donor, or
- complaints about the donor’s care or treatment.

7.22 The standard form for personal welfare LPAs allows attorneys to make decisions about anything that relates to the donor’s personal welfare. But donors can add restrictions or conditions to areas where they would not wish the attorney to have the power to act. For example, a donor might only want an attorney to make decisions about their social care and not their healthcare.
There are particular rules for LPAs authorising an attorney to make decisions about life-sustaining treatment (see paragraphs 7.30–7.31 below).

7.23 A general personal welfare LPA gives the attorney the right to make all of the decisions set out above although this is not a full list of the actions they can take or decisions they can make. However, a personal welfare LPA can only be used at a time when the donor lacks capacity to make a specific welfare decision.

**Scenario: Denying attorneys the right to make certain decisions**

Mrs Hutchison is in the early stages of Alzheimer’s disease. She is anxious to get all her affairs in order while she still has capacity to do so. She makes a personal welfare LPA, appointing her daughter as attorney. But Mrs Hutchison knows that her daughter doesn’t always get on with some members of the family – and she wouldn’t want her daughter to stop those relatives from seeing her.

She states in the LPA that her attorney does not have the authority to decide who can contact her or visit her. If her daughter wants to prevent anyone having contact with Mrs Hutchison, she must ask the Court of Protection to decide.

7.24 Before making a decision under a personal welfare LPA, the attorney must be sure that:

- the LPA has been registered with the OPG
- the donor lacks the capacity to make the particular decision or the attorney reasonably believes that the donor lacks capacity to take the decisions covered by the LPA (having applied the Act’s principles), and
- they are making the decision in the donor’s best interests.

7.25 When healthcare or social care staff are involved in preparing a care plan for someone who has appointed a personal welfare attorney, they must first assess whether the donor has capacity to agree to the care plan or to parts of it. If the donor lacks capacity, professionals must then consult the attorney and get their agreement to the care plan. They will also need to consult the attorney when considering what action is in the person’s best interests.

**Personal welfare LPAs that authorise an attorney to make healthcare decisions**

7.26 A personal welfare LPA allows attorneys to make decisions to accept or refuse healthcare or treatment unless the donor has stated clearly in the LPA that they do not want the attorney to make these decisions.

7.27 Even where the LPA includes healthcare decisions, attorneys do not have the right to consent to or refuse treatment in situations where:

- **the donor has capacity to make the particular healthcare decision (section 11(7)(a))**
  
  An attorney has no decision-making power if the donor can make their own treatment decisions.
• the donor has made an advance decision to refuse the proposed treatment (section 11(7)(b))
An attorney cannot consent to treatment if the donor has made a valid and applicable advance decision to refuse a specific treatment (see chapter 9). But if the donor made an LPA after the advance decision, and gave the attorney the right to consent to or refuse the treatment, the attorney can choose not to follow the advance decision.

• a decision relates to life-sustaining treatment (section 11(7)(c))
An attorney has no power to consent to or refuse life-sustaining treatment, unless the LPA document expressly authorises this (See paragraphs 7.30–7.31 below.)

• the donor is detained under the Mental Health Act (section 28)
An attorney cannot consent to or refuse treatment for a mental disorder for a patient detained under the Mental Health Act 1983 (see also chapter 13).

7.28 LPAs cannot give attorneys the power to demand specific forms of medical treatment that healthcare staff do not believe are necessary or appropriate for the donor’s particular condition.

7.29 Attorneys must always follow the Act’s principles and make decisions in the donor’s best interests. If healthcare staff disagree with the attorney’s assessment of best interests, they should discuss the case with other medical experts and/or get a formal second opinion. Then they should discuss the matter further with the attorney. If they cannot settle the disagreement, they can apply to the Court of Protection (see paragraphs 7.45–7.49 below). While the court is coming to a decision, healthcare staff can give life-sustaining treatment to prolong the donor’s life or stop their condition getting worse.

Personal welfare LPAs that authorise an attorney to make decisions about life-sustaining treatment

7.30 An attorney can only consent to or refuse life-sustaining treatment on behalf of the donor if, when making the LPA, the donor has specifically stated in the LPA document that they want the attorney to have this authority.

7.31 As with all decisions, an attorney must act in the donor’s best interests when making decisions about such treatment. This will involve applying the best interests checklist (see chapter 5) and consulting with carers, family members and others interested in the donor’s welfare. In particular, the attorney must not be motivated in any way by the desire to bring about the donor’s death (see paragraphs 5.29–5.36). Anyone who doubts that the attorney is acting in the donor’s best interests can apply to the Court of Protection for a decision.

Scenario: Making decisions about life-sustaining treatment

Mrs Joshi has never trusted doctors. She prefers to rely on alternative therapies. Because she saw her father suffer after invasive treatment for cancer, she is clear that she would refuse such treatment herself.

She is diagnosed with cancer and discusses her wishes with her husband. Mrs Joshi knows that he would respect her wishes if he ever had to make a decision about her treatment. She makes a personal welfare LPA appointing him as her attorney with authority to make all her welfare and healthcare
decisions. She includes a specific statement authorising him to consent to or refuse life-sustaining treatment.

He will then be able to consider her views and make decisions about treatment in her best interests if she later lacks capacity to make those decisions herself.

**Property and affairs LPAs**

7.32 A donor can make an LPA giving an attorney the right to make decisions about property and affairs (including financial matters). Unless the donor states otherwise, once the LPA is registered, the attorney is allowed to make all decisions about the donor’s property and affairs even if the donor still has capacity to make the decisions for themselves. In this situation, the LPA will continue to apply when the donor no longer has capacity.

7.33 Alternatively a donor can state in the LPA document that the LPA should only apply when they lack capacity to make a relevant decision. It is the donor’s responsibility to decide how their capacity should then be assessed. For example, the donor may trust the attorney to carry out an assessment, or they may say that the LPA only applies if their GP or another doctor confirms in writing that they lack capacity to make specific decisions about property or finances. Financial institutions may wish to see the written confirmation before recognising the attorney’s authority to act under the LPA.

7.34 The fact that someone has made a property and affairs LPA does not mean that they cannot continue to carry out financial transactions for themselves. The donor may have full capacity, but perhaps anticipates that they may lack capacity at some future time. Or they may have fluctuating or partial capacity and therefore be able to make some decisions (or at some times), but need an attorney to make others (or at other times). The attorney should allow and encourage the donor to do as much as possible, and should only act when the donor asks them to or to make those decisions the donor lacks capacity to make. However, in other cases, the donor may wish to hand over responsibility for all decisions to the attorney, even those they still have capacity to make.

7.35 If the donor restricts the decisions an attorney can make, banks may ask the attorney to sign a declaration that protects the bank from liability if the attorney misuses the account.  

7.36 If a donor does not restrict decisions the attorney can make, the attorney will be able to decide on any or all of the person’s property and financial affairs. This might include:

- buying or selling property
- opening, closing or operating any bank, building society or other account
- giving access to the donor’s financial information

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28 See British Banking Association’s guidance for bank staff on ‘Banking for mentally incapacitated and learning disabled customers’.
claiming, receiving and using (on the donor’s behalf) all benefits, pensions, allowances and rebates (unless the Department for Work and Pensions has already appointed someone and everyone is happy for this to continue)

• receiving any income, inheritance or other entitlement on behalf of the donor
• dealing with the donor’s tax affairs
• paying the donor’s mortgage, rent and household expenses
• insuring, maintaining and repairing the donor’s property
• investing the donor’s savings
• making limited gifts on the donor’s behalf (but see paragraphs 7.40–7.42 below)
• paying for private medical care and residential care or nursing home fees
• applying for any entitlement to funding for NHS care, social care or adaptations
• using the donor’s money to buy a vehicle or any equipment or other help they need
• repaying interest and capital on any loan taken out by the donor.

A general property and affairs LPA will allow the attorney to carry out any or all of the actions above (although this is not a full list of the actions they can take). However, the donor may want to specify the types of powers they wish the attorney to have, or to exclude particular types of decisions. If the donor holds any assets as trustee, they should get legal advice about how the LPA may affect this.

The attorney must make these decisions personally and cannot generally give someone else authority to carry out their duties (see paragraphs 7.61–7.62 below). But if the donor wants the attorney to be able to give authority to a specialist to make specific decisions, they need to state this clearly in the LPA document (for example, appointing an investment manager to make particular investment decisions).

Donors may like to appoint someone (perhaps a family member or a professional) to go through their accounts with the attorney from time to time. This might help to reassure donors that somebody will check their financial affairs when they lack capacity to do so. It may also be helpful for attorneys to arrange a regular check that everything is being done properly. The donor should ensure that the person is willing to carry out this role and is prepared to ask for the accounts if the attorney does not provide them. They should include this arrangement in the signed LPA document. The LPA should also say whether the person can charge a fee for this service.

What gifts can an attorney make under a property and affairs LPA?

An attorney can only make gifts of the donor’s money or belongings to people who are related to or connected with the donor (including the attorney) on specific occasions, including:

• births or birthdays
• weddings or wedding anniversaries
• civil partnership ceremonies or anniversaries, or
• any other occasion when families, friends or associates usually give presents (section 12(3)(b)).

7.41 If the donor previously made donations to any charity regularly or from time to time, the attorney can make donations from the person’s funds. This also applies if the donor could have been expected to make such payments (section 12(2)(b)). But the value of any gift or donation must be reasonable and take into account the size of the donor’s estate. For example, it would not be reasonable to buy expensive gifts at Christmas if the donor was living on modest means and had to do without essential items in order to pay for them.

7.42 The donor cannot use the LPA to make more extensive gifts than those allowed under section 12 of the Act. But they can impose stricter conditions or restrictions on the attorney’s powers to make gifts. They should state these restrictions clearly in the LPA document when they are creating it. When deciding on appropriate gifts, the attorney should consider the donor’s wishes and feelings to work out what would be in the donor’s best interests. The attorney can apply to the Court of Protection for permission to make gifts that are not included in the LPA (for example, for tax planning purposes).

Are there any other restrictions on attorneys’ powers?

7.43 Attorneys are not protected from liability if they do something that is intended to restrain the donor, unless:

• the attorney reasonably believes that the donor lacks capacity to make the decision in question, and
• the attorney reasonably believes that restraint is necessary to prevent harm to the donor, and
• the type of restraint used is in proportion to the likelihood and the seriousness of the harm.

If an attorney needs to make a decision or take action which may involve the use of restraint, they should take account of the guidance set out in chapter 6.

7.44 Attorneys have no authority to take actions that result in the donor being deprived of their liberty. Any deprivation of liberty will only be lawful if this has been properly authorised and there is other protection available for the person who lacks capacity. An example would be the protection around detention under the Mental Health Act 1983 (see chapter 13) or a court ruling. Chapter 6 gives more guidance on working out whether an action is restraint or a deprivation of liberty.

What powers does the Court of Protection have over LPAs?

7.45 The Court of Protection has a range of powers to:

• determine whether an LPA is valid
• give directions about using the LPA, and
• to remove an attorney (for example, if the attorney does not act in the best interests of the donor).

Chapter 8 gives more information about the Court of Protection’s powers.

7.46 If somebody has doubts over whether an LPA is valid, they can ask the court to decide whether the LPA:
• meets the Act’s requirements
• has been revoked (cancelled) by the donor, or
• has come to an end for any other reason.

7.47 The court can also stop somebody registering an LPA or rule that an LPA is invalid if:
• the donor made the LPA as a result of undue pressure or fraud, or
• the attorney behaves, has behaved or is planning to behave in a way that goes against their duties or is not in the donor’s best interests.

7.48 The court can also clarify an LPA’s meaning, if it is not clear, and it can tell attorneys how they should use an LPA. If an attorney thinks that an LPA does not give them enough powers, they can ask the court to extend their powers – if the donor no longer has capacity to authorise this. The court can also authorise an attorney to give a gift that the Act does not normally allow (section 12(2)), if it is in the donor’s best interests.

7.49 All attorneys should keep records of their dealings with the donor’s affairs (see also paragraph 7.67 below). The court can order attorneys to produce records (for example, financial accounts) and to provide specific reports, information or documentation. If somebody has concerns about an attorney’s payment or expenses, the court could resolve the matter.

What responsibilities do attorneys have?

7.50 A donor cannot insist on somebody agreeing to become an attorney. It is down to the proposed attorney to decide whether to take on this responsibility. When an attorney accepts the role by signing the LPA document, this is confirmation that they are willing to act under the LPA once it is registered. An attorney can withdraw from the appointment if they ever become unable or unwilling to act, but if the LPA has been registered they must follow the correct procedures for withdrawing. (see paragraph 7.66 below).

7.51 Once the attorney starts to act under an LPA, they must meet certain standards. If they don’t carry out the duties below, they could be removed from the role. In some circumstances they could face charges of fraud or negligence.

What duties does the Act impose?

7.52 Attorneys acting under an LPA have a duty to:
• follow the Act’s statutory principles (see chapter 2)
• make decisions in the donor’s best interests
• have regard to the guidance in the Code of Practice
• only make those decisions the LPA gives them authority to make.

Principles and best interests
7.53 Attorneys must act in accordance with the Act’s statutory principles (section 1) and in the best interests of the donor (the steps for working out best interests are set out in section 4). In particular, attorneys must consider whether the donor has capacity to make the decision for themselves. If not, they should consider whether the donor is likely to regain capacity to make the decision in the future. If so, it may be possible to delay the decision until the donor can make it.

The Code of Practice
7.54 As well as this chapter, attorneys should pay special attention to the following guidance set out in the Code:

• chapter 2, which sets out how the Act’s principles should be applied
• chapter 3, which describes the steps which can be taken to try to help the person make decisions for themselves
• chapter 4, which describes the Act’s definition of lack of capacity and gives guidance on assessing capacity, and
• chapter 5, which gives guidance on working out the donor’s best interests.

7.55 In some circumstances, attorneys might also find it useful to refer to guidance in:

• chapter 6, which explains when attorneys who have caring responsibilities may have protection from liability and gives guidance on the few circumstances when the Act allows restraint in connection with care and treatment
• chapter 8, which gives a summary of the Court of Protection’s powers relating to LPAs
• chapter 9, which explains how LPAs may be affected if the donor has made an advance decision to refuse treatment, and
• chapter 15, which describes ways to settle disagreements.

Only making decisions covered by an LPA
7.56 A personal welfare attorney has no authority to make decisions about a donor’s property and affairs (such as their finances). A property and affairs attorney has no authority in decisions about a donor’s personal care. (But the same person could be appointed in separate LPAs to carry out both these roles.) Under any LPA, the attorney will have authority in a wide range of decisions. But if a donor includes restrictions in the LPA document, this will limit the attorney’s authority (section 9(4)(b)). If the attorney thinks that they need greater powers, they can apply to the Court of Protection which may
It is good practice for decision-makers to consult attorneys about any decision or action, whether or not it is covered by the LPA. This is because an attorney is likely to have known the donor for some time and may have important information about their wishes and feelings. Researchers can also consult attorneys if they are thinking about involving the donor in research (see chapter 11).

**Scenario: Consulting attorneys**

Mr Varadi makes a personal welfare LPA appointing his son and daughter as his joint attorneys. He also makes a property and affairs LPA, appointing his son and his solicitor to act jointly and severally. He registers the property and affairs LPA straight away, so his attorneys can help with financial decisions.

Two years later, Mr Varadi has a stroke, is unable to speak and has difficulty communicating his wishes. He also lacks the capacity to make decisions about treatment. The attorneys apply to register the personal welfare LPA. Both feel that they should delay decisions about Mr Varadi’s future care, because he might regain capacity to make the decisions himself. But they agree that some decisions cannot wait.

Although the solicitor has no authority to make welfare decisions, the welfare attorneys consult him about their father’s best interests. They speak to him about immediate treatment decisions and suggest that they delay making decisions about his future care. Similarly, the property and affairs attorneys consult the daughter about the financial decisions that Mr Varadi does not have the capacity to make himself.

**What are an attorney’s other duties?**

An attorney appointed under an LPA is acting as the chosen agent of the donor and therefore, under the law of agency, the attorney has certain duties towards the donor. An attorney takes on a role which carries a great deal of power, which they must use carefully and responsibly. They have a duty to:

- apply certain standards of care and skill (duty of care) when making decisions
- carry out the donor’s instructions
- not take advantage of their position and not benefit themselves, but benefit the donor (fiduciary duty)
- not delegate decisions, unless authorised to do so
- act in good faith
- respect confidentiality
- comply with the directions of the Court of Protection
- not give up the role without telling the donor and the court.

In relation to property and affairs LPAs, they have a duty to:
• keep accounts
• keep the donor’s money and property separate from their own.

**Duty of care**

7.59 ‘Duty of care’ means applying a certain standard of care and skill – depending on whether the attorney is paid for their services or holds relevant professional qualifications.

• Attorneys who are not being paid must apply the same care, skill and diligence they would use to make decisions about their own life. An attorney who claims to have particular skills or qualifications must show greater skill in those particular areas than someone who does not make such claims.
• If attorneys are being paid for their services, they should demonstrate a higher degree of care and skill.
• Attorneys who undertake their duties in the course of their professional work (such as solicitors or corporate trustees) must display professional competence and follow their profession’s rules and standards.

**Fiduciary duty**

7.60 A fiduciary duty means attorneys must not take advantage of their position. Nor should they put themselves in a position where their personal interests conflict with their duties. They also must not allow any other influences to affect the way in which they act as an attorney. Decisions should always benefit the donor, and not the attorney. Attorneys must not profit or get any personal benefit from their position, apart from receiving gifts where the Act allows it, whether or not it is at the donor’s expense.

**Duty not to delegate**

7.61 Attorneys cannot usually delegate their authority to someone else. They must carry out their duties personally. The attorney may seek professional or expert advice (for example, investment advice from a financial adviser or advice on medical treatment from a doctor). But they cannot, as a general rule, allow someone else to make a decision that they have been appointed to make, unless this has been specifically authorised by the donor in the LPA.

7.62 In certain circumstances, attorneys may have limited powers to delegate (for example, through necessity or unforeseen circumstances, or for specific tasks which the donor would not have expected the attorney to attend to personally). But attorneys cannot usually delegate any decisions that rely on their discretion.

**Duty of good faith**

7.63 Acting in good faith means acting with honesty and integrity. For example, an attorney must try to make sure that their decisions do not go against a decision the donor made while they still had capacity (unless it would be in the donor’s best interests to do so).

**Duty of confidentiality**

7.64 Attorneys have a duty to keep the donor’s affairs confidential, unless:
• before they lost capacity to do so, the donor agreed that some personal or financial information may be revealed for a particular purpose (for example, they have named someone they want to check their financial accounts), or

• there is some other good reason to release it (for example, it is in the public interest or the best interests of the person who lacks capacity, or there is a risk of harm to the donor or others).

In the latter circumstances, it may be advisable for the attorney to get legal advice. Chapter 16 gives more information about confidentiality.

**Duty to comply with the directions of the Court of Protection**

7.65 Under sections 22 and 23 of the Act, the Court of Protection has wide-ranging powers to decide on issues relating to the operation or validity of an LPA. It can also:

• give extra authority to attorneys

• order them to produce records (for example, financial accounts), or

• order them to provide specific information or documentation to the court.

Attorneys must comply with any decision or order that the court makes.

**Duty not to disclaim without notifying the donor and the OPG**

7.66 Once someone becomes an attorney, they cannot give up that role without notifying the donor and the OPG. If they decide to give up their role, they must follow the relevant guidance available from the OPG.

**Duty to keep accounts**

7.67 Property and affairs attorneys must keep accounts of transactions carried out on the donor's behalf. Sometimes the Court of Protection will ask to see accounts. If the attorney is not a financial expert and the donor's affairs are relatively straightforward, a record of the donor's income and expenditure (for example, through bank statements) may be enough. The more complicated the donor’s affairs, the more detailed the accounts may need to be.

**Duty to keep the donor’s money and property separate**

7.68 Property and affairs attorneys should usually keep the donor’s money and property separate from their own or anyone else’s. There may be occasions where donors and attorneys have agreed in the past to keep their money in a joint bank account (for example, if a husband is acting as his wife's attorney). It might be possible to continue this under the LPA. But in most circumstances, attorneys must keep finances separate to avoid any possibility of mistakes or confusion.

**How does the Act protect donors from abuse?**

**What should someone do if they think an attorney is abusing their position?**

7.69 Attorneys are in a position of trust, so there is always a risk of them abusing their position. Donors can help prevent abuse by carefully choosing a suitable and trustworthy attorney. But others have a role to play in looking out for
possible signs of abuse or exploitation, and reporting any concerns to the OPG. The OPG will then follow this up in co-operation with relevant agencies.

7.70 Signs that an attorney may be exploiting the donor (or failing to act in the donor’s best interests) include:

• stopping relatives or friends contacting the donor – for example, the attorney may prevent contact or the donor may suddenly refuse visits or telephone calls from family and friends for no reason
• sudden unexplained changes in living arrangements (for example, someone moves in to care for a donor they’ve had little contact with)
• not allowing healthcare or social care staff to see the donor
• taking the donor out of hospital against medical advice, while the donor is having necessary medical treatment
• unpaid bills (for example, residential care or nursing home fees)
• an attorney opening a credit card account for the donor
• spending money on things that are not obviously related to the donor’s needs
• the attorney spending money in an unusual or extravagant way
• transferring financial assets to another country.

7.71 Somebody who suspects abuse should contact the OPG immediately. The OPG may direct a Court of Protection Visitor to visit an attorney to investigate. In cases of suspected physical or sexual abuse, theft or serious fraud, the person should contact the police. They might also be able to refer the matter to the relevant local adult protection authorities.

7.72 In serious cases, the OPG will refer the matter to the Court of Protection. The court may revoke (cancel) the LPA or (through the OPG) prevent it being registered, if it decides that:

• the LPA does not meet the legal requirements for creating an LPA
• the LPA has been revoked or come to an end for any other reason
• somebody used fraud or undue pressure to get the donor to make the LPA
• the attorney has done something that they do not have authority to do, or
• the attorney has behaved or is planning to behave in a way that is not in the donor’s best interests.

The court might then consider whether the authority previously given to an attorney can be managed by:

• the court making a single decision, or
• appointing a deputy.

What should an attorney do if they think someone else is abusing the donor?

7.73 An attorney who thinks someone else is abusing or exploiting the donor should report it to the OPG and ask for advice on what action they should
take. They should contact the police if they suspect physical or sexual abuse, theft or serious fraud. They might also be able to refer the matter to local adult protection authorities.

7.74 Chapter 13 gives more information about protecting vulnerable people from abuse, ill treatment or neglect. It also discusses the duties and responsibilities of the various agencies involved, including the OPG and local authorities. In particular, it is a criminal offence (with a maximum penalty of five years’ imprisonment, a fine, or both) for anyone (including attorneys) to wilfully neglect or ill-treat a person in their care who lacks capacity to make decisions for themselves (section 44).

What happens to existing EPAs once the Act comes into force?

7.75 Once the Act comes into force, it will not be possible to make new EPAs. Only LPAs can then be made.

7.76 Some donors will have created EPAs before the Act came into force with the expectation that their chosen attorneys will manage their property and affairs in the future, whether or not they have capacity to do so themselves.

7.77 If donors still have capacity after the Act comes into force, they can cancel the EPA and make an LPA covering their property and affairs. They should also notify attorneys and anyone else aware of the EPA (for example, a bank) that they have cancelled it.

7.78 Some donors will choose not to cancel their EPA or they may already lack the capacity to do so. In such cases, the Act allows existing EPAs, whether registered or not, to continue to be valid so that attorneys can meet the donor’s expectations (Schedule 4). An EPA must be registered with the OPG when the attorney thinks the donor lacks capacity to manage their own affairs, or is beginning to lack capacity to do so.

7.79 EPA attorneys may find guidance in this chapter helpful. In particular, all attorneys must comply with the duties described in paragraphs 7.58–7.68 above. EPA attorneys can also be found liable under section 44 of the new Act, which sets out the new criminal offences of ill treatment and wilful neglect. The OPG has produced guidance on EPAs (see Annex A for details of publications and contact information).
8 What is the role of the Court of Protection and court-appointed deputies?

This chapter describes the role of the Court of Protection and the role of court-appointed deputies. It explains the powers that the court has and how to make an application to the court. It also looks at how the court appoints a deputy to act and make decisions on behalf of someone who lacks capacity to make those decisions. In particular, it gives guidance on a deputy’s duties and the consequences of not carrying them out responsibly.

The Office of the Public Guardian (OPG) produces detailed guidance for deputies. See the Annex for more details of the publications and how to get them. Further details on the court’s procedures are given in the Court of Protection Rules and Practice Directions issued by the court.

In this chapter, as throughout the Code, a person’s capacity (or lack of capacity) refers specifically to their capacity to make a particular decision at the time it needs to be made.

Quick summary

The Court of Protection has powers to:

• decide whether a person has capacity to make a particular decision for themselves
• make declarations, decisions or orders on financial or welfare matters affecting people who lack capacity to make such decisions
• appoint deputies to make decisions for people lacking capacity to make those decisions
• decide whether an LPA or EPA is valid, and
• remove deputies or attorneys who fail to carry out their duties.

Before accepting an appointment as a deputy, a person the court nominates should consider whether:

• they have the skills and ability to carry out a deputy’s duties (especially in relation to property and affairs)
• they actually want to take on the duties and responsibilities.

Anyone acting as a deputy must:

• make sure that they only make those decisions that they are authorised to make by the order of the court
• make sure that they follow the Act’s statutory principles, including:
  – considering whether the person has capacity to make a particular decision for themselves. If they do, the deputy should allow them to do so unless the person agrees that the deputy should make the decision
  – taking all possible steps to try to help a person make the particular decision
• always make decisions in the person’s best interests
• have regard to guidance in the Code of Practice that is relevant to the situation
• fulfil their duties towards the person concerned (in particular the duty of care and fiduciary duties to respect the degree of trust placed in them by the court).

What is the Court of Protection?

8.1 Section 45 of the Act sets up a specialist court, the Court of Protection, to deal with decision-making for adults (and children in a few cases) who may lack capacity to make specific decisions for themselves. The new Court of Protection replaces the old court of the same name, which only dealt with decisions about the property and financial affairs of people lacking capacity to manage their own affairs. As well as property and affairs, the new court also deals with serious decisions affecting healthcare and personal welfare matters. These were previously dealt with by the High Court under its inherent jurisdiction.

8.2 The new Court of Protection is a superior court of record and is able to establish precedent (it can set examples for future cases) and build up expertise in all issues related to lack of capacity. It has the same powers, rights, privileges and authority as the High Court. When reaching any decision, the court must apply all the statutory principles set out in section 1 of the Act. In particular, it must make a decision in the best interests of the person who lacks capacity to make the specific decision. There will usually be a fee for applications to the court.\footnote{Details of the fees charged by the court, and the circumstances in which the fees may be waived or remitted, are available from the Office of the Public Guardian (OPG).}

How can somebody make an application to the Court of Protection?

8.3 In most cases concerning personal welfare matters, the core principles of the Act and the processes set out in chapters 5 and 6 will be enough to:

• help people take action or make decisions in the best interests of someone who lacks capacity to make decisions about their own care or treatment, or
• find ways of settling disagreements about such actions or decisions.

But an application to the Court of Protection may be necessary for:

• particularly difficult decisions
• disagreements that cannot be resolved in any other way (see chapter 15), or
• situations where ongoing decisions may need to be made about the personal welfare of a person who lacks capacity to make decisions for themselves.

8.4 An order of the court will usually be necessary for matters relating to the property and affairs (including financial matters) of people who lack capacity to make specific financial decisions for themselves, unless:
• their only income is state benefits (see paragraph 8.36 below), or
• they have previously made an Enduring Power of Attorney (EPA) or a Lasting Power of Attorney (LPA) to give somebody authority to manage their property and affairs (see chapter 7).

8.5 Receivers appointed by the court before the Act commences will be treated as deputies. But they will keep their existing powers and duties. They must meet the requirements set out in the Act and, in particular, follow the statutory principles and act in the best interests of the person for whom they have been appointed. They must also have regard to guidance in this chapter and other parts of the Code of Practice. Further guidance for receivers is available from the OPG.

Cases involving young people aged 16 or 17

8.6 Either a court dealing with family proceedings or the Court of Protection can hear cases involving people aged 16 or 17 who lack capacity. In some cases, the Court of Protection can hear cases involving people younger than 16 (for example, when somebody needs to be appointed to make longer-term decisions about their financial affairs). Under section 21 of the Mental Capacity Act, the Court of Protection can transfer cases concerning children to a court that has powers under the Children Act 1989. Such a court can also transfer cases to the Court of Protection, if necessary. Chapter 12 gives more detail on cases where this might apply.

Who should make the application?

8.7 The person making the application will vary, depending on the circumstances. For example, a person wishing to challenge a finding that they lack capacity may apply to the court, supported by others where necessary. Where there is a disagreement among family members, for example, a family member may wish to apply to the court to settle the disagreement – bearing in mind the need, in most cases, to get permission beforehand (see paragraphs 8.11–8.12 below).

8.8 For cases about serious or major decisions concerning medical treatment (see paragraphs 8.18–8.24 below), the NHS Trust or other organisation responsible for the patient’s care will usually make the application. If social care staff are concerned about a decision that affects the welfare of a person who lacks capacity, the relevant local authority should make the application.

8.9 For decisions about the property and affairs of someone who lacks capacity to manage their own affairs, the applicant will usually be the person (for example, family carer) who needs specific authority from the court to deal with the individual’s money or property.

8.10 If the applicant is the person who is alleged to lack capacity, they will always be a party to the court proceedings. In all other cases, the court will decide whether the person who lacks, or is alleged to lack, capacity should be involved as a party to the case. Where the person is a party to the case, the court may appoint the Official Solicitor to act for them.
Who must ask the court for permission to make an application?

8.11 As a general rule, potential applicants must get the permission of the Court of Protection before making an application (section 50). People who the Act says do not need to ask for permission include:

- a person who lacks, or is alleged to lack, capacity in relation to a specific decision or action (or anyone with parental responsibility, if the person is under 18 years)
- the donor of the LPA an application relates to – or their attorney
- a deputy who has been appointed by the court to act for the person concerned, and
- a person named in an existing court order relating to the application.

The Court of Protection Rules also set out specific types of cases where permission is not required.

8.12 When deciding whether to give permission for an application, the court must consider:

- the applicant’s connection to the person the application is about
- the reasons for the application
- whether a proposed order or direction of the court will benefit the person the application is about, and
- whether it is possible to get that benefit another way.

Scenario: Considering whether to give permission for an application

Sunita, a young Asian woman, has always been close to her older brother, who has severe learning disabilities and lives in a care home. Two years ago, Sunita married a non-Asian man, and her family cut off contact with her. She still wants to visit her brother and to be consulted about his care and what is in his best interests. But the family is not letting her. The Court of Protection gives Sunita permission to apply to the court for an order allowing her contact with her brother.

What powers does the Court of Protection have?

8.13 The Court of Protection may:

- make declarations, decisions and orders on financial and welfare matters affecting people who lack, or are alleged to lack, capacity (the lack of capacity must relate to the particular issue being presented to the court)
- appoint deputies to make decisions for people who lack capacity to make those decisions
- remove deputies or attorneys who act inappropriately.

The Court can also hear cases about LPAs and EPAs. The court’s powers concerning EPAs are set out in Schedule 4 of the Act.
The court must always follow the statutory principles set out in section 1 of the Act (see chapter 2) and make the decision in the best interests of the person concerned (see chapter 5).

What declarations can the court make?

Section 15 of the Act provides the court with powers to make a declaration (a ruling) on specific issues. For example, it can make a declaration as to whether a person has capacity to make a particular decision or give consent for or take a particular action. The court will require evidence of any assessment of the person's capacity and may wish to see relevant written evidence (for example, a diary, letters or other papers). If the court decides the person has capacity to make that decision, they will not take the case further. The person can now make the decision for themselves.

Applications concerning a person’s capacity are likely to be rare – people can usually settle doubts and disagreements informally (see chapters 4 and 15). But an application may be relevant if:

- a person wants to challenge a decision that they lack capacity
- professionals disagree about a person’s capacity to make a specific (usually serious) decision
- there is a dispute over whether the person has capacity (for example, between family members).

The court can also make a declaration as to whether a specific act relating to a person’s care or treatment is lawful (either where somebody has carried out the action or is proposing to). Under section 15, this can include an omission or failure to provide care or treatment that the person needs.

This power to decide on the lawfulness of an act is particularly relevant for major medical treatment cases where there is doubt or disagreement over whether the treatment would be in the person’s best interests. Healthcare staff can still give life-sustaining treatment, or treatment which stops a person’s condition getting seriously worse, while the court is coming to a decision.

Serious healthcare and treatment decisions

Prior to the Act coming into force, the courts decided that some decisions relating to the provision of medical treatment were so serious that in each case, an application should be made to the court for a declaration that the proposed action was lawful before that action was taken. Cases involving any of the following decisions should therefore be brought before a court:

- decisions about the proposed withholding or withdrawal of artificial nutrition and hydration (ANH) from patients in a permanent vegetative state (PVS)
- cases involving organ or bone marrow donation by a person who lacks capacity to consent
- cases involving the proposed non-therapeutic sterilisation of a person who lacks capacity to consent to this (e.g. for contraceptive purposes) and
- all other cases where there is a doubt or dispute about whether a particular treatment will be in a person’s best interests.
The case law requirement to seek a declaration in cases involving the withholding or withdrawing of artificial nutrition and hydration to people in a permanent vegetative state is unaffected by the Act and as a matter of practice, these cases should be put to the Court of Protection for approval.

8.20 Cases involving organ or bone marrow donation by a person who lacks capacity to consent should also be referred to the Court of Protection. Such cases involve medical procedures being performed on a person who lacks capacity to consent but which would benefit a third party (though would not necessarily directly or physically benefit the person who lacks capacity). However, sometimes such procedures may be in the person’s overall best interests (see chapter 5). For example, the person might receive emotional, social and psychological benefits as a result of the help they have given, and in some cases the person may experience only minimal physical discomfort.

8.21 A prime example of this is the case of Re Y where it was found to be in Y’s best interests for her to donate bone marrow to her sister. The court decided that it was in Y’s best interests to continue to receive strong emotional support from her mother, which might be diminished if her sister’s health were to deteriorate further, or she were to die. Further details on this area are available in Department of Health or Welsh Assembly guidance.

8.22 Non-therapeutic sterilisation is the sterilisation for contraceptive purposes of a person who cannot consent. Such cases will require a careful assessment of whether such sterilisation would be in the best interests of the person who lacks capacity and such cases should continue to be referred to the court. The court has also given guidance on when certain termination of pregnancy cases should be brought before the court.

8.23 Other cases likely to be referred to the court include those involving ethical dilemmas in untested areas (such as innovative treatments for variant CJD), or where there are otherwise irresolvable conflicts between healthcare staff, or between staff and family members.

8.24 There are also a few types of cases that should generally be dealt with by the court, since other dispute resolution methods are unlikely to be appropriate.

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30 Airedale NHS Trust v Bland [1993] AC 789

31 Re Y (Mental incapacity: Bone marrow transplant) [1996] 2 FLR 787


33 See e.g. Re A (medical treatment: male sterilisation) (1999) 53 BMLR 66 where a mother applied for a declaration that a vasectomy was in the best interests of A, her son, (who had Down’s syndrome and was borderline between significant and severe impairment of intelligence), in the absence of his consent. After balancing the burdens and benefits of the proposed vasectomy to A, the Court of Appeal held that the vasectomy would not be in A’s best interests.

34 D v An NHS Trust (Medical Treatment: Consent: Termination) [2004] 1 FLR 1110
What powers does the court have to make decisions and appoint deputies?

8.25 In cases of serious dispute, where there is no other way of finding a solution or when the authority of the court is needed in order to make a particular decision or take a particular action, the court can be asked to make a decision to settle the matter using its powers under section 16.

However, if there is a need for ongoing decision-making powers and there is no relevant EPA or LPA, the court may appoint a deputy to make future decisions. It will also state what decisions the deputy has the authority to make on the person’s behalf.

8.26 In deciding what type of order to make, the court must apply the Act’s principles and the best interests checklist. In addition, it must follow two further principles, intended to make any intervention as limited as possible:

- Where possible, the court should make the decision itself in preference to appointing a deputy.
- If a deputy needs to be appointed, their appointment should be as limited in scope and for as short a time as possible.

What decisions can the court make?

8.27 In some cases, the court must make a decision, because someone needs specific authority to act and there is no other route for getting it. These include cases where:

- there is no EPA or property and affairs LPA in place and someone needs to make a financial decision for a person who lacks capacity to make that decision (for example, the decision to terminate a tenancy agreement), or
- it is necessary to make a will, or to amend an existing will, on behalf of a person who lacks capacity to do so.

8.28 Examples of other types of cases where a court decision might be appropriate include cases where:

- there is genuine doubt or disagreement about the existence, validity or applicability of an advance decision to refuse treatment (see chapter 9)
- there is a major disagreement regarding a serious decision (for example, about where a person who lacks capacity to decide for themselves should live)
- a family carer or a solicitor asks for personal information about someone who lacks capacity to consent to that information being revealed (for example, where there have been allegations of abuse of a person living in a care home)
- someone suspects that a person who lacks capacity to make decisions to protect themselves is at risk of harm or abuse from a named individual (the court could stop that individual contacting the person who lacks capacity).
Anyone carrying out actions under a decision or order of the court must still also follow the Act’s principles.

**Scenario: Making a decision to settle disagreements**

Mrs Worrell has Alzheimer’s disease. Her son and daughter argue over which care home their mother should move to. Although Mrs Worrell lacks the capacity to make this decision herself, she has enough money to pay the fees of a care home.

Her solicitor acts as attorney in relation to her financial affairs under a registered EPA. But he has no power to get involved in this family dispute – nor does he want to get involved.

The Court of Protection makes a decision in Mrs Worrell’s best interests, and decides which care home can best meet her needs. Once this matter is resolved, there is no need to appoint a deputy.

**What powers does the court have in relation to LPAs?**

The Court of Protection can determine the validity of an LPA or EPA and can give directions as to how an attorney should use their powers under an LPA (see chapter 7). In particular, the court can cancel an LPA and end the attorney’s appointment. The court might do this if the attorney was not carrying out their duties properly or acting in the best interests of the donor. The court must then decide whether it is necessary to appoint a deputy to take over the attorney’s role.

**What are the rules for appointing deputies?**

Sometimes it is not practical or appropriate for the court to make a single declaration or decision. In such cases, if the court thinks that somebody needs to make future or ongoing decisions for someone whose condition makes it likely they will lack capacity to make some further decisions in the future, it can appoint a deputy to act for and make decisions for that person. A deputy’s authority should be as limited in scope and duration as possible (see paragraphs 8.35–8.39 below).

**How does the court appoint deputies?**

It is for the court to decide who to appoint as a deputy. Different skills may be required depending on whether the deputy’s decisions will be about a person’s welfare (including healthcare), their finances or both. The court will decide whether the proposed deputy is reliable and trustworthy and has an appropriate level of skill and competence to carry out the necessary tasks.

In the majority of cases, the deputy is likely to be a family member or someone who knows the person well. But in some cases the court may decide to appoint a deputy who is independent of the family (for example, where the person’s affairs or care needs are particularly complicated). This could be, for example, the Director of Adult Services in the relevant local authority (but see paragraph 8.60 below) or a professional deputy. The OPG has a panel of professional deputies (mainly solicitors who specialise in this area of law) who may be appointed to deal with property and affairs if the court decides that would be in the person’s best interests.
When might a deputy need to be appointed?

8.34 Whether a person who lacks capacity to make specific decisions needs a deputy will depend on:

- the individual circumstances of the person concerned
- whether future or ongoing decisions are likely to be necessary, and
- whether the appointment is for decisions about property and affairs or personal welfare.

Property and affairs

8.35 The court will appoint a deputy to manage a person’s property and affairs (including financial matters) in similar circumstances to those in which they would have appointed a receiver in the past. If a person who lacks capacity to make decisions about property and affairs has not made an EPA or LPA, applications to the court are necessary:

- for dealing with cash assets over a specified amount that remain after any debts have been paid
- for selling a person’s property, or
- where the person has a level of income or capital that the court thinks a deputy needs to manage.

8.36 If the only income of a person who lacks capacity is social security benefits and they have no property or savings, there will usually be no need for a deputy to be appointed. This is because the person’s benefits can be managed by an appointee, appointed by the Department for Work and Pensions to receive and deal with the benefits of a person who lacks capacity to do this for themselves. Although appointees are not covered by the Act, they will be expected to act in the person’s best interests and must do so if they are involved in caring for the person. If the court does appoint a property and affairs deputy for someone who has an appointee, it is likely that the deputy would take over the appointee’s role.

8.37 Anybody considered for appointment as a property and affairs deputy will need to sign a declaration giving details of their circumstances and ability to manage financial affairs. The declaration will include details of the tasks and duties the deputy must carry out. The deputy must assure the court that they have the skills, knowledge and commitment to carry them out.

Personal welfare (including healthcare)

8.38 Deputies for personal welfare decisions will only be required in the most difficult cases where:

- important and necessary actions cannot be carried out without the court’s authority, or
- there is no other way of settling the matter in the best interests of the person who lacks capacity to make particular welfare decisions.

8.39 Examples include when:
• someone needs to make a series of linked welfare decisions over time and it would not be beneficial or appropriate to require all of those decisions to be made by the court. For example, someone (such as a family carer) who is close to a person with profound and multiple learning disabilities might apply to be appointed as a deputy with authority to make such decisions

• the most appropriate way to act in the person’s best interests is to have a deputy, who will consult relevant people but have the final authority to make decisions

• there is a history of serious family disputes that could have a detrimental effect on the person’s future care unless a deputy is appointed to make necessary decisions

• the person who lacks capacity is felt to be at risk of serious harm if left in the care of family members. In these rare cases, welfare decisions may need to be made by someone independent of the family, such as a local authority officer. There may even be a need for an additional court order prohibiting those family members from having contact with the person.

Who can be a deputy?

8.40 Section 19(1) states that deputies must be at least 18 years of age. Deputies with responsibility for property and affairs can be either an individual or a trust corporation (often parts of banks or other financial institutions). No-one can be appointed as a deputy without their consent.

8.41 Paid care workers (for example, care home managers) should not agree to act as a deputy because of the possible conflict of interest – unless there are exceptional circumstances (for example, if the care worker is the only close relative of the person who lacks capacity). But the court can appoint someone who is an office-holder or in a specified position (for example, the Director of Adult Services of the relevant local authority). In this situation, the court will need to be satisfied that there is no conflict of interest before making such an appointment (see paragraphs 8.58–8.60).

8.42 The court can appoint two or more deputies and state whether they should act ‘jointly’, ‘jointly and severally’ or ‘jointly in respect of some matters and jointly and severally in respect of others’ (section 19 (4)(c)).

• Joint deputies must always act together. They must all agree decisions or actions, and all sign any relevant documents.

• Joint and several deputies can act together, but they may also act independently if they wish. Any action taken by any deputy alone is as valid as if that person were the only deputy.

8.43 Deputies may be appointed jointly for some issues and jointly and severally for others. For example, two deputies could be appointed jointly and severally for most decisions, but the court might rule that they act jointly when selling property.

Scenario: Acting jointly and severally
Toby had a road accident and suffered brain damage and other disabilities. He gets financial compensation but lacks capacity to manage this amount of money or make decisions about his future care. His divorced parents are arguing about where their son should live and how his compensation money should be used. Toby has always been close to his sister, who is keen to be involved but is anxious about dealing with such a large amount of money.

The court decides where Toby will live. It also appoints his sister and a solicitor as joint and several deputies to manage his property and affairs. His sister can deal with any day-to-day decisions that Toby lacks capacity to make, and the solicitor can deal with more complicated matters.

What happens if a deputy can no longer carry out their duties?

8.44 When appointing a deputy, the court can also appoint someone to be a successor deputy (someone who can take over the deputy’s duties in certain situations). The court will state the circumstances under which this could occur. In some cases it will also state a period of time in which the successor deputy can act. Appointment of a successor deputy might be useful if the person appointed as deputy is already elderly and wants to be sure that somebody will take over their duties in the future, if necessary.

Scenario: Appointing a successor deputy

Neil, a man with Down’s syndrome, inherits a lot of money and property. His parents were already retired when the court appointed them as joint deputies to manage Neil’s property and affairs. They are worried about what will happen to Neil when they cannot carry out their duties as deputies any more. The court agrees to appoint other relatives as successor deputies. They will then be able to take over as deputies after the parents’ death or if his parents are no longer able to carry out the deputy’s role.

Can the court protect people lacking capacity from financial loss?

8.45 Under section 19(9)(a) of the Act the court can ask a property and affairs deputy to provide some form of security (for example, a guarantee bond) to the Public Guardian to cover any loss as a result of the deputy’s behaviour in carrying out their role. The court can also ask a deputy to provide reports and accounts to the Public Guardian, as it sees fit.

Are there any restrictions on a deputy’s powers?

8.46 Section 20 sets out some specific restrictions on a deputy’s powers. In particular, a deputy has no authority to make decisions or take action:

- if they do something that is intended to restrain the person who lacks capacity – apart from under certain circumstances (guidance on the circumstances when restraint might be permitted is given in chapter 6)\(^\text{35}\)

\(^{35}\) It is worth noting that there is a drafting error in section 20 of the Act. The word ‘or’ in section 20(11)(a) should have been ‘and’ in order to be consistent with sections 6(3)(a) and 11(4)(a). The Government will make the necessary amendment to correct this error at the earliest available legislative opportunity.
• if they think that the person concerned has capacity to make the particular
decision for themselves

• if their decision goes against a decision made by an attorney acting under a
  Lasting Power of Attorney granted by the person before they lost capacity,
or

• to refuse the provision or continuation of life-sustaining treatment for a
  person who lacks capacity to consent – such decisions must be taken by
  the court.

If a deputy thinks their powers are not enough for them to carry out their duties
effectively, they can apply to the court to change their powers. See paragraph
8.54 below.

What responsibilities do deputies have?

8.47 Once a deputy has been appointed by the court, the order of appointment will
set out their specific powers and the scope of their authority. On taking up the
appointment, the deputy will assume a number of duties and responsibilities
and will be required to act in accordance with certain standards. Failure to
comply with the duties set out below could result in the Court of Protection
revoking the order appointing the deputy and, in some circumstances, the
deputy could be personally liable to claims for negligence or criminal charges
of fraud.

8.48 Deputies should always inform any third party they are dealing with that the
court has appointed them as deputy. The court will give the deputy official
documents to prove their appointment and the extent of their authority.

8.49 A deputy must act whenever a decision or action is needed and it falls within
their duties as set out in the court order appointing them. A deputy who fails to
act at all in such situations could be in breach of duty.

What duties does the Act impose?

8.50 Deputies must:

• follow the Act’s statutory principles (see chapter 2)

• make decisions or act in the best interests of the person who lacks capacity

• have regard to the guidance in this Code of Practice

• only make decisions the Court has given them authority to make.

Principles and best interests

8.51 Deputies must act in accordance with the Act’s statutory principles (section 1)
and in particular the best interests of the person who lacks capacity (the steps
for working out best interests are set out in section 4). In particular, deputies
must consider whether the person has capacity to make the decision for
themselves. If not, they should consider whether the person is likely to regain
capacity to make the decision in the future. If so, it may be possible to delay
the decision until the person can make it.
The Code of Practice

8.52 As well as this chapter, deputies should pay special attention to the following guidance set out in the Code:

- chapter 2, which sets out how the Act’s principles should be applied
- chapter 3, which describes the steps which can be taken to try to help the person make decisions for themselves
- chapter 4, which describes the Act’s definition of lack of capacity and gives guidance on assessing capacity, and
- chapter 5, which gives guidance on working out someone’s best interests.

8.53 In some situations, deputies might also find it useful to refer to guidance in:

- chapter 6, which explains when deputies who have caring responsibilities may have protection from liability and gives guidance on the few circumstances when the Act allows restraint in connection with care and treatment, and
- chapter 15, which describes ways to settle disagreements.

Only making decisions the court authorises a deputy to make

8.54 A deputy has a duty to act only within the scope of the actual powers given by the court, which are set out in the order of appointment. It is possible that a deputy will think their powers are not enough for them to carry out their duties effectively. In this situation, they must apply to the court either to:

- ask the court to make the decision in question, or
- ask the court to change the deputy’s powers.

What are a deputy’s other duties?

8.55 Section 19(6) states that a deputy is to be treated as ‘the agent’ of the person who lacks capacity when they act on their behalf. Being an agent means that the deputy has legal duties (under the law of agency) to the person they are representing. It also means that when they carry out tasks within their powers, they are not personally liable to third parties.

8.56 Deputies must carry out their duties carefully and responsibly. They have a duty to:

- act with due care and skill (duty of care)
- not take advantage of their situation (fiduciary duty)
- indemnify the person against liability to third parties caused by the deputy’s negligence
- not delegate duties unless authorised to do so
- act in good faith
- respect the person’s confidentiality, and
- comply with the directions of the Court of Protection.
Property and affairs deputies also have a duty to:

- keep accounts, and
- keep the person’s money and property separate from own finances.

**Duty of care**

8.57 ‘Duty of care’ means applying a certain standard of care and skill – depending on whether the deputy is paid for their services or holds relevant professional qualifications.

- Deputies who are not being paid must use the same care, skill and diligence they would use when making decisions for themselves or managing their own affairs. If they do not, they could be held liable for acting negligently. A deputy who claims to have particular skills or qualifications must show greater skill in those particular areas than a person who does not make such claims.
- If deputies are being paid for their services, they are expected to demonstrate a higher degree of care or skill when carrying out their duties.
- Deputies whose duties form part of their professional work (for example, solicitors or accountants) must display normal professional competence and follow their profession’s rules and standards.

**Fiduciary duty**

8.58 A fiduciary duty means deputies must not take advantage of their position. Nor should they put themselves in a position where their personal interests conflict with their duties. For example, deputies should not buy property that they are selling for the person they have been appointed to represent. They should also not accept a third party commission in any transactions. Deputies must not allow anything else to influence their duties. They cannot use their position for any personal benefit, whether or not it is at the person’s expense.

8.59 In many cases, the deputy will be a family member. In rare situations, this could lead to potential conflicts of interests. When making decisions, deputies should follow the Act’s statutory principles and apply the best interests checklist and not allow their own personal interests to influence the decision.

8.60 Sometimes the court will consider appointing the Director of Adult Services in England or Director of Social Services in Wales of the relevant local authority as a deputy. The court will need to be satisfied that the authority has arrangements to avoid possible conflicts of interest. For example where the person for whom a financial deputy is required receives community care services from the local authority, the court will wish to be satisfied that decisions about the person’s finances will be made in the best interests of that person, regardless of any implications for the services provided.

**Duty not to delegate**

8.61 A deputy may seek professional or expert advice (for example, investment advice from a financial adviser or a second medical opinion from a doctor). But they cannot give their decision-making responsibilities to someone else. In certain circumstances, the court will authorise the delegation of specific tasks
(for example, appointing a discretionary investment manager for the conduct of investment business).

8.62 In certain circumstances, deputies may have limited powers to delegate (for example, through necessity or unforeseen circumstances, or for specific tasks which the court would not have expected the deputy to attend to personally). But deputies cannot usually delegate any decisions that rely on their discretion. If the deputy is the Director of Adult Services in England or Director of Social Services in Wales, or a solicitor, they can delegate specific tasks to other staff. But the deputy is still responsible for any actions or decisions taken, and can therefore be held accountable for any errors that are made.

**Duty of good faith**

8.63 Acting in good faith means acting with honesty and integrity. For example, a deputy must try to make sure that their decisions do not go against a decision the person made while they still had capacity (unless it would be in the person’s best interests to do so).

**Duty of confidentiality**

8.64 Deputies have a duty to keep the person’s affairs confidential, unless:

- before they lost capacity to do so, the person agreed that information could be revealed where necessary
- there is some other good reason to release information (for example, it is in the public interest or in the best interests of the person who lacks capacity, or where there is a risk of harm to the person concerned or to other people).

In the latter circumstances, it is advisable for the deputy to contact the OPG for guidance or get legal advice. See chapter 16 for more information about revealing personal information.

**Duty to comply with the directions of the Court of Protection**

8.65 The Court of Protection may give specific directions to deputies about how they should use their powers. It can also order deputies to provide reports (for example, financial accounts or reports on the welfare of the person who lacks capacity) to the Public Guardian at any time or at such intervals as the court directs. Deputies must comply with any direction of the court or request from the Public Guardian.

**Duty to keep accounts**

8.66 A deputy appointed to manage property and affairs is expected to keep, and periodically submit to the Public Guardian, correct accounts of all their dealings and transactions on the person’s behalf.

**Duty to keep the person’s money and property separate**

8.67 Property and affairs deputies should usually keep the person’s money and property separate from their own or anyone else’s. This is to avoid any possibility of mistakes or confusion in handling the person’s affairs. Sometimes there may be good reason not to do so (for example, a husband
might be his wife’s deputy and they might have had a joint account for many years).

Changes of contact details

8.68 A deputy should inform the OPG of any changes of contact details or circumstances (for the deputy or the person they are acting for). This will help make sure that the OPG has up-to-date records. It will also allow the court to discharge people who are no longer eligible to act as deputies.

Who is responsible for supervising deputies?

8.69 Deputies are accountable to the Court of Protection. The court can cancel a deputy’s appointment at any time if it decides the appointment is no longer in the best interests of the person who lacks capacity.

8.70 The OPG is responsible for supervising and supporting deputies. But it must also protect people lacking capacity from possible abuse or exploitation. Anybody who suspects that a deputy is abusing their position should contact the OPG immediately. The OPG may instruct a Court of Protection Visitor to visit a deputy to investigate any matter of concern. It can also apply to the court to cancel a deputy’s appointment.

8.71 The OPG will consider carefully any concerns or complaints against deputies. But if somebody suspects physical or sexual abuse or serious fraud, they should contact the police and/or social services immediately, as well as informing the OPG. Chapter 14 gives more information about the role of the OPG. It also discusses the protection of vulnerable people from abuse, ill treatment or wilful neglect and the responsibilities of various relevant agencies.
9 What does the Act say about advance decisions to refuse treatment?

This chapter explains what to do when somebody has made an advance decision to refuse treatment. It sets out:

• what the Act means by an ‘advance decision’
• guidance on making, updating and cancelling advance decisions
• how to check whether an advance decision exists
• how to check that an advance decision is valid and that it applies to current circumstances
• the responsibilities of healthcare professionals when an advance decision exists
• how to handle disagreements about advance decisions.

In this chapter, as throughout the Code, a person’s capacity (or lack of capacity) refers specifically to their capacity to make a particular decision at the time it needs to be made.

Quick summary

• An advance decision enables someone aged 18 and over, while still capable, to refuse specified medical treatment for a time in the future when they may lack the capacity to consent to or refuse that treatment.
• An advance decision to refuse treatment must be valid and applicable to current circumstances. If it is, it has the same effect as a decision that is made by a person with capacity: healthcare professionals must follow the decision.
• Healthcare professionals will be protected from liability if they:
  – stop or withhold treatment because they reasonably believe that an advance decision exists, and that it is valid and applicable
  – treat a person because, having taken all practical and appropriate steps to find out if the person has made an advance decision to refuse treatment, they do not know or are not satisfied that a valid and applicable advance decision exists.
• People can only make an advance decision under the Act if they are 18 or over and have the capacity to make the decision. They must say what treatment they want to refuse, and they can cancel their decision – or part of it – at any time.
• If the advance decision refuses life-sustaining treatment, it must:
  – be in writing (it can be written by a someone else or recorded in healthcare notes)
  – be signed and witnessed, and
  – state clearly that the decision applies even if life is at risk.
• To establish whether an advance decision is valid and applicable, healthcare professionals must try to find out if the person:
– has done anything that clearly goes against their advance decision
– has withdrawn their decision
– has subsequently conferred the power to make that decision on an attorney, or
– would have changed their decision if they had known more about the current circumstances.

• Sometimes healthcare professionals will conclude that an advance decision does not exist, is not valid and/or applicable – but that it is an expression of the person’s wishes. The healthcare professional must then consider what is set out in the advance decision as an expression of previous wishes when working out the person’s best interests (see chapter 5).

• Some healthcare professionals may disagree in principle with patients’ decisions to refuse life-sustaining treatment. They do not have to act against their beliefs. But they must not simply abandon patients or act in a way that that affects their care.

• Advance decisions to refuse treatment for mental disorder may not apply if the person who made the advance decision is or is liable to be detained under the Mental Health Act 1983.

How can someone make an advance decision to refuse treatment?

What is an advance decision to refuse treatment?

9.1 It is a general principle of law and medical practice that people have a right to consent to or refuse treatment. The courts have recognised that adults have the right to say in advance that they want to refuse treatment if they lose capacity in the future – even if this results in their death. A valid and applicable advance decision to refuse treatment has the same force as a contemporaneous decision. This has been a fundamental principle of the common law for many years and it is now set out in the Act. Sections 24–26 of the Act set out the when a person can make an advance decision to refuse treatment. This applies if:

• the person is 18 or older, and
• they have the capacity to make an advance decision about treatment.

Information on advance decisions to refuse treatment made by young people (under the age of 18) will be available at www.dh.gov.uk/consent

9.2 Healthcare professionals must follow an advance decision if it is valid and applies to the particular circumstances. If they do not, they could face criminal prosecution (they could be charged for committing a crime) or civil liability (somebody could sue them).

9.3 Advance decisions can have serious consequences for the people who make them. They can also have an important impact on family and friends, and professionals involved in their care. Before healthcare professionals can apply an advance decision, there must be proof that the decision:

• exists
• is valid, and
• is applicable in the current circumstances.

These tests are legal requirements under section 25(1). Paragraphs 9.38–9.44 explain the standard of proof the Act requires.

Who can make an advance decision to refuse treatment?

9.4 It is up to individuals to decide whether they want to refuse treatment in advance. They are entitled to do so if they want, but there is no obligation to do so. Some people choose to make advance decisions while they are still healthy, even if there is no prospect of illness. This might be because they want to keep some control over what might happen to them in the future. Others may think of an advance decision as part of their preparations for growing older (similar to making a will). Or they might make an advance decision after they have been told they have a specific disease or condition.

Many people prefer not to make an advance decision, and instead leave healthcare professionals to make decisions in their best interests at the time a decision needs to be made. Another option is to make a Lasting Power of Attorney. This allows a trusted family member or friend to make personal welfare decisions, such as those around treatment, on someone’s behalf, and in their best interests if they ever lose capacity to make those decisions themselves (see paragraph 9.33 below and chapter 7).

9.5 People can only make advance decisions to refuse treatment. Nobody has the legal right to demand specific treatment, either at the time or in advance. So no-one can insist (either at the time or in advance) on being given treatments that healthcare professionals consider to be clinically unnecessary, futile or inappropriate. But people can make a request or state their wishes and preferences in advance. Healthcare professionals should then consider the request when deciding what is in a patient’s best interests (see chapter 5) if the patient lacks capacity.

9.6 Nobody can ask for and receive procedures that are against the law (for example, help with committing suicide). As section 62 sets out, the Act does not change any of the laws relating to murder, manslaughter or helping someone to commit suicide.

Capacity to make an advance decision

9.7 For most people, there will be no doubt about their capacity to make an advance decision. Even those who lack capacity to make some decisions may have the capacity to make an advance decision. In some cases it may be helpful to get evidence of a person’s capacity to make the advance decision (for example, if there is a possibility that the advance decision may be challenged in the future). It is also important to remember that capacity can change over time, and a person who lacks capacity to make a decision now might be able to make it in the future.

Chapter 3 explains how to assess a person’s capacity to make a decision.

Scenario: Respecting capacity to make an advance decision

Mrs Long’s family has a history of polycystic ovary syndrome. She has made a written advance decision refusing any treatment or procedures that might
affect her fertility. The document states that her ovaries and uterus must not be removed. She is having surgery to treat a blocked fallopian tube and, during the consent process, she told her doctor about her advance decision.

During surgery the doctor discovers a solid mass that he thinks might be cancerous. In his clinical judgement, he thinks it would be in Mrs Long’s best interests for him to remove the ovary. But he knows that Mrs Long had capacity when she made her valid and applicable advance decision, so he must respect her rights and follow her decision. After surgery, he can discuss the matter with Mrs Long and advise her about treatment options.

9.8 In line with principle 1 of the Act, that ‘a person must be assumed to have capacity unless it is established that he lacks capacity’, healthcare professionals should always start from the assumption that a person who has made an advance decision had capacity to make it, unless they are aware of reasonable grounds to doubt the person had the capacity to make the advance decision at the time they made it. If a healthcare professional is not satisfied that the person had capacity at the time they made the advance decision, or if there are doubts about its existence, validity or applicability, they can treat the person without fear of liability. It is good practice to record their decisions and the reasons for them. The Act does not require them to record their assessment of the person’s capacity at the time the decision was made, but it would be good practice to do so.

9.9 Healthcare professionals may have particular concerns about the capacity of someone with a history of suicide attempts or suicidal thoughts who has made an advance decision. It is important to remember that making an advance decision which, if followed, may result in death does not necessarily mean a person is or feels suicidal. Nor does it necessarily mean the person lacks capacity to make the advance decision. If the person is clearly suicidal, this may raise questions about their capacity to make an advance decision at the time they made it.

What should people include in an advance decision?

9.10 There are no particular formalities about the format of an advance decision. It can be written or verbal, unless it deals with life-sustaining treatment, in which case it must be written and specific rules apply (see paragraphs 9.24–9.28 below).

9.11 An advance decision to refuse treatment:

- must state precisely what treatment is to be refused – a statement giving a general desire not to be treated is not enough
- may set out the circumstances when the refusal should apply – it is helpful to include as much detail as possible
- will only apply at a time when the person lacks capacity to consent to or refuse the specific treatment.

Specific rules apply to life-sustaining treatment.
9.12 People can use medical language or everyday language in their advance decision. But they must make clear what their wishes are and what treatment they would like to refuse.

9.13 An advance decision refusing all treatment in any situation (for example, where a person explains that their decision is based on their religion or personal beliefs) may be valid and applicable.

9.14 It is recommended that people who are thinking about making an advance decision get advice from:

- healthcare professionals (for example, their GP or the person most closely involved with current healthcare or treatment), or
- an organisation that can provide advice on specific conditions or situations (they might have their own format for recording an advance decision).

But it is up to the person whether they want to do this or not. Healthcare professionals should record details of any discussion on healthcare records.

9.15 Some people may also want to get legal advice. This will help them make sure that they express their decision clearly and accurately. It will also help to make sure that people understand their advance decision in the future.

9.16 It is a good idea to try to include possible future circumstances in the advance decision. For example, a woman may want to state in the advance decision whether or not it should still apply if she later becomes pregnant. If the document does not anticipate a change in circumstance, healthcare professionals may decide that it is not applicable if those particular circumstances arise.

9.17 If an advance decision is recorded on a patient’s healthcare records, it is confidential. Some patients will tell others about their advance decision (for example, they might tell healthcare professionals, friends or family). Others will not. People who do not ask for their advance decision to be recorded on their healthcare record will need to think about where it should be kept and how they are going to let people know about their decision.

**Written advance decisions**

9.18 A written document can be evidence of an advance decision. It is helpful to tell others that the document exists and where it is. A person may want to carry it with them in case of emergency, or carry a card, bracelet or other indication that they have made an advance decision and explaining where it is kept.

9.19 There is no set form for written advance decisions, because contents will vary depending on a person’s wishes and situation. But it is helpful to include the following information:

- full details of the person making the advance decision, including date of birth, home address and any distinguishing features (in case healthcare professionals need to identify an unconscious person, for example)
- the name and address of the person’s GP and whether they have a copy of the document
• a statement that the document should be used if the person ever lacks
capacity to make treatment decisions
• a clear statement of the decision, the treatment to be refused and the
circumstances in which the decision will apply
• the date the document was written (or reviewed)
• the person’s signature (or the signature of someone the person has asked
to sign on their behalf and in their presence)
• the signature of the person witnessing the signature, if there is one (or a
statement directing somebody to sign on the person’s behalf).

See paragraphs 9.24–9.28 below if the advance decision deals with life-
sustaining treatment.

9.20 Witnessing the person’s signature is not essential, except in cases where the
person is making an advance decision to refuse life-sustaining treatment. But if
there is a witness, they are witnessing the signature and the fact that it
confirms the wishes set out in the advance decision. It may be helpful to give
a description of the relationship between the witness and person making the
advance decision. The role of the witness is to witness the person’s signature,
it is not to certify that the person has the capacity to make the advance
decision – even if the witness is a healthcare professional or knows the
person.

9.21 It is possible that a professional acting as a witness will also be the person
who assesses the person’s capacity. If so, the professional should also make
a record of the assessment, because acting as a witness does not prove that
there has been an assessment.

Verbal advance decisions

9.22 There is no set format for verbal advance decisions. This is because they will
vary depending on a person’s wishes and situation. Healthcare professionals
will need to consider whether a verbal advance decision exists and whether it
is valid and applicable (see paragraphs 9.38–9.44).

9.23 Where possible, healthcare professionals should record a verbal advance
decision to refuse treatment in a person’s healthcare record. This will produce
a written record that could prevent confusion about the decision in the future.
The record should include:

• a note that the decision should apply if the person lacks capacity to make
treatment decisions in the future
• a clear note of the decision, the treatment to be refused and the
circumstances in which the decision will apply
• details of someone who was present when the oral advance decision was
recorded and the role in which they were present (for example, healthcare
professional or family member), and
• whether they heard the decision, took part in it or are just aware that it
exists.
What rules apply to advance decisions to refuse life-sustaining treatment?

9.24 The Act imposes particular legal requirements and safeguards on the making of advance decisions to refuse life-sustaining treatment. Advance decisions to refuse life-sustaining treatment must meet specific requirements:

- They must be put in writing. If the person is unable to write, someone else should write it down for them. For example, a family member can write down the decision on their behalf, or a healthcare professional can record it in the person’s healthcare notes.

- The person must sign the advance decision. If they are unable to sign, they can direct someone to sign on their behalf in their presence.

- The person making the decision must sign in the presence of a witness to the signature. The witness must then sign the document in the presence of the person making the advance decision. If the person making the advance decision is unable to sign, the witness can witness them directing someone else to sign on their behalf. The witness must then sign to indicate that they have witnessed the nominated person signing the document in front of the person making the advance decision.

- The advance decision must include a clear, specific written statement from the person making the advance decision that the advance decision is to apply to the specific treatment even if life is at risk.

- If this statement is made at a different time or in a separate document to the advance decision, the person making the advance decision (or someone they have directed to sign) must sign it in the presence of a witness, who must also sign it.

9.25 Section 4(10) states that life-sustaining treatment is treatment which a healthcare professional who is providing care to the person regards as necessary to sustain life. This decision will not just depend on the type of treatment. It will also depend on the circumstances in which the healthcare professional is giving it. For example, in some situations antibiotics may be life-sustaining, but in others they can be used to treat conditions that do not threaten life.

9.26 Artificial nutrition and hydration (ANH) has been recognised as a form of medical treatment. ANH involves using tubes to provide nutrition and fluids to someone who cannot take them by mouth. It bypasses the natural mechanisms that control hunger and thirst and requires clinical monitoring. An advance decision can refuse ANH. Refusing ANH in an advance decision is likely to result in the person’s death, if the advance decision is followed.

9.27 It is very important to discuss advance decisions to refuse life-sustaining treatment with a healthcare professional. But it is not compulsory. A healthcare professional will be able to explain:

- what types of treatment may be life-sustaining treatment, and in what circumstances
• the implications and consequences of refusing such treatment (see also paragraph 9.14).

9.28 An advance decision cannot refuse actions that are needed to keep a person comfortable (sometimes called basic or essential care). Examples include warmth, shelter, actions to keep a person clean and the offer of food and water by mouth. Section 5 of the Act allows healthcare professionals to carry out these actions in the best interests of a person who lacks capacity to consent (see chapter 6). An advance decision can refuse artificial nutrition and hydration.

When should someone review or update an advance decision?

9.29 Anyone who has made an advance decision is advised to regularly review and update it as necessary. Decisions made a long time in advance are not automatically invalid or inapplicable, but they may raise doubts when deciding whether they are valid and applicable. A written decision that is regularly reviewed is more likely to be valid and applicable to current circumstances – particularly for progressive illnesses. This is because it is more likely to have taken on board changes that have occurred in a person’s life since they made their decision.

9.30 Views and circumstances may change over time. A new stage in a person’s illness, the development of new treatments or a major change in personal circumstances may be appropriate times to review and update an advance decision.

How can someone withdraw an advance decision?

9.31 Section 24(3) allows people to cancel or alter an advance decision at any time while they still have capacity to do so. There are no formal processes to follow. People can cancel their decision verbally or in writing, and they can destroy any original written document. Where possible, the person who made the advance decision should tell anybody who knew about their advance decision that it has been cancelled. They can do this at any time. For example, they can do this on their way to the operating theatre or immediately before being given an anaesthetic. Healthcare professionals should record a verbal cancellation in healthcare records. This then forms a written record for future reference.

How can someone make changes to an advance decision?

9.32 People can makes changes to an advance decision verbally or in writing (section 24(3)) whether or not the advance decision was made in writing. It is good practice for healthcare professionals to record a change of decision in the person’s healthcare notes. But if the person wants to change an advance decision to include a refusal of life-sustaining treatment, they must follow the procedures described in paragraphs 9.24–9.28.
How do advance decisions relate to other rules about decision-making?

9.33 A valid and applicable advance decision to refuse treatment is as effective as a refusal made when a person has capacity. Therefore, an advance decision overrules:

- the decision of any personal welfare Lasting Power of Attorney (LPA) made before the advance decision was made. So an attorney cannot give consent to treatment that has been refused in an advance decision made after the LPA was signed
- the decision of any court-appointed deputy (so a deputy cannot give consent to treatment that has been refused in an advance decision which is valid and applicable)
- the provisions of section 5 of the Act, which would otherwise allow healthcare professionals to give treatment that they believe is in a person’s best interests.

9.34 An LPA made after an advance decision will make the advance decision invalid, if the LPA gives the attorney the authority to make decisions about the same treatment (see paragraph 9.40).

9.35 The Court of Protection may make declarations as to the existence, validity and applicability of an advance decision, but it has no power to overrule a valid and applicable advance decision to refuse treatment.

9.36 Where an advance decision is being followed, the best interests principle (see chapter 5) does not apply. This is because an advance decision reflects the decision of an adult with capacity who has made the decision for themselves. Healthcare professionals must follow a valid and applicable advance decision, even if they think it goes against a person’s best interests.

Advance decisions regarding treatment for mental disorder

9.37 Advance decisions can refuse any kind of treatment, whether for a physical or mental disorder. But generally an advance decision to refuse treatment for mental disorder can be overruled if the person is detained in hospital under the Mental Health Act 1983, when treatment could be given compulsorily under Part 4 of that Act. Advance decisions to refuse treatment for other illnesses or conditions are not affected by the fact that the person is detained in hospital under the Mental Health Act. For further information see chapter 13.

How can somebody decide on the existence, validity and applicability of advance decisions?

Deciding whether an advance decision exists

9.38 It is the responsibility of the person making the advance decision to make sure their decision will be drawn to the attention of healthcare professionals when it is needed. Some people will want their decision to be recorded on their healthcare records. Those who do not will need to find other ways of alerting people that they have made an advance decision and where somebody will
find any written document and supporting evidence. Some people carry a card or wear a bracelet. It is also useful to share this information with family and friends, who may alert healthcare professionals to the existence of an advance decision. But it is not compulsory. Providing their GP with a copy of the written document will allow them to record the decision in the person’s healthcare records.

9.39 It is important to be able to establish that the person making the advance decision was 18 or over when they made their decision, and that they had the capacity to make that decision when they made it, in line with the two-stage test for capacity set out in chapter 3. But as explained in paragraphs 9.7–9.9 above, healthcare professionals should always start from the assumption that the person had the capacity to make the advance decision.

**Deciding whether an advance decision is valid**

9.40 An existing advance decision must still be valid at the time it needs to be put into effect. Healthcare professionals must consider the factors in section 25 of the Act before concluding that an advance decision is valid. Events that would make an advance decision invalid include those where:

- the person withdrew the decision while they still had capacity to do so
- after making the advance decision, the person made a Lasting Power of Attorney (LPA) giving an attorney authority to make treatment decisions that are the same as those covered by the advance decision (see also paragraph 9.33)
- the person has done something that clearly goes against the advance decision which suggests that they have changed their mind.

**Scenario: Assessing whether an advance decision is valid**

A young man, Angus, sees a friend die after prolonged hospital treatment. Angus makes a signed and witnessed advance decision to refuse treatment to keep him alive if he is ever injured in this way. The advance decision includes a statement that this will apply even if his life is at risk.

A few years later, Angus is seriously injured in a road traffic accident. He is paralysed from the neck down and cannot breathe without the help of a machine. At first he stays conscious and gives permission to be treated. He takes part in a rehabilitation programme. Some months later he loses consciousness.

At this point somebody finds his written advance decision, even though Angus has not mentioned it during his treatment. His actions before his lack of capacity obviously go against the advance decision. Anyone assessing the advance decision needs to consider very carefully the doubt this has created about the validity of the advance decision, and whether the advance decision is valid and applicable as a result.

**Deciding whether an advance decision is applicable**

9.41 To be applicable, an advance decision must apply to the situation in question and in the current circumstances. Healthcare professionals must first determine if the person still has capacity to accept or refuse treatment at the
relevant time (section 25(3)). If the person has capacity, they can refuse treatment there and then. Or they can change their decision and accept treatment. The advance decision is not applicable in such situations.

9.42 The advance decision must also apply to the proposed treatment. It is not applicable to the treatment in question if (section 25(4)):

- the proposed treatment is not the treatment specified in the advance decision
- the circumstances are different from those that may have been set out in the advance decision, or
- there are reasonable grounds for believing that there have been changes in circumstance, which would have affected the decision if the person had known about them at the time they made the advance decision.

9.43 So when deciding whether an advance decision applies to the proposed treatment, healthcare professionals must consider:

- how long ago the advance decision was made, and
- whether there have been changes in the patient’s personal life (for example, the person is pregnant, and this was not anticipated when they made the advance decision) that might affect the validity of the advance decision, and
- whether there have been developments in medical treatment that the person did not foresee (for example, new medications, treatment or therapies).

9.44 For an advance decision to apply to life-sustaining treatment, it must meet the requirements set out in paragraphs 9.24–9.28.

**Scenario: Assessing if an advance decision is applicable**

Mr Moss is HIV positive. Several years ago he began to have AIDS-related symptoms. He has accepted general treatment, but made an advance decision to refuse specific retro-viral treatments, saying he didn’t want to be a ‘guinea pig’ for the medical profession. Five years later, he is admitted to hospital seriously ill and keeps falling unconscious.

The doctors treating Mr Moss examine his advance decision. They are aware that there have been major developments in retro-viral treatment recently. They discuss this with Mr Moss’s partner and both agree that there are reasonable grounds to believe that Mr Moss may have changed his advance decision if he had known about newer treatment options. So the doctors decide the advance decision does not apply to the new retro-virals and give him treatment.

If Mr Moss regains his capacity, he can change his advance decision and accept or refuse future treatment.
What should healthcare professionals do if an advance decision is not valid or applicable?

9.45 If an advance decision is not valid or applicable to current circumstances:

- healthcare professionals must consider the advance decision as part of their assessment of the person’s best interests (see chapter 5) if they have reasonable grounds to think it is a true expression of the person’s wishes, and
- they must not assume that because an advance decision is either invalid or not applicable, they should always provide the specified treatment (including life-sustaining treatment) – they must base this decision on what is in the person’s best interests.

What happens to decisions made before the Act comes into force?

9.46 Advance decisions made before the Act comes into force may still be valid and applicable. Healthcare professionals should apply the rules in the Act to advance decisions made before the Act comes into force, subject to the transitional protections that will apply to advance decisions that refuse life-sustaining treatment. Further guidance will be available at www.dh.gov.uk/consent.

What implications do advance decisions have for healthcare professionals?

What are healthcare professionals’ responsibilities?

9.47 Healthcare professionals should be aware that:

- a patient they propose to treat may have refused treatment in advance, and
- valid and applicable advance decisions to refuse treatment have the same legal status as decisions made by people with capacity at the time of treatment.

9.48 Where appropriate, when discussing treatment options with people who have capacity, healthcare professionals should ask if there are any specific types of treatment they do not wish to receive if they ever lack capacity to consent in the future.

9.49 If somebody tells a healthcare professional that an advance decision exists for a patient who now lacks capacity to consent, they should make reasonable efforts to find out what the decision is. Reasonable efforts might include having discussions with relatives of the patient, looking in the patient’s clinical notes held in the hospital or contacting the patient’s GP.

9.50 Once they know a verbal or written advance decision exists, healthcare professionals must determine whether:

- it is valid (see paragraph 9.40), and
- it is applicable to the proposed treatment (see paragraphs 9.41–9.44).
9.51 When establishing whether an advance decision applies to current circumstances, healthcare professionals should take special care if the decision does not seem to have been reviewed or updated for some time. If the person’s current circumstances are significantly different from those when the decision was made, the advance decision may not be applicable. People close to the person concerned, or anyone named in the advance decision, may be able to help explain the person’s prior wishes.

9.52 If healthcare professionals are satisfied that an advance decision to refuse treatment exists, is valid and is applicable, they must follow it and not provide the treatment refused in the advance decision.

9.53 If healthcare professionals are not satisfied that an advance decision exists that is both valid and applicable, they can treat the person without fear of liability. But treatment must be in the person’s best interests (see chapter 5). They should make clear notes explaining why they have not followed an advance decision which they consider to be invalid or not applicable.

9.54 Sometimes professionals can give or continue treatment while they resolve doubts over an advance decision. It may be useful to get information from someone who can provide information about the person’s capacity when they made the advance decision. The Court of Protection can settle disagreements about the existence, validity or applicability of an advance decision. Section 26 of the Act allows healthcare professionals to give necessary treatment, including life-sustaining treatment, to stop a person’s condition getting seriously worse while the court decides.

**Do advance decisions apply in emergencies?**

9.55 A healthcare professional must provide treatment in the patient’s best interests, unless they are satisfied that there is a advance decision that is:

- valid, and
- applicable in the circumstances.

9.56 Healthcare professionals should not delay emergency treatment to look for an advance decision if there is no clear indication that one exists. But if it is clear that a person has made an advance decision that is likely to be relevant, healthcare professionals should assess its validity and applicability as soon as possible. Sometimes the urgency of treatment decisions will make this difficult.

**When can healthcare professionals be found liable?**

9.57 Healthcare professionals must follow an advance decision if they are satisfied that it exists, is valid and is applicable to their circumstances. Failure to follow an advance decision in this situation could lead to a claim for damages for battery or a criminal charge of assault.

9.58 But they are protected from liability if they are not:

- aware of an advance decision, or
- satisfied that an advance decision exists, is valid and is applicable to the particular treatment and the current circumstances (section 26(2)).
If healthcare professionals have genuine doubts, and are therefore not ‘satisfied’, about the existence, validity or applicability of the advance decision, treatment can be provided without incurring liability.

9.59 Healthcare professionals will be protected from liability for failing to provide treatment if they ‘reasonably believe’ that a valid and applicable advance decision to refuse that treatment exists. But they must be able to demonstrate that their belief was reasonable (section 26(3)) and point to reasonable grounds showing why they believe this. Healthcare professionals can only base their decision on the evidence that is available at the time they need consider an advance decision.

9.60 Some situations might be enough in themselves to raise concern about the existence, validity or applicability of an advance decision to refuse treatment. These could include situations when:

- a disagreement between relatives and healthcare professionals about whether verbal comments were really an advance decision
- evidence about the person’s state of mind raises questions about their capacity at the time they made the decision (see paragraphs 9.7–9.9)
- evidence of important changes in the person’s behaviour before they lost capacity that might suggest a change of mind.

In cases where serious doubt remains and cannot be resolved in any other way, it will be possible to seek a declaration from the court.

What if a healthcare professional has a conscientious objection to stopping or providing life-sustaining treatment?

9.61 Some healthcare professionals may disagree in principle with patients’ rights to refuse life-sustaining treatment. The Act does not change the current legal situation. They do not have to do something that goes against their beliefs. But they must not simply abandon patients or cause their care to suffer.

9.62 Healthcare professionals should make their views clear to the patient and the healthcare team as soon as someone raises the subject of withholding, stopping or providing life-sustaining treatment. Patients who still have capacity should then have the option of transferring their care to another healthcare professional, if it is possible to do this without affecting their care.

9.63 In cases where the patient now lacks capacity but has made a valid and applicable advance decision to refuse treatment which a doctor or health professional cannot, for reasons of conscience, comply with, arrangements should be made for the management of the patient’s care to be transferred to another healthcare professional. Where a transfer cannot be agreed, the Court of Protection can direct those responsible for the person’s healthcare (for example, a Trust, doctor or other health professional) to make arrangements to take over responsibility for the person’s healthcare (section 17(1)(e)).
What happens if there is a disagreement about an advance decision?

9.64 It is ultimately the responsibility of the healthcare professional who is in charge of the person’s care when the treatment is required to decide whether there is an advance decision which is valid and applicable in the circumstances. In the event of disagreement about an advance decision between healthcare professionals, or between healthcare professionals and family members or others close to the person, the senior clinician must consider all the available evidence. This is likely to be a hospital consultant or the GP where the person is being treated in the community.

9.65 The senior clinician may need to consult with relevant colleagues and others who are close to or familiar with the patient. All staff involved in the person’s care should be given the opportunity to express their views. If the person is in hospital, their GP may also have relevant information.

9.66 The point of such discussions should not be to try to overrule the person’s advance decision but rather to seek evidence concerning its validity and to confirm its scope and its applicability to the current circumstances. Details of these discussions should be recorded in the person’s healthcare records. Where the senior clinician has a reasonable belief that an advance decision to refuse medical treatment is both valid and applicable, the person’s advance decision should be complied with.

When can somebody apply to the Court of Protection?

9.67 The Court of Protection can make a decision where there is genuine doubt or disagreement about an advance decision’s existence, validity or applicability. But the court does not have the power to overturn a valid and applicable advance decision.

9.68 The court has a range of powers (sections 16–17) to resolve disputes concerning the personal care and medical treatment of a person who lacks capacity (see chapter 8). It can decide whether:

• a person has capacity to accept or refuse treatment at the time it is proposed
• an advance decision to refuse treatment is valid
• an advance decision is applicable to the proposed treatment in the current circumstances.

9.69 While the court decides, healthcare professionals can provide life-sustaining treatment or treatment to stop a serious deterioration in their condition. The court has emergency procedures which operate 24 hours a day to deal with urgent cases quickly. See chapter 8 for guidance on applying to the court.
10 What is the new Independent Mental Capacity Advocate service and how does it work?

This chapter describes the new Independent Mental Capacity Advocate (IMCA) service created under the Act. The purpose of the IMCA service is to help particularly vulnerable people who lack the capacity to make important decisions about serious medical treatment and changes of accommodation, and who have no family or friends that it would be appropriate to consult about those decisions. IMCAs will work with and support people who lack capacity, and represent their views to those who are working out their best interests.

The chapter provides guidance both for IMCAs and for everyone who may need to instruct an IMCA. It explains how IMCAs should be appointed. It also explains the IMCA’s duties and the situations when an IMCA should be instructed. Both IMCAs and decision-makers are required to have regard to the Code of Practice.

In this chapter, as throughout the Code, a person’s capacity (or lack of capacity) refers specifically to their capacity to make a particular decision at the time it needs to be made.

Quick summary

Understanding the role of the IMCA service

• The aim of the IMCA service is to provide independent safeguards for people who lack capacity to make certain important decisions and, at the time such decisions need to be made, have no-one else (other than paid staff) to support or represent them or be consulted.

• IMCAs must be independent.

Instructing and consulting an IMCA

• An IMCA must be instructed, and then consulted, for people lacking capacity who have no-one else to support them (other than paid staff), whenever:
  – an NHS body is proposing to provide serious medical treatment, or
  – an NHS body or local authority is proposing to arrange accommodation (or a change of accommodation) in hospital or a care home, and
  – the person will stay in hospital longer than 28 days, or
  – they will stay in the care home for more than eight weeks.

• An IMCA may be instructed to support someone who lacks capacity to make decisions concerning:
  – care reviews, where no-one else is available to be consulted
  – adult protection cases, whether or not family, friends or others are involved

Ensuring an IMCA’s views are taken into consideration

• The IMCA’s role is to support and represent the person who lacks capacity.
Because of this, IMCAs have the right to see relevant healthcare and social care records.

- Any information or reports provided by an IMCA must be taken into account as part of the process of working out whether a proposed decision is in the person’s best interests.

**What is the IMCA service?**

10.1 Sections 35–41 of the Act set up a new IMCA service that provides safeguards for people who:

- lack capacity to make a specified decision at the time it needs to be made
- are facing a decision on a long-term move or about serious medical treatment and
- have nobody else who is willing and able to represent them or be consulted in the process of working out their best interests.

10.2 Regulations made under the Act also state that IMCAs may be involved in other decisions, concerning:

- a care review, or
- an adult protection case.

In adult protection cases, an IMCA may be appointed even where family members or others are available to be consulted.

10.3 Most people who lack capacity to make a specific decision will have people to support them (for example, family members or friends who take an interest in their welfare). Anybody working out a person’s best interests must consult these people, where possible, and take their views into account (see chapter 5). But if a person who lacks capacity has nobody to represent them or no-one who it is appropriate to consult, an IMCA must be instructed in prescribed circumstances. The prescribed circumstances are:

- providing, withholding or stopping serious medical treatment
- moving a person into long-term care in hospital or a care home (see 10.11 for definition), or
- moving the person to a different hospital or care home.

The only exception to this can be in situations where an urgent decision is needed. Further details on the situations where there is a duty to instruct an IMCA are given in paragraphs 10.40–10.58.

In other circumstances, an IMCA may be appointed for the person (see paragraphs 10.59–10.68). These include:

- care reviews or
- adult protection cases.
10.4 The IMCA will:

- be independent of the person making the decision
- provide support for the person who lacks capacity
- represent the person without capacity in discussions to work out whether the proposed decision is in the person’s best interests
- provide information to help work out what is in the person’s best interests (see chapter 5), and
- raise questions or challenge decisions which appear not to be in the best interests of the person.

The information the IMCA provides must be taken into account by decision-makers whenever they are working out what is in a person’s best interests. See paragraphs 10.20–10.39 for more information on an IMCA’s role. For more information on who is a decision-maker, see chapter 5.

10.5 The IMCA service will build on good practice in the independent advocacy sector. But IMCAs have a different role from many other advocates. They:

- provide statutory advocacy
- are instructed to support and represent people who lack capacity to make decisions on specific issues
- have a right to meet in private the person they are supporting
- are allowed access to relevant healthcare records and social care records
- provide support and representation specifically while the decision is being made, and
- act quickly so their report can form part of decision-making.

**Who is responsible for delivering the service?**

10.6 The IMCA service is available in England and Wales. Both countries have regulations for setting up and managing the service.

- The regulations for Wales[^37] are available at www.new.wales.gov.uk/

[^36]: *The Mental Capacity Act 2005 (Independent Mental Capacity Advocate) (General) Regulations 2006 SI: 2006 /No 1832*. The ‘General Regulations’. These regulations set out the details on how the IMCA will be appointed, the functions of the IMCA, including their role in challenging the decision-maker and include definitions of ‘serious medical treatment’ and ‘NHS body’.

[^37]: *The Mental Capacity Act 2005 (Independent Mental Capacity Advocate) (Wales) Regulations 2007 SI: /No (W.).* These regulations will remain in draft form until they are made by the National Assembly for Wales. The target coming into force date is 1 October 2007. Unlike the two sets of English regulations there will be one set only for Wales. Although the Welsh regulations will remain
Guidance has been issued to local health boards and local authorities involved in commissioning IMCA services for their area.

10.7 In England the Secretary of State for Health delivers the service through local authorities, who work in partnership with NHS organisations. Local authorities have financial responsibility for the service. In Wales the National Assembly for Wales delivers the service through local health boards, who have financial responsibility for the service and work in partnership with local authority social services departments and other NHS organisations. The service is commissioned from independent organisations, usually advocacy organisations.

10.8 Local authorities or NHS organisations are responsible for instructing an IMCA to represent a person who lacks capacity. In these circumstances they are called the ‘responsible body’.

10.9 For decisions about serious medical treatment, the responsible body will be the NHS organisation providing the person’s healthcare or treatment. But if the person is in an independent or voluntary sector hospital, the responsible body will be the NHS organisation arranging and funding the person’s care, which should have arrangements in place with the independent or voluntary sector hospital to ensure an IMCA is appointed promptly.

10.10 For decisions about admission to accommodation in hospital for 28 days or more, the responsible body will be the NHS body that manages the hospital. For admission to an independent or voluntary sector hospital for 28 days or more, the responsible body will be the NHS organisation arranging and funding the person’s care. The independent or voluntary hospital must have arrangements in place with the NHS organisation to ensure that an IMCA can be appointed without delay.

10.11 For decisions about moves into long-term accommodation (for eight weeks or longer), or about a change of accommodation, the responsible body will be either:

• the NHS body that proposes the move or change of accommodation (e.g. a nursing home), or

• the local authority that has carried out an assessment of the person under the NHS and Community Care Act 1990 and decided the move may be necessary.

10.12 Sometimes NHS organisations and local authorities will make decisions together about moving a person into long-term care. In these cases, the organisation that must instruct the IMCA is the one that is ultimately

38 This may be accommodation in a care home, nursing home, ordinary and sheltered housing, housing association or other registered social housing or in private sector housing provided by a local authority or in hostel accommodation.
responsible for the decision to move the person. The IMCA to be instructed is
the one who works wherever the person is at the time that the person needs
support and representation.

What are the responsible body’s duties?

10.13 The responsible body:

- must instruct an IMCA to support and represent a person in the situations
  set out in paragraphs 10.40–10.58
- may decide to instruct an IMCA in situations described in paragraphs
  10.59–10.68
- must, in all circumstances when an IMCA is instructed, take properly into
  account the information that the IMCA provides when working out whether
  the particular decision (such as giving, withholding or stopping treatment,
  changing a person’s accommodation, or carrying out a recommendation
  following a care review or an allegation requiring adult protection) is in the
  best interests of the person who lacks capacity.

10.14 The responsible body should also have procedures, training and awareness
programmes to make sure that:

- all relevant staff know when they need to instruct an IMCA and are able to
do so promptly
- all relevant staff know how to get in touch with the IMCA service and know
  the procedure for instructing an IMCA
- they record an IMCA’s involvement in a case and any information the IMCA
  provides to help decision-making
- they also record how a decision-maker has taken into account the IMCA’s
  report and information as part of the process of working out the person’s
  best interests (this should include reasons for disagreeing with that advice,
  if relevant)
- they give access to relevant records when requested by an IMCA under
  section 35(6)(b) of the Act
- the IMCA gets information about changes that may affect the support and
  representation the IMCA provides
- decision-makers let all relevant people know when an IMCA is working on a
  person’s case, and
- decision-makers inform the IMCA of the final decision taken and the reason
  for it.

10.15 Sometimes an IMCA and staff working for the responsible body might
disagree. If this happens, they should try to settle the disagreement through
discussion and negotiation as soon as possible. If they cannot do this, they
should then follow the responsible body’s formal procedures for settling
disputes or complaints (see paragraphs 10.34 to 10.39 below).

10.16 In some situations the IMCA may challenge a responsible body’s decision, or
they may help somebody who is challenging a decision. The General
Regulations in England and the Regulations in Wales set out when this may
happen (see also chapter 15). If there is no other way of resolving the
disagreement, the decision may be challenged in the Court of Protection.

Who can be an IMCA?

10.17 In England, a person can only be an IMCA if the local authority approves their
appointment. In Wales, the local health board will provide approval. Qualified
employees of an approved organisation can act as IMCAs. Local authorities
and health boards will usually commission independent advocacy
organisations to provide the IMCA service. These organisations will work to
appropriate organisational standards set through the
contracting/commissioning process.

10.18 Individual IMCAs must:

- have specific experience
- have IMCA training
- have integrity and a good character, and
- be able to act independently.

All IMCAs must complete the IMCA training in order that they can work as an
independent mental capacity advocate. A national advocacy qualification is
also being developed, which will include the IMCA training.

Before a local authority or health board appoints an IMCA, they must carry out
checks with the Criminal Records Bureau (CRB) to get a criminal record
certificate or enhanced criminal record certificate for that individual.

10.19 IMCAs must be independent. People cannot act as IMCAs if they:

- care for or treat (in a paid or professional capacity) the person they will be
  representing (this does not apply if they are an existing advocate acting for
  that person), or
- have links to the person instructing them, to the decision-maker or to other
  individuals involved in the person’s care or treatment that may affect their
  independence.

What is an IMCA’s role?

10.20 An IMCA must decide how best to represent and support the person who
lacks capacity that they are helping. They:

- must confirm that the person instructing them has the authority to do so
- should interview or meet in private the person who lacks capacity, if possible
- must act in accordance with the principles of the Act (as set out in section 1

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39 IMCAs were named as a group that is subject to mandatory checking under the new vetting and
barring system in the Safeguarding Vulnerable Groups Act 2006. Roll-out of the bulk of the scheme
will take place in 2008.
of the Act and chapter 2 of the Code) and take account of relevant guidance in the Code

- may examine any relevant records that section 35(6) of the Act gives them access to
- should get the views of professionals and paid workers providing care or treatment for the person who lacks capacity
- should get the views of anybody else who can give information about the wishes and feelings, beliefs or values of the person who lacks capacity
- should get hold of any other information they think will be necessary
- must find out what support a person who lacks capacity has had to help them make the specific decision
- must try to find out what the person’s wishes and feelings, beliefs and values would be likely to be if the person had capacity
- should find out what alternative options there are
- should consider whether getting another medical opinion would help the person who lacks capacity, and
- must write a report on their findings for the local authority or NHS body.

10.21 Where possible, decision-makers should make decisions based on a full understanding of a person’s past and present wishes. The IMCA should provide the decision-maker with as much of this information as possible – and anything else they think is relevant. The report they give the decision-maker may include questions about the proposed action or may include suggested alternatives, if they think that these would be better suited to the person’s wishes and feelings.

10.22 Another important part of the IMCA’s role is communicating their findings. Decision-makers should find the most effective way to enable them to do this. In some of the IMCA pilot areas, hospital discharge teams added a ‘Need to instruct an IMCA?’ question on their patient or service user forms. This allowed staff to identify the need for an IMCA as early as possible, and to discuss the timetable for the decision to be made. Some decisions need a very quick IMCA response, others will allow more time. In the pilot areas, IMCA involvement led to better informed discharge planning, with a clearer focus on the best interests of a person who lacked capacity. It did not cause additional delays in the hospital discharge.

Representing and supporting the person who lacks capacity

10.23 IMCAs should take account of the guidance in chapter 5.

- IMCAs should find out whether the decision-maker has given all practical and appropriate support to help the person who lacks capacity to be involved as much as possible in decision-making. If the person has communication difficulties, the IMCA should also find out if the decision-maker has obtained any specialist help (for example, from a speech and

40 For further information see www.dh.gov.uk/imca
language therapist).

- Sometimes an IMCA may find information to suggest a person might regain capacity in the future, either so they can make the decision themselves or be more involved in decision-making. In such a situation, the IMCA can ask the decision-maker to delay the decision, if it is not urgent.

- The IMCA will need to get as much information as possible about the person’s wishes, feelings, beliefs and values – both past and present. They should also consider the person’s religion and any cultural factors that may influence the decision.

10.24 Sometimes a responsible body will not have time to instruct an IMCA (for example in an emergency or if a decision is urgent). If this is the case, this should be recorded, with the reason an IMCA has not been instructed. Where the decision concerns a move of accommodation, the local authority must appoint an IMCA as soon as possible afterwards. Sometimes the IMCA will not have time to carry out full investigations. In these situations, the IMCA must make a judgement about what they can achieve in the time available to support and represent the person who lacks capacity.

10.25 Sometimes an IMCA might not be able to get a good picture of what the person might want. They should still try to make sure the decision-maker considers all relevant information by:

- raising relevant issues and questions, and
- providing additional, relevant information to help the final decision.

Finding and evaluating information

10.26 Section 35(6) provides IMCAs with certain powers to enable them to carry out their duties. These include:

- the right to have an interview in private with the person who lacks capacity, and
- the right to examine, and take copies of, any records that the person holding the record thinks are relevant to the investigation (for example, clinical records, care plans, social care assessment documents or care home records).

10.27 The IMCA may also need to meet professionals or paid carers providing care or treatment for the person who lacks capacity. These people can help assess the information in case records or other sources. They can also comment on possible alternative courses of action. Ultimately, it is the decision-maker’s responsibility to decide whether a proposed course of action is in the person’s best interests. However, the Act requires the decision-maker to take account of the reports made and information given by the IMCA. In most cases a decision on the person’s best interests will be made through discussion involving all the relevant people who are providing care or treatment, as well as the IMCA.

Finding out the person’s wishes and feelings, beliefs and values

10.28 The IMCA needs to try and find out what the person’s wishes and feelings might be, and what their underlying beliefs and values might also be. The
IMCA should try to communicate both verbally and non-verbally with the person who may lack capacity, as appropriate. For example, this might mean using pictures or photographs. But there will be cases where the person cannot communicate at all (for example, if they are unconscious). The IMCA may also talk to other professionals or paid carers directly involved in providing present or past care or treatment. The IMCA might also need to examine health and social care records and any written statements of preferences the person may have made while they still had capacity to do so.

Chapter 5 contains further guidance on finding out the views of people who lack capacity. Chapter 3 contains further guidance on helping someone to make their own decision.

**Considering alternative courses of action**

10.29 The IMCA will need to check whether the decision-maker has considered all possible options. They should also ask whether the proposed option is less restrictive of the person’s rights or future choices or would allow them more freedom (chapter 2, principle 5).

10.30 The IMCA may wish to discuss possible options with other professionals or paid carers directly involved in providing care or treatment for the person. But they must respect the confidentiality of the person they are representing.

**Scenario: Using an IMCA**

Mrs Nolan has dementia. She is being discharged from hospital. She has no close family or friends. She also lacks the capacity to decide whether she should return home or move to a care home. The local authority instructs an IMCA.

Mrs Nolan tells the IMCA that she wants to go back to her own home, which she can remember and describe. But the hospital care team thinks she needs additional support, which can only be provided in a care home.

The IMCA reviewed all the assessments of Mrs Nolan’s needs, spoke to people involved in her care and wrote a report stating that Mrs Nolan had strong and clear wishes. The IMCA also suggested that a care package could be provided to support Mrs Nolan if she were allowed to return home. The care manager now has to decide what is in Mrs Nolan’s best interests. He must consider the views of the hospital care team and the IMCA’s report.

**Getting a second medical opinion**

10.31 For decisions about serious medical treatment, the IMCA may consider seeking a second medical opinion from a doctor with appropriate expertise. This puts a person who lacks the capacity to make a specific decision in the same position as a person who has capacity, who has the right to request a second opinion.
What happens if the IMCA disagrees with the decision-maker?

10.32 The IMCA’s role is to support and represent their client. They may do this through asking questions, raising issues, offering information and writing a report. They will often take part in a meeting involving different healthcare and social care staff to work out what is in the person’s best interests. There may sometimes be cases when an IMCA thinks that a decision-maker has not paid enough attention to their report and other relevant information and is particularly concerned about the decision made. They may then need to challenge the decision.

10.33 An IMCA has the same rights to challenge a decision as any other person caring for the person or interested in his welfare. The right of challenge applies both to decisions about lack of capacity and a person’s best interests.

10.34 Chapter 15 sets out how disagreements can be settled. The approach will vary, depending on the type and urgency of the disagreement. It could be a formal or informal approach.

Disagreements about health care or treatment

- Consult the Patient Advice and Liaison Service (England)
- Consult the Community Health Council (Wales)
- Use the NHS Complaints Procedure
- Refer the matter to the local continuing care review panel
- Engage the services of the Independent Complaints Advocacy Service (England) or another advocate.

Disagreements about social care

- Use the care home’s complaints procedure (if the person is in a care home)
- Use the local authority complaints procedure.

10.35 Before using these formal methods, the IMCA and the decision-maker should discuss the areas they disagree about – particularly those that might have a serious impact on the person the IMCA is representing. The IMCA and decision-maker should make time to listen to each other’s views and to understand the reason for the differences. Sometimes these discussions can help settle a disagreement.

10.36 Sometimes an IMCA service will have a steering group, with representatives from the local NHS organisations and the local authority. These representatives can sometimes negotiate between two differing views. Or they can clarify policy on a certain issue. They should also be involved if an IMCA believes they have discovered poor practice on an important issue.

10.37 IMCAs may use complaints procedures as necessary to try to settle a disagreement – and they can pursue a complaint as far as the relevant ombudsman if needed. In particularly serious or urgent cases, an IMCA may seek permission to refer a case to the Court of Protection for a decision. The
Court will make a decision in the best interests of the person who lacks capacity.

10.38 The first step in making a formal challenge is to approach the Official Solicitor (OS) with the facts of the case. The OS can decide to apply to the court as a litigation friend (acting on behalf of the person the IMCA is representing). If the OS decides not to apply himself, the IMCA can ask for permission to apply to the Court of Protection. The OS can still be asked to act as a litigation friend for the person who lacks capacity.

10.39 In extremely serious cases, the IMCA might want to consider an application for judicial review in the High Court. This might happen if the IMCA thinks there are very serious consequences to a decision that has been made by a public authority. There are time limits for making an application, and the IMCA would have to instruct solicitors – and may be liable for the costs of the case going to court. So IMCAs should get legal advice before choosing this approach. The IMCA can also ask the OS to consider making the claim.

**What decisions require an IMCA?**

10.40 There are three types of decisions which require an IMCA to be instructed for people who lack capacity. These are:

- decisions about providing, withholding or stopping serious medical treatment
- decisions about whether to place people into accommodation (for example a care home or a long stay hospital), and
- decisions about whether to move people to different long stay accommodation.

For these decisions all local authorities and all health bodies must refer the same kinds of decisions to an IMCA for anyone who lacks capacity and qualifies for the IMCA service.

10.41 There are two further types of decisions where the responsible body has the power to instruct an IMCA for a person who lacks capacity. These are decisions relating to:

- care reviews and
- adult protection cases.

In such cases, the relevant local authority or NHS body must decide in each individual case whether it would be of particular benefit to the person who lacks capacity to have an IMCA to support them. The factors which should be considered are explained in paragraphs 10.59–10.68.\(^{41}\)

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\(^{41}\) See chapter 11 for information about the role of ‘consultees’ when research is proposed involving a person who lacks capacity to make a decision about whether to agree to take part in research. In certain situations IMCAs may be involved as consultees for research purposes.
Decisions about serious medical treatment

10.42 Where a serious medical treatment decision is being considered for a person who lacks the capacity to consent, and who qualifies for additional safeguards, section 37 of the Act imposes a duty on the NHS body to instruct an IMCA. NHS bodies must instruct an IMCA whenever they are proposing to take a decision about ‘serious medical treatment’, or proposing that another organisation (such as a private hospital) carry out the treatment on their behalf, if:

- the person concerned does not have the capacity to make a decision about the treatment, and
- there is no-one appropriate to consult about whether the decision is in the person’s best interests, other than paid care staff.

10.43 Regulations for England and Wales set out the definition of ‘serious medical treatment’ for decisions that require an IMCA. It includes treatments for both mental and physical conditions.

Serious medical treatment is defined as treatment which involves giving new treatment, stopping treatment that has already started or withholding treatment that could be offered in circumstances where:

- if a single treatment is proposed there is a fine balance between the likely benefits and the burdens to the patient and the risks involved
- a decision between a choice of treatments is finely balanced, or
- what is proposed is likely to have serious consequences for the patient.

10.44 ‘Serious consequences’ are those which could have a serious impact on the patient, either from the effects of the treatment itself or its wider implications. This may include treatments which:

- cause serious and prolonged pain, distress or side effects
- have potentially major consequences for the patient (for example, stopping life-sustaining treatment or having major surgery such as heart surgery), or
- have a serious impact on the patient’s future life choices (for example, interventions for ovarian cancer).

10.45 It is impossible to set out all types of procedures that may amount to ‘serious medical treatment’, although some examples of medical treatments that might be considered serious include:

- chemotherapy and surgery for cancer
- electro-convulsive therapy
- therapeutic sterilisation
- major surgery (such as open-heart surgery or brain/neuro-surgery)
- major amputations (for example, loss of an arm or leg)
- treatments which will result in permanent loss of hearing or sight
- withholding or stopping artificial nutrition and hydration, and
• termination of pregnancy.

These are illustrative examples only, and whether these or other procedures are considered serious medical treatment in any given case, will depend on the circumstances and the consequences for the patient. There are also many more treatments which will be defined as serious medical treatments under the Act’s regulations. Decision-makers who are not sure whether they need to instruct an IMCA should consult their colleagues.

10.46 The only situation in which the duty to instruct an IMCA need not be followed, is when an urgent decision is needed (for example, to save the person’s life). This decision must be recorded with the reason for the non-referral. Responsible bodies will however still need to instruct an IMCA for any serious treatment that follows the emergency treatment.

10.47 While a decision-maker is waiting for the IMCA’s report, they must still act in the person’s best interests (for example, to give treatment that stops the person’s condition getting worse).

Scenario: Using an IMCA for serious medical treatment

Mr Jones had a fall and suffered serious head injuries. Hospital staff could not find any family or friends. He needed urgent surgery, but afterwards still lacked capacity to accept or refuse medical treatment.

The hospital did not involve an IMCA in the decision to operate, because it needed to make an emergency decision. But it did instruct an IMCA when it needed to carry out further serious medical treatment.

The IMCA met with Mr Jones looked at his case notes and reviewed the options with the consultant. The decision-maker then made the clinical decision about Mr Jones’ best interests taking into account the IMCA’s report.

10.48 Some decisions about medical treatment are so serious that the courts need to make them (see chapter 8). But responsible bodies should still instruct an IMCA in these cases. The OS may be involved as a litigation friend of the person who lacks capacity.

10.49 Responsible bodies do not have to instruct an IMCA for patients detained under the Mental Health Act 1983, if:

• the treatment is for mental disorder, and
• they can give it without the patient’s consent under that Act.

10.50 If serious medical treatment proposed for the detained patient is not for their mental disorder, the patient then has a right to an IMCA – as long as they meet the Mental Capacity Act’s requirements. So a detained patient without capacity to consent to cancer treatment, for example, should qualify for an IMCA if there are no family or friends whom it would be appropriate to consult.

Decisions about accommodation or changes of residence

10.51 The Act imposes similar duties on NHS bodies and local authorities who are responsible for long-term accommodation decisions for a person who lacks
the capacity to agree to the placement and who qualifies for the additional safeguard of an IMCA. The right to an IMCA applies to decisions about long-term accommodation in a hospital or care home if it is:

- provided or arranged by the NHS, or
- residential care that is provided or arranged by the local authority or provided under section 117 of the Mental Health Act 1983, or
- a move between such accommodation.

10.52 Responsible bodies have a duty to instruct an IMCA if:

- an NHS organisation proposes to place a person who lacks capacity in a hospital – or to move them to another hospital – for longer than 28 days, or
- an NHS organisation proposes to place a person who lacks capacity in a care home – or to move them to a different care home – for what is likely to be longer than eight weeks.

In either situation the other qualifying conditions apply. So, if the accommodation is for less than 28 days in a hospital or less than 8 weeks in a care home, then an IMCA need not be appointed.

10.53 The duty also applies if a local authority carries out an assessment under section 47 of the NHS and Community Care Act 1990, and it decides to:

- provide care services for a person who lacks capacity in the form of residential accommodation in a care home or its equivalent (see paragraph 10.11) which is likely to be longer than eight weeks, or
- move a person who lacks capacity to another care home or its equivalent for a period likely to exceed eight weeks.

10.54 In some cases, a care home may decide to de-register so that they can provide accommodation and care in a different way. If a local authority makes the new arrangements, then an IMCA should still be instructed if a patient lacks capacity and meets the other qualifying conditions.

10.55 Sometimes a person’s placement will be longer than expected. The responsible body should involve an IMCA as soon as they realise the stay will be longer than 28 days or eight weeks, as appropriate.

10.56 People who fund themselves in long-term accommodation have the same rights to an IMCA as others, if the local authority:

- carries out an assessment under section 47 of the NHS and Community Care Act 1990, and
- decides it has a duty to the person (under either section 21 or 29 of the National Assistance Act 1947 or section 117 of the Mental Health Act 1983).

10.57 Responsible bodies can only put aside the duty to involve an IMCA if the placement or move is urgent (for example, an emergency admission to
hospital or possible homelessness). The decision-maker must involve an IMCA as soon as possible after making an emergency decision, if:

- the person is likely to stay in hospital for longer than 28 days, or
- they will stay in other accommodation for longer than eight weeks.

10.58 Responsible bodies do not have to involve IMCAs if the person in question is going to be required to stay in the accommodation under the Mental Health Act 1983. But if a person is discharged from detention, they have a right to an IMCA in future accommodation decisions (if they meet the usual conditions set out in the Act).

When can a local authority or NHS body decide to instruct an IMCA?

10.59 The Expansion Regulations have given local authorities and NHS bodies the power to apply the IMCA role to two further types of decisions:

- a care review, and
- adult protection cases that involve vulnerable people.

10.60 In these situations, the responsible body must consider in each individual case whether to instruct an IMCA. Where an IMCA is instructed:

- the decision-maker must be satisfied that having an IMCA will be of particular benefit to the person who lacks capacity
- the decision-maker must also follow the best interests checklist, including getting the views of anyone engaged in caring for a person when assessing their best interests, and
- the decision-maker must consider the IMCA’s report and related information when making a decision.

10.61 Responsible bodies are expected to take a strategic approach in deciding when they will use IMCAs in these two additional situations. They should establish a policy locally for determining these decisions, setting out the criteria for appointing an IMCA including the issues to be taken into account when deciding if an IMCA will be of particular benefit to the person concerned. However, decision-makers will need to consider each case separately to see if the criteria are met. Local authorities or NHS bodies may want to publish their approach for ease of access, setting out the ways they intend to use these additional powers and review it periodically.

Involving an IMCA in care reviews

10.62 A responsible body can instruct an IMCA to support and represent a person who lacks capacity when:

- they have arranged accommodation for that person
- they aim to review the arrangements (as part of a care plan or otherwise), and
- there are no family or friends who it would be appropriate to consult.
Section 7 of the Local Authority Social Services Act 1970 sets out current requirements for care reviews. It states that there should be a review ‘within three months of help being provided or major changes made to services’. There should then be a review every year – or more often, if needed.

Reviews should relate to decisions about accommodation:

- for someone who lacks capacity to make a decision about accommodation
- that will be provided for a continuous period of more than 12 weeks
- that are not the result of an obligation under the Mental Health Act 1983, and
- that do not relate to circumstances where sections 37 to 39 of the Act would apply.

Where the person is to be detained or required to live in accommodation under the Mental Health Act 1983, an IMCA will not be needed since the safeguards available under that Act will apply.

Involving IMCAs in adult protection cases

Responsible bodies have powers to instruct an IMCA to support and represent a person who lacks capacity where it is alleged that:

- the person is or has been abused or neglected by another person, or
- the person is abusing or has abused another person.

The responsible bodies can only instruct an IMCA if they propose to take, or have already taken, protective measures. This is in accordance with adult protection procedures set up under statutory guidance.\(^4\)

In adult protection cases (and no other cases), access to IMCAs is not restricted to people who have no-one else to support or represent them. People who lack capacity who have family and friends can still have an IMCA to support them in the adult protection procedures.

In some situations, a case may start out as an adult protection case where a local authority may consider whether or not to involve an IMCA under the criteria they have set – but may then become a case where the allegations or evidence give rise to the question of whether the person should be moved in their best interests. In these situations the case has become one where an IMCA must be involved if there is no-one else appropriate to support and represent the person in this decision.

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42 Published guidance: *No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse* for England (on the Department of Health website) and *In safe hands* in Wales.

No secrets applies to adults aged 18 or over. The Children Act 1989 applies to 16 and 17 year olds who may be facing abuse. Part V of the Act covers the Protection of Children, which includes at section 47 the duty to investigate by a local authority in order to decide whether they should take any action to safeguard or promote a child’s welfare where he or she requires protection or may suffer harm. See also chapter 12 of this Code.
Who qualifies for an IMCA?

10.69 Apart from the adult protection cases discussed above, IMCAs are only available to people who:

- lack capacity to make a specific decision about serious medical treatment or long-term accommodation, and
- have no family or friends who are available and appropriate to support or represent them apart from professionals or paid workers providing care or treatment, and
- have not previously named someone who could help with a decision, and
- have not made a Lasting Power of Attorney or Enduring Power of Attorney (see paragraph 10.70 below).

10.70 The Act says that IMCAs cannot be instructed if:

- a person who now lacks capacity previously named a person that should be consulted about decisions that affect them, and that person is available and willing to help
- the person who lacks capacity has appointed an attorney, either under a Lasting Power of Attorney or an Enduring Power of Attorney, and the attorney continues to manage the person’s affairs
- the Court of Protection has appointed a deputy, who continues to act on the person’s behalf.

10.71 However, where a person has no family or friends to represent them, but does have an attorney or deputy who has been appointed solely to deal with their property and affairs, they should not be denied access to an IMCA. The Government is seeking to amend the Act at the earliest opportunity to ensure that, in such circumstances, an IMCA should always be appointed to represent the person’s views when they lack the capacity to make decisions relating to serious medical treatment or long-term accommodation moves.

10.72 A responsible body can still instruct an IMCA if the Court of Protection is deciding on a deputy, but none is in place when a decision needs to be made.

Scenario: Qualifying for an IMCA

Ms Lewis, a woman with a history of mental health problems has lived in a care home for several years. Her home will soon close, and she has no-one who could help her. She has become very anxious and now lacks capacity to make a decision about future accommodation. The local authority instructs an IMCA to support her. The IMCA visits Ms Lewis, talks to staff who have been involved in her care and reviews her case notes.

In his report, the IMCA includes the information that Ms Lewis is very close to another client in the care home. The IMCA notes that they could move together – if it is also in the interests of the other client. The local authority now has to decide on the best interests of the client, considering the information that the IMCA has provided.
Will IMCAs be available to people in prisons?

10.73 IMCAs should be available to people who are in prison and lack capacity to make decisions about serious medical treatment or long-term accommodation.

Who is it ‘appropriate to consult’?

10.74 The IMCA is a safeguard for those people who lack capacity, who have no-one close to them who ‘it would be appropriate to consult’. (This is apart from adult protection cases where this criterion does not apply.) The safeguard is intended to apply to those people who have little or no network of support, such as close family or friends, who take an interest in their welfare or no-one willing or able to be formally consulted in decision-making processes.

10.75 The Act does not define those ‘whom it would be appropriate to consult’ and the evaluation of the IMCA pilots reported that decision-makers in the local authority and in the NHS, whose decision it is to determine this, sometimes found it difficult to establish when an IMCA was required.\(^\text{43}\) Section 4(7) provides that consultation about a person’s best interests shall include among others, anyone:

- named by the person as someone to be consulted on a relevant decision
- engaged in caring for them, or
- interested in their welfare (see chapter 4).

10.76 The decision-maker must determine if it is possible and practical to speak to these people, and those described in paragraph 10.70 when working out whether the proposed decision is in the person’s best interests. If it is not possible, practical and appropriate to consult anyone, an IMCA should be instructed.

10.77 There may be situations where a person who lacks capacity has family or friends, but it is not practical or appropriate to consult them. For example, an elderly person with dementia may have an adult child who now lives in Australia, or an older person may have relatives who very rarely visit. Or, a family member may simply refuse to be consulted. In such cases, decision-makers must instruct an IMCA – for serious medical treatment and care moves and record the reason for the decision.

10.78 The person who lacks capacity may have friends or neighbours who know their wishes and feelings but are not willing or able to help with the specific decision to be made. They may think it is too much of a responsibility. If they are elderly and frail themselves, it may be too difficult for them to attend case conferences and participate formally. In this situation, the responsible body should instruct an IMCA, and the IMCA may visit them and enable them to be involved more informally.

\(^{43}\) see www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SocialCare/IMCA/fs/en
10.79 If a family disagrees with a decision-maker’s proposed action, this is not grounds for concluding that there is nobody whose views are relevant to the decision.

10.80 A person who lacks capacity and already has an advocate may still be entitled to an IMCA. The IMCA would consult with the advocate. Where that advocate meets the appointment criteria for the IMCA service, they may be appointed to fulfil the IMCA role for this person in addition to their other duties.