



Northern Ireland
Assembly

Ad Hoc Joint Committee on the Mental Capacity Bill

Report on the Mental Capacity Bill

Together with the Minutes of Proceedings of the Committee Relating to the Report,
Minutes of Evidence, Written Submissions and Other Papers

Ordered by the Ad Hoc Joint Committee on the Mental Capacity Bill
to be printed on 25 January 2016

Report: NIA 252/11-16

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Membership and Powers

Powers

Under Standing Order 64, where a matter may be of concern to two or more committees it may be dealt with by an ad hoc joint committee established for that purpose, in accordance with Standing Order 64C.

Given that the Mental Capacity Bill contains both health and justice provisions, it is of concern to the Committee for Health, Social Services and Public Safety and the Committee for Justice.

The Ad Hoc Joint Committee on the Mental Capacity Bill was established by resolution of the Assembly on 11 May 2015 in accordance with Standing Order 64C. The remit of the Committee was to consider the Mental Capacity Bill and to submit a report to the Assembly by 28 January 2016.

Each ad hoc committee may exercise the power in section 44 (1) of the Northern Ireland Act 1998 as below:

- (1) The Assembly may require any person-
 - (a) To attend its proceedings for the purpose of giving evidence; or
 - (b) To produce documents in his custody or under his control, relating to any of the matters mentioned in subsection (2).

- (2) Those matters are-
 - (a) transferred matters concerning Northern Ireland; and
 - (b) other matters in relation to which statutory functions are exercisable by Ministers or the Northern Ireland departments.

Membership

The Committee has 11 members, including a Chairperson and Deputy Chairperson, and a quorum of five members. In accordance with Standing Order 64C (3), the membership is drawn from the memberships of the relevant committees - the Committee for Health, Social Services and Public Safety and the Committee for Justice.

The membership of the Committee is as follows:

- Mr Alastair Ross MLA (Chairperson)
- Mr Patsy McGlone MLA (Deputy Chairperson)
- Mrs Pam Cameron MLA
- Mrs Jo-Anne Dobson MLA
- Mr Alex Easton MLA
- Mr Paul Frew MLA¹
- Mr Danny Kennedy MLA^{2 3}
- Mr Seán Lynch MLA
- Mr Raymond McCartney MLA
- Mr Kieran McCarthy MLA
- Ms Rosie McCorley MLA

¹ With effect from 30 September 2015 Mr Paul Frew MLA replaced Mr Edwin Poots MLA

² With effect from 30 November 2015 Mr Danny Kennedy MLA replaced Mr Neil Somerville MLA

³ With effect from 30 June 2015 Mr Neil Somerville MLA replaced Mr Tom Elliott MLA

List of abbreviations and acronyms used in this Report

BMA	British Medical Association
BPS	British Psychological Society
CDLP	Centre for Disability Law and Policy
CLC	Children’s Law Centre
COPNI	Commissioner for Older People for Northern Ireland
DHSSPS	Department for Health, Social Services and Public Safety
DOJ	Department of Justice
EAP	Essex Autonomy Project
ECHR	European Convention on Human Rights
ECT	Electro-Convulsive Therapy
EPA	Enduring Power of Attorney
GMC	General Medical Council
HSC	Health and Social Care
HSCB	Health and Social Care Board
ICO	Information Commissioner’s Office
LCNI	Law Centre Northern Ireland
LPA	Lasting Power of Attorney
LSNI	Law Society Northern Ireland
MCA	Mental Capacity Act (2005)
NHSCT	Northern Health and Social Care Trust
NIACRO	Northern Ireland Association for the Care and Resettlement of Offenders
NIAMH	Northern Ireland Association for Mental Health
NIAS	Northern Ireland Ambulance Service

NIASW	Northern Ireland Association of Social Workers
NIASWTP	Northern Ireland Approved Social Worker Training Programme
NICCY	Northern Ireland Commissioner for Children and Young People
NICTS	Northern Ireland Courts and Tribunals Service
NIHRC	Northern Ireland Human Rights Commission
NIPB	Northern Ireland Policy Board
NIPBPB	Northern Ireland Policy Board Performance Board
NIPEC	Northern Ireland Practice and Education Council
NIRDP	Northern Ireland Rare Disease Partnership
PHA	Public Health Agency
PSNI	Police Service of Northern Ireland
PBNI	Probation Board for Northern Ireland
PPOs	Public Protection Orders
PPS	Public Prosecution Service
RCN	Royal College of Nursing
RCPNI	Royal College of Psychiatrists in Northern Ireland
RCSLT	Royal College of Speech and Language Therapists
RQIA	Regulation and Quality Improvement Authority
SEHSCT	South Eastern Health and Social Care Trust
SHSCT	Southern Health and Social Care Trust
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities

Executive Summary

1. The purpose of the Bill is to introduce mental capacity legislation and reform mental health law in Northern Ireland. This approach of combining mental capacity and mental health legislation within a single Bill was a key recommendation of a report produced as part of the Bamford Review. That report concluded that a single legislative framework would help reduce the stigma associated with having separate mental health law and would provide an opportunity to enhance protections for people who are unable to make a specific decision in relation to their health, welfare or finances because of a lack of capacity. It also recommended that the same provisions apply to those people subject to the criminal justice system.
2. The majority of stakeholders supported the broad objectives of the Bill, although a few key issues did emerge.
3. The first key issue concerned the Department's decision to recognise but not codify advance decisions within the Bill, but rather to leave the matter to common law. Stakeholders believed that an opportunity had been missed to create more clarity and certainty for both individuals and professionals as to what constitutes an effective advance decision. The Committee was concerned with the Department's approach of allowing case law to develop once the Bill is in place, rather than set the policy itself. In the Committee's view, this would leave patients and healthcare professionals in a vulnerable and uncertain position. The Committee therefore asked the Department to bring forward a "review and report" amendment, which would require the Department to review the law on advance decisions and to lay a report before the Assembly. The Department accepted the Committee's rationale and drafted an amendment which would require this to happen within three years of the Bill coming into operation.
4. The second key issue related to the Department's approach to Lasting Powers of Attorney (LPA) and Enduring Powers of Attorney (EPA). The Bill will create a new system of LPAs which cover decisions relating to a person's health, welfare and finances. It will also prevent any further EPAs, which relate to a person's property and affairs, being made once the Bill comes into operation.

The Committee was concerned that given the potential complexity and costs associated with making an LPA, many people would simply not make one. It was therefore of the view that the EPA system should be allowed to remain in place, to allow people a wider range of options in terms of planning for their future needs. The Committee therefore agreed to register its opposition to clause 110.

5. The third issue related to the conditions for detention under a Public Protection Order (PPO) within the criminal justice provisions of the Bill. Public Protection Orders are being created through the Bill to deal with people who are not culpable for their actions, but cannot be released because they pose a danger to others. The Bill as drafted stipulated that for someone to be subject to a PPO, he or she had to pose a risk of “serious physical harm to other persons”. The Committee was concerned that this criterion may not always be met, even when the crime committed would be deemed to be serious, but had not resulted in “serious physical harm” to the victim. The Department recognised that this was a potential loophole and proposed a range of amendments to the Bill, so that the risk a person poses in terms of “serious physical or psychological harm” to others must be considered in relation to PPOs.
6. The fourth issue was the Department’s powers to make further provision by means of secondary legislation. As drafted, the Bill permitted the Department to amend any part of the Act by secondary legislation. The Committee was of the view that this power was too wide-ranging. The Department accepted the Committee’s viewpoint and drafted amendments to limit the power to amend the Act to Part 2, and to require that powers to amend any other pieces of legislation as a consequence of the Act would be done through the draft affirmative procedure.
7. The fifth issue was that of the costs associated with the Bill, which are estimated at between £76 to £84 million for year one implementation costs, and £68 to £76 million for recurrent costs. The Committee was seriously concerned about the lack of certainty in terms of whether the monies required will be forthcoming from the Departments and the Executive, given the current financial climate.

Introduction

1. The Ad Hoc Joint Committee was established by the Assembly on Monday 11 May 2015, by means of the following motion:

Resolved:

That, as provided for in Standing Order 64C, this Assembly appoints an Ad Hoc Joint Committee to consider the Mental Capacity Bill; and to submit a report to the Assembly by 28 January 2016.

Composition: Democratic Unionist Party, 4

Sinn Féin, 3

Ulster Unionist Party, 2

Social Democratic and Labour Party, 1

Alliance Party, 1

Quorum: The quorum shall be five members except when no decision is taken or question put to the Committee, when the quorum shall be four.

Procedure: The procedures of the Committee shall be such as the Committee shall determine.

2. The Mental Capacity Bill (NIA 49/11-16) was introduced to the Assembly on 8 June 2015 by the Minister for Health, Social Services and Public Safety when he said:
3. “I beg to introduce the Mental Capacity Bill [NIA 49/11-16], which is a Bill to make new provision relating to persons who lack capacity; to make provision about the powers of criminal courts in respect of persons with disorder; to dis-apply Part 2 of the Mental Health (Northern Ireland) Order 1986 in relation to persons aged 16 or over and make other amendments of that order; to make provision in connection with the Convention on the International Protection of Adults signed at the Hague on 13 January 2000; and for connected purposes.”
4. The Bill passed its Second Stage on 16 June 2015. The Bill as introduced contains 295 Clauses and 11 Schedules and will aim to provide a legislative

framework that introduces mental capacity legislation and reforms mental health law in Northern Ireland.

5. During the period covered by this Report, the Committee considered the Bill and related issues at 24 meetings. The relevant extracts from the Minutes of Proceedings for these meetings are included at Appendix 1.
6. At its first meeting on 19 May 2015, the Committee elected Mr Alastair Ross MLA as Chairperson and Mr Patsy McGlone MLA as deputy Chairperson.
7. The Committee agreed to issue a 4 week call for evidence from 9 June to 7 July 2015. Fifty three submissions were received and details of submissions received are at Appendix 3.
8. The Committee held four introductory briefings with the Departments from 1 June to 22 June 2015.
9. On 29 June, the Committee held a roundtable evidence session with international experts and academics. Those who attended were:

Caroline Bielanska

Professor Phil Fennell

Professor Julian Hughes

Alex Ruck Keane

Professor Wayne Martin

Professor George Szmukler
10. The Committee took oral evidence from a range of stakeholders from 7 September to 19 October as follows:

Alzheimer's Society

Association for Real Change

BMA

British Psychological Society NI

Children's Law Centre

Commissioner for Older People NI

Compassion in Dying

Disability Action

Law Centre NI

Law Society NI

Mencap

Mindwise

NICCY

NI Approved Social Worker Training Programme

NI Association of Social Workers

NI Human Rights Commission

NI Rare Disease Partnership

RQIA

Royal College of Nursing

Royal College of Psychiatrists in NI

Royal College of Speech and Language Therapists

PHA

PSNI

Southern HSCT

The Centre for Disability Law and Policy

The NI Practice and Education Council for Nursing & Midwifery

11. From 2 November to 4 January, the Committee deliberated on the Bill and took further oral evidence from the Departments on relevant issues.
12. The Committee carried out its clause by clause scrutiny of the Bill on 11 January 2016. At its meeting on 25 January 2016 the Committee agreed its report on the Bill and that it should be printed.

Acknowledgements

13. The Committee wishes to express its sincere appreciation to all those who provided written and oral evidence.

Consideration of the Bill

Introduction

14. This section of the report provides a summary of the key issues which the Committee deliberated on. Given the length of the Bill, the evidence received on every single clause and Schedule is not rehearsed in this section of the report - a complete picture of the written and oral evidence received can be found in Appendices 2 and 3.

PART 1

Clause 1

15. A range of stakeholders supported clause 1 and the principle of capacity including the Northern Ireland Association for Mental Health, the Commissioner for Older People Northern Ireland, the Northern Ireland Association of Social Workers, the RQIA, the Association for Real Change, the Royal College of Psychiatrists in Northern Ireland, the Royal College of Nursing, the General Medical Council, Mencap, Disability Action, and the PSNI.

Disability Action stated:

"We broadly support the definition of capacity and welcome the assumption that a disabled person has capacity unless it is otherwise established. We welcome the fact that the Bill defines the term "lacks capacity" in a way that is not a blanket assessment. That is particularly relevant because of the wide range of decisions that this will cover in the making of decisions about a person's life". (Appendix 2)

16. Other stakeholders made the point that some of the other principles set out in the Bamford Review had not been included on the face of the Bill (e.g. justice, least harm, benefit, reciprocity). This view was expressed by the Children's Law Centre, the South Eastern Health and Social Care Trust, the Northern Health and Social Care Trust, and the Northern Ireland Commissioner for Children and Young People.

17. The Committee questioned the Department on its rationale for selecting “capacity” and “best interests” as the two principles to appear on the face of the Bill. Officials stated:

“ . . . the Bamford principles have acted as a reference point throughout the drafting of the Bill. Although they do not appear in words on the face of the Bill, they very much underpin the core provisions. The principles of capacity and best interests are linked to the provisions in the protection from liability clause in Part 2, which are about how you can be protected from liability when you act in relation to somebody who lacks capacity. So, that is why we concentrated on the principles of capacity and best interests”. (Appendix 2)

18. The Committee was content with the Department’s explanation.
19. Stakeholders suggested a variety of amendments to clause 1. The Law Centre Northern Ireland suggested that clause 1 (3) (b) should be amended to include the wording “any condition, disorder or disability that the person has”. The Department’s position was that the term “condition” covers disorder and disability, so an amendment would not be required. The Committee accepted this rationale.
20. The Commissioner for Older People NI argued that clause 1 (3) (b) should make specific mention of “age” as a characteristic of a person which should not be used by others to make assumptions about a person’s ability to make a decision. When this was discussed with the Department, officials stated:
- “For the purposes of the Bill, a person's inability to make a decision is to be judged solely in accordance with the criteria set out in clauses 3 and 4, so, to all intents and purposes, age is irrelevant for the purposes of the Bill. To include a reference to age there might suggest otherwise; so, that is why it is not included in that provision”. (Appendix 2)*
21. The Committee accepted this rationale.
22. The Centre for Disability Law and Policy proposed that clause 1 should be deleted and replaced with a different set of principles: the equal right to make decisions; support; will, preferences and rights; and safeguards. It explained its thinking on the matter:

“First, the principle of capacity in clause 1, particularly in clause 1(3), in my view sets the bar too high for all those over 16 years of age who want to make legally binding decisions. It also makes the exercise of an individual’s legal capacity contingent on passing an assessment of mental capacity. The functional assessment of mental capacity enshrined in clause 1 has been criticised in the human rights community, and it has been particularly strongly criticised by the UN Committee on the Rights of Persons with Disabilities”. (Appendix 2)

23. The Committee discussed the issue of compliance with the UN Committee on the Rights of Persons with Disabilities (UNCRPD) with the Department, and officials advised:

“We are very conscious that the Bill is part of an ongoing conversation, locally and internationally, about the United Nations Convention on the Rights of Persons with Disability. We are conscious that the general comment issued last year, which has been the foundation for a lot of the comment today from stakeholders, is part of that conversation as well. As you probably heard today, it is fair to say that not everybody agrees with that general comment and the positions in it. There are practical implications with what is being suggested, issues around ECHR compliance and, for us and you as the Assembly, ECHR compliance being paramount. Having said that, we have made concerted efforts to take account of the UNCRPD in the Bill. We have the support principle and the support clause itself. We have the requirement to have special regard for P’s wishes and feelings as part of the best-interests test. There is that considerable effort, as well as provision in clause 3, I think, to make it clear that it is irrelevant whether the person’s impairment or disturbance is caused by disability or otherwise. We have made concerted efforts to do that and take account of the UNCRPD, but ECHR compliance would be paramount”. (Appendix 2)

24. The Committee acknowledged the difficulties around balancing the implications of the UNCRPD and the ECHR. It accepted that the Department had attempted to take account of emerging thinking in relation to the UNCRPD.
25. Disability Action suggested that clause 1 (4) should be amended to include the wording “a person must be supported to make a decision”, instead of the current wording of “all practicable help and support . . . have been given”. The

Department's view on this suggestion was outlined in a letter dated 3 November 2015:

"The Department would not support the suggestion put forward by Disability Action that the principle in clause 1(4) should be re-drafted to read "the person must be supported to make a decision" for a number of reasons. Firstly, it would involve the imposition of a duty on the decision maker that in many cases would be impossible to comply with. The most obvious example would be if P were in a coma. Clearly, in that case, it would simply be impossible to support P to make a relevant decision. Fundamentally, the wording suggested by Disability Action would also be incompatible with clause 1(1) which makes clear that the principles apply where a determination falls to be made of whether a person who is 16 or over lacks capacity in relation to a matter. If, as the suggested wording would infer, everyone could be supported to make a decision, the need for a determination of whether a person lacks capacity would never arise. This would clearly be at odds with the core purpose of the Bill which, as the long title states, makes new provision relating to persons who lack capacity.

The Department would also wish to advise the Committee that the framing of the principles, including clause 1(4), is intended to tie them directly to the definition of "lacks capacity" and the core decision making framework in Part 2 of the Bill. This is to ensure that the principles have practical effect on the ground". (Appendix 4)

26. The Committee discussed the matter further with officials during an evidence session on 16 November. The Department provided further detail on why it could not support such an amendment:

"If the Bill were to place a statutory obligation on healthcare professionals that they must support a person – for example, a person in a coma – to make a decision for themselves, the outcome would be inevitable in our view: a decision would simply not be made for that person. That sits at odds entirely with what the Bill is trying to achieve, not least with the healthcare professionals' duty of care.

The same could be said for someone with advanced dementia or a person who is simply unconscious at the side of the road following a car accident. That is why clause 1(4) is framed as it is, as is clause 5. It rightly says that you cannot jump to the conclusion that someone is unable to make a decision for themselves. You must first give that person all practicable help and support, taking the steps outlined in clause 5, which, as the Committee will be aware, goes further than the English legislation. Most importantly, the clause has been drafted to take account of the fact that that may not in reality be possible. The Department believes, therefore, that it has gone as far as it can in relation to the clause". (Appendix 2)

27. The Committee was content with the Department's position on this issue.

Clause 2

28. A range of stakeholders supported clause 2 and the principle of best interests including the Probation Board NI, the Northern Ireland Association of Social Workers, the RQIA, the Royal College of Nursing, and the PSNI.
29. Other stakeholders were opposed to the principle of best interests because they believed it is paternalistic, does not promote the autonomy of the individual, or is not compliant with the UNCRPD. This view was expressed by the Northern Ireland Association for Mental Health, the Centre for Disability Law and Policy, Professor Penelope Weller, Mencap, and Disability Action. These stakeholders advocated for the Bill to be re-framed around the concept of "will and preferences" rather than "best interests".

Disability Action stated:

"We believe that amendments are needed so that the Bill refers to "will and preferences" so that the autonomy of the individual is the overriding principle. If you consider the evidence of the House of Lords reports on the post-legislative scrutiny of the Mental Capacity Act 2005 of England and Wales, you find that the Select Committee identified that the continued reliance on the use of the best interests test permitted the continuing dominance of a paternalistic authoritarian model of care". (Appendix 2)

30. During an oral evidence session there was a debate between stakeholders on whether “will and preferences” is required by the UNCRPD. The CDLP stated:

“Article 12(4) of the UN convention specifically uses the term that all:

“measures relating to the exercise of legal capacity respect the rights, will and preferences of the person”.

There are other aspects of that article, but that appears in it and the states that ratified it are well aware of the obligation to respects rights, will and preferences”. (Appendix 2)

31. However, the Law Centre NI contended:

“If someone's will and preferences are clear and indisputable and, for example, he or she does not want a life-saving medical intervention because he or she considers a psychiatrist to be an assassin, a certain amount of time can go by, but there is no contradicting what his or her best will and preferences are. Will and preferences could be articulate and reasoned beyond any reasonable doubt, but it would be a travesty and a human rights violation not to protect their life and their right to health by making an intervention. I do not think that will and preferences can do all the work. There is always a need for a substitute decision to be made, and it has to be made in the best interests of the person”. (Appendix 2)

32. The CDLP countered with the following point:

“Even though we think that the person who refuses mental health treatment because they believe that the psychiatrist is an assassin is not making a decision based on all the right information, we still – for adults at least – accept that they have a dignity of risk to make the wrong decisions sometimes. I know that that is very serious and that sometimes people make the wrong decisions that result in their death. Ultimately, for me, the principle of autonomy is more important, and I would trust the person more than external factors, and I would trust the person, in conjunction with the people around them who can support them to make that decision, than I would to give a place to best interests”. (Appendix 2)

33. The Department's position on this debate was that the Bill had attempted to reconcile the requirements of the UNCRPD and ECHR. Departmental officials explained:

"The question in the Bill is about trying to provide the balance between maximising the person's ability to make decisions, their decisions having power over the system, – particularly in cases where you are thinking about best interests and there is no advance notification of what they might think – and someone having to make a judgement. Their will and preferences, or as we have worded it differently, are clearly important, but they are within a certain limit. That limit is imposed by the ECHR and by other social and moral limits that we might not all agree on but which are codified in the ECHR.

It is also important to look not just at clause 7 and the principle in clause 1 but at the additional safeguards provided in Part 2. Those need to be looked at in totality, because their effect is to require further scrutiny and checks to be done on best interests where you are moving away from what the person might want to happen and where there is any sort of resistance or objection".
(Appendix 2)

34. The Committee acknowledged the difficulties around balancing the implications of the UNCRPD and the ECHR in terms of the concept of best interests, and concluded that the Department had attempted to achieve an appropriate balance.

Clause 3

35. The meaning of "lacks capacity" was welcomed by a range of stakeholders including the Northern Ireland Association for Mental Health, the Royal College of Nursing, and Disability Action.
36. Clause 3 provides a functional test of capacity with a diagnostic element. Some stakeholders argued that the diagnostic element of this test would disproportionately affect persons with disabilities because people with learning disabilities, mental health issues, and dementia will be the main target of these clauses. They argued that this would therefore make the clause in breach of the UNCRPD.

37. This view was expressed by the CDLP, the NIHRC, Alex Ruck Keene, Professor Bernadette McSherry, Professor Penelope Weller and the Law Society NI. For example, the NIHRC stated:

“The committee makes it clear that frameworks which indirectly discriminate against persons with disabilities are in breach of the UNCRPD article 12. Despite the very welcome safeguard at subsection (3) of the clause, which makes clear that the presence of a disability or disorder is irrelevant to decisions regarding capacity, the commission advises that a functional test with its diagnostic element would disproportionately affect persons with disabilities and, as such, would breach the UNCRPD article 12 as interpreted by the committee”. (Appendix 2)

38. However, other organisation contended that if the reference to the impairment or disturbance in the functioning of the mind or brain is removed from the clause, this leaves an open-ended test for capacity which potentially any person could meet. According to that view, given that the Bill provides for deprivation of liberty, removing this reference would render clause 3 incompatible with article 5 of the ECHR, which requires an individual to be of “unsound mind” before they can be deprived of their liberty on public protection grounds. This point was made by the NIHRC and the Royal College of Psychiatrists, the latter stating:

“If you take away the diagnostic element that was discussed earlier, one of the difficulties is that you could end up detaining people who have no mental illness, which, obviously, is not what we want to do”. (Appendix 2)

39. The Department’s position was that the diagnostic element of the test is necessary for ECHR compliance. The Committee acknowledged the complexities around this clause, and came to the conclusion that the Department was taking the appropriate approach.

Clause 4

40. The Royal College of Speech and Language Therapists suggested an amendment to clause 4 (1). They argued that because of the importance of establishing whether a person with a communication disability may have ca-

capacity, but not the means to communicate without appropriate support, more emphasis needs to be placed on clause 4 (1) (d). They proposed that this clause becomes clause 4 (1) (a) and therefore appears first in the list of reasons why a person may be unable to make a decision. The Royal College of Speech and Language Therapists explained:

“Making the ability to communicate the paramount consideration will trigger people to think about whether they are in a position to make a judgement about somebody else’s communication skills on their own, or whether they need to seek additional support or guidance”. (Appendix 2)

41. The Law Centre NI supported this view and argued that health and social care staff will read the clause sequentially.

42. The Committee asked the Department for its views on moving clause 4 (1) (d) to become clause 4 (1) (a). The Department’s response in a letter dated 3 November 2015 stated:

“The Department’s view is that RCSLT’s proposed amendment to subsection (1) would make no difference to the legal effect of clause 4 and, therefore, is unnecessary. It is important to note that clause 4 links directly to clauses 1(4) and 5. If these clauses have not been complied with, the conditions in clause 9 (1)(c) and (d) will not have been met and the decision maker will not be protected from liability. In other words, when read together, these clauses already achieve the intention behind the proposed amendment as we understand it”. (Appendix 4)

43. The Committee took the view that clause 4 is drafted to reflect a logical sequence in terms of the steps involved in making a decision - understanding the information, retaining the information, appreciating the relevance of the information and finally communicating the decision. The Committee therefore agreed that it was content with clause 4 as drafted.

44. A variety of views were expressed in relation to the word “appreciate” in clause 4 (1) (c), which does not appear in the Mental Capacity Act 2005. Those who queried the use of “appreciate” argued that it may be interpreted as simply making sure that people are only judged to have capacity if the decisions they make are “risk-averse”; that it introduced a degree of subjectivity

into the capacity test;- and that it may raise the bar in relation to the threshold for capacity. These views were expressed by Professor Julian Hughes, the General Medical Council, the BMA, and the Law Centre NI. The BMA stated:

“The word "appreciate" is an addition to the criteria used to determine capacity in other jurisdictions in the UK. This addition may make the criteria for making a decision more stringent and raise the bar in relation to the threshold for capacity. Furthermore, there are no legal precedents for the judicial interpretation of what "appreciate" means. The term is subjective and open to interpretation. Great care needs to be taken to ensure that this clause does not result in many more people being found to lack capacity. People do have the right to make what may seem to us unwise decisions”. (Appendix 2)

45. However, the Royal College of Psychiatrists stated that they recognised that the word “appreciate” had been inserted into the Bill to address criticisms that the Mental Capacity Act 2005 does not lend itself well to psychiatric disorders where cognitive processes may be intact, but the person lacks insight or is affected by delusional thinking. They welcomed the word “appreciate” but also stated that there needs to be practical guidance as to how psychiatrists would apply clause 4 (1) (c) in everyday situations. The Royal College of Psychiatrists explained:

“One of the important symptoms that we in psychiatry come across is lack of insight, which is, in essence, the inability to know that one is unwell. From our point of view, "appreciation" introduces that into the capacity test, and, without that, we feel that the test is less practically applicable to people with psychiatric disorders. I take Dr Flynn's point that capacity is very subjective, although there is some evidence that it can be assessed objectively. Definitions, as already said, need to be clear, and we hope that that guards against some of the risk of subjectivity”. (Appendix 2)

46. The Department’s position was that the word “appreciate” had been included in the clause to attempt to achieve a balance between the protection of autonomy and the protection of the interests of others. Departmental officials explained:

“It is intended to get beyond the cognitive understanding that paragraphs (a) and (b) are really about. It is that state where there might be something that is dominating your thinking so much that it is preventing you making a decision and is beyond your cognitive understanding, which is something that the Bamford review pointed out in relation to the equivalent test in the Mental Capacity Act”. (Appendix 2)

47. The Committee accepted the Department’s rationale on the inclusion of the word “appreciate” within the clause.

Clause 5

48. A range of stakeholders welcomed the emphasis on supported decision making set out in clause 5.
49. The Royal College of Speech and Language Therapists suggested an amendment to clause 5 (2) (a) in relation to communication support. Given that clause 4 states that the ability to communicate is one of the criteria for being able to make a decision, the RCSLT considered that communication support be specifically referenced as a step in clause 5 (2). The Department’s initial response was that the amendment was not required, as clause 5 does not in any way limit the requirements of clause 1 (4) which requires all practicable help and support to be given to the person to enable them to make a decision.

Departmental officials stated:

“It may elevate it in a way that confuses people who are trying to apply it because it is elevating communication above other aspects that you might need to consider. Clause 1(4) refers to “all practicable help and support”, and that is about as broadly drawn as it could be. I do not necessarily think that you would need to expand on that, because it is just saying that everything practicable that you could possibly do to help the person should be done. If you were then to say, “and also you must place special regard to a particular type of problem or disability”, you might end up confusing that. Why have something so wide and then have a subset of things specified?” (Appendix 2)

50. After considering the Department’s response, the Committee suggested that it look at inserting the word “communication” into clause 5 (2) (a), to ensure that

the information is both provided to and communicated to the individual concerned. The Department's response in a letter dated 4 January 2016 advised that it had prepared amendments to clauses 4, 5, and 158 to address the concerns expressed by the Committee and the RCSLT (Appendix 4). The Department explained that the purpose of the amendment to clause 4 was to make clear on the face of the Bill that help and support must be given to enable the person to communicate his or her decision. In terms of the amendment to clause 5, its intention was to amplify clause 5 (2) to bring out the point that help and support must be given to enable the person to communicate his or her decision, without affecting the generality of clause 5 (2). The amendment to clause 158 was consequential in nature. The Committee agreed that it was content with the Department's proposed amendments.

51. The Essex Autonomy Project suggested an amendment to clause 5 (2) to reference the involvement or exclusion of other people in the decision making process. The Department's response was that the objective of these proposed amendments could be best achieved through clear guidance and the code of practice. The Committee was content with the Department's position.

Clause 7

52. A range of stakeholders expressed a concern that the concept of best interests permits a paternalistic, authoritarian model of care, and referenced the findings of the report of the House of Lords Select Committee on the Mental Capacity Act 2005. Others argued that "best interests" breaches the UNCRPD. These views were expressed by the Law Society NI, NIHRC, NI Association for Mental Health, Professor Bernadette McSherry, Professor Penelope Weller, and the CDLP. The Law Society NI stated:

"The Law Society is concerned that the regime of substituting decision-making in a person's best interests, pursuant to clauses 7 and 8, is unlawful by virtue of being a breach of the UNCRPD". (Appendix 2)

53. However, other stakeholders supported the concept of best interests with different degrees of qualification, including COPNI, the Royal College of Psychiatrists, Compassion in Dying, the Royal College of Nursing, and the Essex Au-

tonomy Project , the latter arguing that substitute decision-making under the best-interests standards can comply with the UNCRPD.

COPNI stated:

“On clause 7, the Commissioner for Older People is of the view that the statutory principle of best interests in decision-making relating to the care of older people, if affectively adhered to and appropriately managed, is an important step in safeguarding their rights and interests. Placing the best-interests principle on a statutory footing as defined by clause 7 can, in the right circumstances, provide significant safeguards for older people”. (Appendix 2)

54. The Royal College of Psychiatrists set out the following view:

“The Royal College of Psychiatrists supports the principle that intervention in the life of an incapacitous person should respect their autonomy as far as possible and that, in making any determination, P’s wishes should be respected and given special regard wherever possible. However, the clinical reality is that in some situations P’s views cannot be ascertained, where, for example, P is unconscious or extremely confused. While it is very important that people with mental disorder, especially those with lifelong conditions like learning disability, are not excluded from making decisions about their own lives, there are also, clearly, situations where a very ill or incapacitated person is not able to make their preferences known. A degree of beneficent intervention is required in those situations.

Debate rages around the UNCRPD, as we have heard. As psychiatrists, we do not feel that we are experts in that debate. In some ways, it is more of a legal debate. The Bill needs to give sufficient regard to a person’s wishes, but whatever conception is used, whether best interest or something else, it must be flexible enough to accommodate the range of situations that are encountered in clinical practice”. (Appendix 2)

55. Various ideas for amendments were put forward. The Law Society NI suggested that the person’s wishes and feelings should be given greater weight in terms of the factors considered when determining best interests, and perhaps the factors to be considered should be put in rank order. The NIHRC suggested that the clause could be amended to state that the person’s wishes and

feelings would be followed unless harm would arise. Similarly, the NI Association of Social Workers suggested specifying that the person's preferences are paramount but not absolute.

56. The Essex Autonomy Project put forward specific amendments to reference "will and preferences", rather than "wishes and feelings" within the principle of best interests. In addition they suggested additional clauses which would require "will and preferences" to be followed unless it would have serious adverse consequences for the individual (*Appendix 3*).

57. The Committee asked the Department for its views on the Essex Autonomy Project's proposed amendments. The Department's response dated 3 November 2015 stated:

"In sub-section (5), it has been suggested that "encourage and help" should be replaced with "support". The Department would not be supportive of this amendment. In drafting terms, it is the Department's view that the current wording relates better to "participate". The current wording also avoids any potential confusion with clause 5 and the role of others involved in the best interests decision making process, such as the nominated person and the independent advocate who have clear support functions under the Bill. Turning to the amendment to subsection (6) and the new subsections (8), (9) and (10) proposed by the EAP, it is the Department's understanding that these are intended to create a rebuttable presumption that it will always be in the best interests, of a person who lacks capacity to make a particular decision, to act in accordance with that person's will and preferences. Compelling reasons amounting to serious adverse consequences for P would be required to rebut this presumption. The Department's current view is that, bearing in mind the very wide range of decisions to which the Bill applies, the practical effect of these amendments could be to set such a stringent bar in all cases as to potentially make the framework provided for in the Bill unworkable on the ground. In the absence of any evidence to the contrary, it is also unclear whether the proposed amendments would in fact achieve in all cases what we understand to be the intention behind them i.e. to ensure that the rights of people who lack capacity are protected.

The Department would, however, wish to emphasise that the above points do not in any way mean that we are dismissive of, or do not share, the EAP's motivation in bringing forward the proposed amendments to clause 7. Rather, it is the Department's view that clause 7 as currently drafted, together with the additional safeguards in Part 2 of the Bill, already achieve the desired objective. Evidence to support this view can be found in recent judgments of the Court of Protection in England and Wales, such as Wye Valley NHS Trust v Mr B [2015 EWCOP 60]. In that case, the judge applied the best interests test in section 4 of the Mental Capacity Act 2005 (MCA) and came to the conclusion that an enforced amputation would not be in Mr B's best interest, having placed considerable weight on Mr B's clearly expressed wishes. The Bill of course builds on section 4 of the MCA to provide even further protections by placing a clear and specific focus on the need to identify P's wishes and feelings through the use of "special regard" in clause 7(6) and by requiring more to be done, through the additional safeguards in Part 2 in particular, where there are disputes to ensure that what is being proposed is necessary and proportionate taking account of all the relevant circumstances". (Appendix 4)

58. The Committee was content with the Department's position on this matter.
59. The Alzheimer's Society suggested that clause 7 (6) (a) and (b) should be amended to make specific reference to an "effective advance decision". However, the Department clarified that if there is an effective advance decision in place, there is no determination of best interests to be made. If an advance decision was not effective, then it would constitute a written statement, which is referenced in clause 7 (6) (a), and special regard has to be paid to that. The Committee was content with the Department's explanation on this matter.
60. The NI Rare Disease Partnership argued that clause 7 (9) needed to be more balanced, in terms of ensuring the safety of other people, in addition to the autonomy of the patient. They suggested that clause 7 (9) should be amended to include a reference to "harm to other persons" independently, and not just with resulting harm to P. However, in contrast, the BMA and the GMC were concerned that the clause as drafted went too far in the other direction, in that incorporating the interests of third parties into an assessment of an individual's

best interests risked moving away from a focus on the person's autonomy.

The Department's position was that the clause had been drafted in this way to create a balance between autonomy and protection. The Committee was content with the Department's rationale on this issue.

61. The Law Society NI pointed that an attorney acting under an EPA was not included in the list of "relevant people" in clause 7, and that this seemed to be an omission. The Department advised the Committee that it could foresee situations where it would be useful to consult with the EPA and agreed to make the amendment.
62. Mindwise was concerned about clause 7 (11) (d) which allows for anyone caring for P or with an interest in his or her welfare to be a "relevant person". Their fear was that in cases where this is a family member and there is no nominated person in place, that family member may not necessarily have P's best interests at heart. In circumstances where the only "relevant person" is a family member (who has not been appointed to the role of nominated person), then Mindwise suggested that an independent advocate should be appointed. The Department's response of 3 November 2015 stated:

"As the Bill requires a nominated person to be in place and consulted for serious interventions, it is assumed that the concern raised by Mindwise relates only to routine interventions proposed under the Bill in respect of which there is no such duty (although it is important to note that, if a nominated person were already in place, clause 7 would require consultation with him/her in respect of routine interventions too). To require an independent advocate to be appointed and consulted where any routine intervention, such as washing or dressing someone, is proposed because the only relevant person under clause 7(11) is a family member would, in the Department's view, be unworkable. It could also potentially undermine the role of family carers. It is the Department's view that the proper application of clause 7 in each individual case will achieve a more proportionate response to the concerns Mindwise raise, bearing in mind that the requirement to consult relevant people does not apply if it is not appropriate to do so and even, if it is considered appropriate, their views are not determinative of best interests". (Appendix 4)

63. The Committee discussed the issue further with officials on 16 November 2015. The Department provided further detail on the issue as follows:

“On closer analysis, it is clear that the issue being raised is already addressed in clause 7. The clause only requires the decision-maker to consult the relevant person:

“so far as it is practicable and appropriate to do so”.

That is made clear at the start of clause 7(7). Whether it is appropriate to undertake the consultation will be dependent on a number of factors, for example, the relationship that the potential consultee has with P.

If we look at the example put forward by MindWise, it would just not be appropriate to consult a person who clearly did not have P's best interests at heart. The code of practice will further clarify that and include case scenarios by way of example. It will also explain that it will be good practice for decision makers to have a record showing how they thought carefully about whom they should and should not consult and, in any event, the weight given to the views expressed by any of the consultees listed in that clause. That will also depend on a number of factors, for example, the extent of their knowledge of P, the amount of contact they have had with P and the relationship with P. The purpose of the consultation is to seek information that would assist the decision-maker in determining best interests. It is not to ask the consultee what decision they would make in that scenario”. (Appendix 2)

64. The Committee was content with the Department's explanation.

65. The Commissioner for Older People NI suggested that clause 7 should contain a statutory right of appeal to allow a person to challenge the determination of what is in their “best interests”. The Department's response of 3 November 2015 stated:

“It is the Department's view that it would be impracticable to provide a statutory right of appeal in respect of every decision made under the Bill given its very wide scope. Instead, the Bill adopts a more proportionate and workable approach that aims to provide some of the most vulnerable in society with more protections than are available under the current law. This is explained below.

In essence, the Bill makes any act done in connection with a person's care, treatment or personal welfare subject to clause 9 where the person lacks capacity to make the particular decision him/herself. Clause 9 provides protection from liability but, crucially, only if the applicable safeguards have been met. The more serious the intervention being proposed, the more safeguards need to be met. For the most serious, authorisation is required and there is a right of review to an independent Review Tribunal. The key point is that, if the applicable safeguards mentioned in clause 9 are not met, the decision maker will not be protected from liability and could be subject to criminal or civil legal proceedings as well as any internal or professional disciplinary processes. Ultimately, recourse to the High Court under Part 6 of the Bill is also available in respect of decisions made on someone's behalf. The High Court also has powers where an attorney acting under an LPA or a deputy is not acting in P's best interests. The Code of Practice will provide further guidance on all aspects of the legal protections available to people who lack capacity under the Bill and how to avail of them". (Appendix 4)

66. The Committee was content with the Department's explanation on the issue.

PART 2

Clause 9

67. The NI Practice and Education Council for Nursing and Midwifery (NIPEC) were concerned about how the term "reasonable steps" will be interpreted in clause 9 (1) (c) and the term "reasonably" in clause 9 (1) (d). This view was also expressed by the Southern Health and Social Care Trust.

68. NIPEC stated:

"The term "reasonableness" in law is one that legislators are familiar with. However, many staff have care responsibilities delegated by a nurse or a midwife. Indeed, whilst we deal with nurses and midwives directly in our organisation, we feel that it is pertinent to point out that this issue will apply to unregulated staff in the social care context as well – I am thinking particularly of those in the community environment. Those staff who have care responsi-

bility delegated by a nurse or a midwife would not frequently use or well understand the term "reasonableness". (Appendix 2)

69. The Department advised that reasonableness is an objective test, and that more would be expected in terms of “reasonable steps” to be taken by a professional than by a family carer. This will be reflected in the code of practice. The Committee was content with the Department’s explanation of the matter.

Clause 11

70. A range of stakeholders were concerned that the Department is not codifying advance decisions in the Bill, but is instead leaving the matter to common law. Advance decisions are codified within the Mental Capacity Act 2005. Stakeholders who expressed this view included the Northern Ireland Association for Mental Health, the Commissioner for Older People NI, the Children’s Law Centre, Compassion in Dying, the Medical Protection Society, Disability Action, and the Alzheimer’s Society.

71. Compassion in Dying explained as follows:

“First, whilst we welcome that the Bill gives legal force to effective advance decisions, as we heard, it leaves exactly what would be defined as an effective advance decision to the common law. We are concerned that that has the potential to create confusion for individuals who would like to plan ahead for their future treatment in the event of loss of capacity and for healthcare professionals who may be faced with an advance decision but are unsure whether it constitutes "effective" and are, therefore, unsure of their obligations to respect it”. (Appendix 2)

72. However, other stakeholders such as the NI Association of Social Workers and the Royal College of Psychiatrists accepted that case law and wider societal debate about advance decisions was still developing. They suggested that the code of practice should contain guidance on how advance decisions should be drafted.

73. The Royal College of Psychiatrists stated:

“ . . . some situations can be very difficult and a source of anxiety for doctors, specifically refusal of life-saving treatment and emergency situations. We take some reassurance from the fact that the Bill appears to allow emergency treatment in cases of doubt while a court decision is awaited. We recognise that the Bill is purposely leaving room for the development of case law in this area, and we understand that when the law is evolving, we understand that providing prescriptive advice is a challenge. However, as far as possible the forthcoming code of practice needs to give clarity on what can be a difficult and confusing area for a doctor”. (Appendix 2)

74. The NI Association for Mental Health, Alzheimer’s Society, and the Commissioner for Older People NI suggested that a commitment should be sought from the Department for a public awareness programme regarding advance decisions. The Department’s response to this suggestion was that it regarded raising awareness on all parts of the Bill as a matter for implementation, rather than the Bill itself.

75. The Department’s initial response was that it is preferable to let case law develop and societal debate continue. Departmental officials advised:

“Our view is that the Bill goes as far as we possibly can go at the moment in giving statutory recognition to advance decisions. We fully appreciate the strength of view on this and gave careful consideration to all the arguments that were put forward, of which not all were in favour of codifying the rules for advance decisions. There was not a great deal of consensus. Others raised issues about the effect on the protection of other rights. We took the view that it would be better to let the debate continue than to fix the rules in statute at this time”. (Appendix 2)

76. The Committee believed that this issue warranted further discussion and arranged a further evidence session with officials on 2 November. It also commissioned two Assembly research papers on the issues (Appendix 5).

77. At the meeting on 2 November 2015, the officials outlined a number of arguments for the Department’s decision not to put the rules around advance decision making on the face of the Bill. One of their key points was that because the Mental Capacity Bill fuses mental health and mental capacity legislation,

there could be a wider range of treatments covered by advance decisions than in England and Wales. The courts have not yet considered these issues. In the Department's view, the courts should have the opportunity to develop the common law rules further. Officials stated:

"The common law rules were developed by the courts in England against a very different legal backdrop. As we have mentioned, there is separate mental health legislation there that can, if necessary, override an advance decision. The law in relation to advance decisions has not therefore, in our view, been fully progressed in England and Wales. Of course, when this Bill comes into effect, there will be a radically different legal framework in Northern Ireland. There will not be separate mental health legislation; we will be fusing the two areas of law. There could, therefore, be a wider range of treatments covered that the courts did not have to consider before. We are developing that legal framework further, so we believe that the courts should also be given the opportunity to develop the common law rules further. Otherwise, we would set in stone rules that were created for a completely different legal landscape. We fear that that could have unintended consequences and might not adequately cover the situations that could arise under the Bill because we are not comparing like with like". (Appendix 2)

78. The Department also suggested that it would be preferable to allow for greater public debate on the issue of advance decisions once the Bill is in operation, rather than setting the rules in law at this point in time. Officials advised that the consultation on the Bill had demonstrated that there is not enough evidence or consensus in order to allow the rules around advance decisions to be set down in the Bill, and that there were still key policy issues to be determined, for example, whether the rules should be the same for all treatments, or for people of all ages. Officials stated:

"We felt there was not enough evidence or consensus in the consultation and policy development phases of the Bill, in which we engaged quite heavily with stakeholders. We feel that, in light of the fused Bill and the fused approach that we are taking, there needs to be a wider debate about what those rules should be. Should the rules be the same, no matter what the treatment or the

scenario is, or should there be different rules for different scenarios?” (Appendix 2)

79. The Committee was concerned that an issue of such significance was going to be left to the courts to determine, rather than the policy being developed by the Department and approved by the Assembly through the Bill. Members questioned the Department further on the issue of existing case law. Officials revealed that there have in fact been no cases to date on advance decisions in the courts in Northern Ireland. They then stated that the public awareness raising as part of the implementation phase of the Bill, might result in people being more aware of advance decisions, and this could generate more court cases. Officials advised:

“By raising awareness as part of the implementation phase, the intention is that more information will be out there about advance decisions and people will be more aware of it. From that, there could, potentially, be more cases. Indeed, this new fused approach, which has not been done before, could generate more cases”. (Appendix 2)

80. The Committee was not satisfied with the notion that people being forced to take court cases, because of a lack of clarity in the law, was somehow a positive thing, in that it would help case law to develop. In the Committee’s view this would be evidence of failure, not success. In addition, it would leave healthcare professionals and patients in a vulnerable and uncertain position, particularly in connection to advance decisions for mental health conditions.
81. However, the Committee acknowledged that not enough policy work had been done by the Department to allow the rules around advance decisions to be put on the face of the Bill. For example, a range of issues would need careful consideration, such as whether advance decisions should be limited to refusal of a specific treatment or should allow for positive statements requesting a specific treatment; whether children and adults should be allowed to make advance decisions; and whether an advance decision should be confined to an already diagnosed condition or extend to a future condition or future circumstances.

82. The Committee therefore agreed to ask the Department to bring forward an amendment to provide for a “review and report” clause, which would require the Department to review the law on advance decisions within a certain time of the Act becoming law, and to lay a report before the Assembly. The Department agreed to make an amendment to require it to review the law in relation to advance decisions and produce a report to be laid before the Assembly within three years of the Bill coming into operation. The Committee supported the proposed amendment.

83. The Children’s Law Centre expressed a concern that under common law, 16 and 17 years olds are not permitted to make advance decisions. The Committee wrote to the Department to clarify the position. The Department’s response dated 3 November 2015 stated:

“The Department is advised that an effective advance decision at common law to refuse treatment can only be made by a competent adult. As a person who is 16 or 17 years of age is a minor and not an adult, it follows that such a person cannot make an effective advance decision under the existing common law. This aligns with the effect of section 4(1) of the Age of Majority Act (NI) 1969, which is identical to its English analogue in the Family Law Reform Act 1969 (see section 8(1)). It also mirrors the effect of the provisions relating to advance decisions in the Mental Capacity Act 2005 which require the person to have reached the age of 18”. (Appendix 4)

Clause 12

84. The NI Practice and Education Council for Nursing and Midwifery (NIPEC) and the Royal College of Nursing took the view that the word “restraint” is outdated, and advocated the use of the term “restrictive interventions” or “restrictive practices” instead.

85. The Department clarified that the clause is not stating that a range of restrictive interventions cannot be used with a person lacking capacity - in fact clause 7 requires that when any act is being considered, regard must be given

to whether it could be done in a way that is less restrictive of the individual's rights and freedom. Rather, clause 11 requires that before "restraint" can be used, the "restraint condition" must be met, which is that the individual would be at risk of harm. The Department also made the point that "restraint" is the language used in court judgements on these sorts of issues. The Committee accepted the Department's explanation of this matter.

86. The Northern Health and Social Care Trust queried why the restraint condition set out in clause 12 (3) only refers to harm to P, and not harm to others. The Department's response was that it could not envisage circumstances where it would be necessary to restrain someone to prevent harm to others and it would at the same time be unnecessary to restrain that person to prevent harm to themselves. The Committee was content with this explanation.
87. The NIHRC suggested that the word "imminent" should be inserted into clause 12 (3), therefore requiring an "imminent risk of harm to P". The Department's response was that the use of the word "imminent" might restrict the use of clause 12 to emergency situations. This might stop something being done that might then result in the situation escalating and putting P in more danger, than would have been the case if action had been taken at an earlier time. The Committee accepted the Department's rationale on this issue.

Clauses 13 & 14

88. The Commissioner for Older People was concerned that the term "recently enough" in clause 13 (3) was too loose, and should be amended to a fixed time period. The Department's response was that "recently enough" has been used to cover a range of situations to take into account factors such as the seriousness of the intervention proposed, how long it takes to do the capacity assessment, whether the condition causing the lack of capacity is likely to change over a period of time and what that time period is likely to be. The Committee was content with the Department's explanation of the matter.
89. The Royal College of Speech and Language Therapists proposed that an additional clause should be inserted to require a formal assessment of communication to take place, where a finding of lack of capacity is based on the per-

son not being able to communicate his or her decision. The Department responded to this suggestion as follows:

“We do not think that that is required, because we think that it is already provided for in the Bill. To be protected from liability in clause 9, you have to check that all the steps that are provided for in Part 1 on lack of capacity are fulfilled. In this case, that would obviously be lack of communication. In the example that was provided last week, that clearly was not the case. Therefore, they would not be protected from liability because they had not ensured that the person actually cannot communicate. We believe that there is no reason to include this, and, if anything, it might create confusion as it would put disproportionate focus on communication, rather than the other three factors, which are also important”. (Appendix 2)

90. The Committee accepted the Department’s rationale on this matter.
91. The British Psychological Society argued that the term “statement of incapacity” used in clauses 13 and 14 implies a more pervasive and long term state than may be the case, and suggest it is replaced by “statement of current incapacity”. The Department’s response was that the word “current” is not helpful because it suggests that the person lacks capacity generally, when in fact the issue is whether they lack capacity to make a particular decision. The Committee was content with this explanation.
92. The Law Centre NI contended that there should be additional clauses in this part of the Bill entitled “Formal assessment of best interests” and “Statement of best interests” to provide a safeguard for P, given that the determination of best interests will have at least as great an impact on P’s life as the assessment that they lack capacity. The Law Centre NI argued that there needs to be documented evidence on how a decision was made in P’s best interests. The Department advised that additional clauses are not required as in order to show that a decision has been taken in someone’s best interests, the decision maker would need evidence that all the steps in clause 7 had been followed, and this would require documentation. For example, in situations where an authorisation is being sought from a Trust panel for a serious intervention, the decision maker will have to show the panel why it was in the person’s best in-

terests - this will require documentary evidence. The Committee accepted the Department's explanation on this matter.

Clauses 16 - 18

93. There was some debate as to who should conduct second opinions. The NI Association of Mental Health suggested that the person providing the second opinion should be from a different HSC Trust. The Northern HSC Trust suggested that rather than second opinions being required to be made by an "appropriate medical practitioner", the phrase should be "professional with lead responsibility for the delivery of the relevant treatment". The British Psychological Society similarly suggested that the phrase be amended to "approved clinician". The Department's response was that second opinions will be required for a very narrow scope of situations and it cannot imagine where a treatment would be prescribed by someone other than a medical practitioner. The Committee was content with this explanation.
94. The Commissioner for Older People NI was concerned that second opinions are not required when the situation is an emergency. The Department's response was that if the emergency clause was removed from the Bill it could result in someone not receiving treatment where there is an unacceptable risk of harm to that person. The Committee was content with this explanation.
95. The Royal College of Psychiatrists and the BMA questioned why electroconvulsive therapy (ECT) had been singled out as a "treatment with serious consequences". In their view many physical treatments are equally, if not more, serious. They argued that mentioning ECT in this way does not seem in line with the objective of the Bill to reduce stigma around mental illness, and consider mental and physical interventions by the same standard. The Department's position was that ECT is the only treatment specified in the Mental Health (NI) Order 1986 that requires a second opinion and it did not want to lose that safeguard and leave the matter to regulations. The Committee was content that the reference to ECT remained in the clause.
96. Disability Action argued that second opinions should be available to people in terms of the assessment of their capacity, and not limited to serious interven-

tions. The Committee sought the Department's view on this issue which was provided in a letter dated 3 November 2015:

“The second opinion provisions in the Bill currently relate to certain serious treatments and require an appropriate medical practitioner to certify that the proposed treatment is in P’s best interests. It is an additional safeguard that the Department considers to be proportionate and workable on the ground. To extend it in the way suggested by Disability Action (so that it would apply every time a person’s capacity is assessed in relation to a particular decision that needs to be made at a particular time for the purposes of the Bill) would, in the Department’s view, make the framework in Part 2 of the Bill inoperable on the ground and unaffordable.

It is important to note, however, that there is nothing in the Bill that stops anyone from seeking another opinion about an assessment that has been made about a person’s capacity for the purposes of an intervention made under the Bill. Furthermore, it is also important to note that dealing with/resolving disagreements is already inherent in the core provisions of the Bill. In other words, it would be the Department’s view that the Bill already addresses Disability Action’s concern, just in a different way that reflects the scope and nature of the framework in Part 2 of the Bill. To briefly explain, the fundamental point is that continuing disputes about a person’s capacity to make a particular decision will clearly have a material impact on whether a decision maker’s belief for the purposes of the condition in clause 9(1)(d)(i) is a reasonable one. If this condition is not met, the decision maker cannot proceed with the intervention without incurring liability for his/her actions. In other words, the legal protection available under clause 9 will not be available. This is a strong protection for P.

The additional safeguards mentioned in clause 9 are also relevant. For example, the requirement for a formal assessment of capacity for all serious interventions is new. These assessments must include a statement of incapacity. This statement cannot be made unless all practicable steps have been taken to help the person make the decision for him/herself. For the most serious interventions, the authorisation safeguard will also apply, triggered by a reasonable objection from the nominated person or in certain cases by

P's resistance. This will involve a separate formal determination of the person's capacity (and of best interests) by, in most cases, a Trust panel. P and his/her nominated person will have a right to challenge any authorisation granted in respect of him/her by making an application to the Review Tribunal. Ultimately, recourse to the High Court under Part 6 of the Bill is also option. The Code of Practice will provide further guidance and examples of how this new framework will operate.” (Appendix 4)

97. The Committee took further oral evidence from the Department on this matter on 16 November. Officials provided further detail as follows:

“After careful consideration of Disability Action's suggestion, our view is that it just would not be practicable to require a second opinion to be obtained every time someone's capacity was assessed under Part 2, particularly when you consider how often and, in some cases, how quickly that may need to be done; for example, where P is in clear danger. It would, in our view, greatly impede the carrying out of routine tasks and potentially make it impossible to lawfully do many of the things that have to be done daily in the lives of people who lack capacity. However, we do not want to appear dismissive. There is obviously a genuine concern behind Disability Action's suggestion that we need to address. It is probably useful if I briefly recap on some of the safeguards that are already provided for in the Bill, just to explain how we might see them working to address that concern.

First, it is important to remember that nothing can be done under Part 2 at all unless the core safeguard in clause 9 is complied with. It requires that the person doing the act must reasonably believe that P lacks capacity in relation to the matter. For example, where P and his carer disagree that P lacks capacity about whether he should have, say, a routine dental check -up, the core safeguard in clause 9 means that D – in this case, probably the dentist – will have to try to resolve that disagreement. Otherwise, it is hard to see how he can provide evidence that his belief that P lacks capacity is a reasonable one. If that belief is not a reasonable one, then the core safeguard in clause 9 is not met, and the dentist will risk legal action if he proceeds with the intervention. That is a really important point about how Part 2 will work in relation to routine interventions. That will, obviously, be explained in a lot more detail in the code

of practice, which will also provide more examples to guide those who work under the Bill and those to whom the Bill will apply.

That is not the end of the matter, because Part 2 goes on to recognise that, where something serious is being done, a formal assessment of capacity must be done, and that must include a statement of incapacity, detailing exactly what in the capacity test P cannot do. That is new. It is not required at the moment, and it is not in the Mental Capacity Act 2005 either. If we use the dental check -up as a routine example, a more serious situation in that domain might be that P has a nasty infection and needs a tooth removed but has a real fear of going to the dentist and clearly does not want to go. He needs to go, but it will cause him serious distress. That would be a serious intervention under Part 2, and the dentist would need to make sure that a formal assessment of capacity has been carried out in that case and that he has complied with all the principles in Part 1, which requires him to have taken all practicable steps to help and support the person to make the decision themselves. That is a new safeguard, and it is commensurate with the seriousness of the intervention in that situation.

Beyond that, in even more serious cases, such as depriving somebody of their liberty or giving them treatment that they are clearly resisting or that the nominated person is objecting to, even more is required through the authorisation safeguard. That, if you like, is another formal check on whether the person has capacity, and it must be done before the intervention can proceed. That authorisation cannot be granted unless all the criteria are met, including that the person lacks capacity. At any time, P and their nominated person can challenge the authorisation by applying to the review tribunal, which is a further opportunity to independently check that the person lacks capacity before the intervention proceeds.

To conclude, we need to be mindful that Part 2 covers a very wide range of interventions from the routine to the serious. We make provision for additional safeguards around the question of whether P lacks capacity, but they need to be proportionate and workable on the ground. After having given it considerable thought, we do not believe that Disability Action's suggestion would satisfy those two criteria, but we think that there are enough safeguards in the Bill to

ensure that interventions proceed only where lack of capacity has been properly established and that there is sufficient provision in the Bill to resolve disputes about the capacity question". (Appendix 2)

98. The Committee came to the view that it would not be practical to require second opinions on an assessment of a person's capacity before undertaking routine interventions, such as washing and dressing. It accepted the Department's position that second opinions were reserved for the more serious interventions, and that this was a proportionate approach.

99. The RQIA and the Commissioner for Older People NI queried the use of the word "may" in clause 18 (2). In their view, it implies that visiting P and requiring his or her medical records is not obligatory, and therefore a second opinion could be obtained without either of these things happening. The organisations argued that the necessity of visiting P and examining his or her records should be made explicit in the Bill. They suggested that "may" be replaced with "will" or "shall". The Committee sought the Department's view on this proposed amendment which was provided in a letter dated 3 November 2015:

"If the intention behind the suggestion made by RQIA and COPNI is that the appropriate medical practitioner should be required to make at least one visit and to have made at least one request for relevant records, it is the Department's view that this would be best achieved by amending subsection (3) to add to the requirements in it, rather than changing "may" to "must" in subsection (2). To do the latter would make subsection (2) unclear". (Appendix 4)

100. The Committee confirmed with the Department that it supported an amendment which will require a medical practitioner to make at least one visit to P and to have made at least one request for P's records before he or she can issue a certificate. The Department agreed to make the proposed amendment.

Clauses 19 - 23

101. A range of stakeholders were concerned that the Bill proposes that each of the five HSC Trusts will operate their own panels to authorise serious interventions, rather than there being one regional panel. The concerns were

around independence and that five different panels would lead to inconsistent decision-making between different trust areas. The Department's view was that any authorisation made by a trust panel is open to right of review at the tribunal. In time, the Department believes that the decisions of the tribunal will filter down into the decision-making processes of the trust panels and this will lead to greater consistency. The Committee was content with the Department's rationale on the matter.

102. The NI Rare Disease Partnership and the Royal College of Psychiatrists queried the definition of the "serious harm condition" set out in clause 21. It refers to "serious harm to P" but "serious physical harm to other persons". They argued that psychological harm to others should also be considered. The Department's response was that it is difficult to justify treating someone on a compulsory basis on the evidence of anything other than a risk of physical harm to others. The Committee accepted this explanation.

103. The Law Centre NI had concerns about clause 22. The prevention of serious harm condition in clause 21 applies in the event of an objection from P's nominated person to treatment with serious consequences (clause 19). However, the prevention of serious harm condition does not have to be met in the event of P resisting. The Law Centre NI argued that it is unfair to P for the prevention of serious harm condition to not be required to be met in these circumstances. In their view clause 22(2) should therefore match clause 19(2) which relates to treatment with serious consequences where there is an objection from the nominated person. The Committee sought the Department's view on this proposed amendment which was provided in a letter dated 3 November 2015:

"The prevention of serious harm condition is a very high bar that a decision maker must be satisfied is met, even in emergencies, before providing certain serious treatments to P where P's nominated person is objecting. In effect, it means that it must be reasonably believed that withholding the treatment would create an unacceptable risk of serious harm even if an alternative treatment were given instead. It is the Department's view that this condition is a necessary and proportionate safeguard where P's nominated person is objecting to the proposed treatment. However, if it were to apply where P alone resists as suggested by the

Law Centre, the result could be that the proposed treatment would have to be withheld even though for example P's resistance is totally unexpected or unrelated to the treatment itself, there is no objection from the nominated person and the treatment is otherwise considered to be in the person's best interests. Such an outcome would, in the Department's view, be difficult to justify. The Department would not therefore support the amendment put forward by the Law Centre.

We would point out, however, that in any case where P is resisting an intervention, the condition in clause 12 (acts of restraint) will always apply. This condition is a significant protection for P where for example the choice is between providing the treatment and delaying in the hope that P may at a later time be persuaded to take the treatment without use of force, in a case where delay will do no harm. It is also a protection against using a large degree of force in order to give a treatment where the harm to P of not having the treatment at all would only be minor. In addition, clause 7(8) will always apply. It requires the decision maker to have regard to less restrictive options and is a protection against any unnecessary use of force. The Code of Practice will provide further guidance on these protections". (Appendix 4)

104. The Committee did not believe that the Department's written response made it sufficiently clear why an objection from P's nominated person carries more weight than resistance by P. It therefore took further oral evidence from the Department on the matter on 16 November. Officials provided the following details:

"I should say that we spent a considerable amount of time discussing this with counsel before arriving at the position that was reflected in the Bill. I will not go into the ins and outs of that, but, in short, we concluded that applying the same condition – the prevention of serious harm condition – to all cases where P resists might produce some perverse results. An example is probably the best way to explain it. In a very probable case, where a person, P, lacks capacity in respect of a proposed serious treatment and is resisting that treatment, the key thing is that it might not be entirely clear at all why he is resisting it. It may even be the case that the reason why it is being resisted is complete-

ly unrelated to the treatment or the consequences of the treatment. However, the key point is that the treatment is in the person's best interests. In such a case, the best course of action will likely be to wait and see if the circumstances will be different later. Clearly, that will not always be practical depending on the circumstances and the treatment. However, the key point is that, if the prevention of serious harm condition were to apply in such a case, it would mean that the treatment could not be given to P unless D reasonably believed that withholding it would cause serious harm. Our sense was that that would be a very high bar to meet, where P is not really in a condition to judge the merits of the treatment. If he were, he would not be treated without his consent. The result would be that P would be deprived of treatment that is considered to be in his best interests. We concluded after much analysis that that would be very difficult to justify where all the other applicable safeguards that are required in the Bill have been met. That is why, as the Bill is currently drafted, the prevention of serious harm condition does not apply where P is resisting. Instead, it is limited to cases where P's nominated person reasonably objects.

As I mentioned at the start, it is ultimately about striking the right balance between conflicting rights, and that is an issue that we come across quite a lot in the Bill. It is our view, after some considerable discussion, that the existing provisions do that, although I accept that it is a difficult issue and there are different views on that". (Appendix 2)

105. However, the Committee was not convinced by the Department's rationale on this issue. It therefore agreed to bring forward its own amendment to require the "prevention of harm" condition to be met where P resists treatment, so that the same standard is required when P resists treatment as when P's nominated person objects to treatment.

Clauses 24 - 27

106. The Older Person's Commissioner was concerned that the prevention of serious harm condition set out in clause 25 is not clear, and argued that "serious

harm” needs to be defined in the Bill. The Royal College of Psychiatrists also stated that more clarity was needed on the interpretation of “serious harm”.

COPNI stated:

“If, under clause 24, liberty is to be deprived to prevent a risk of serious harm to an older person or to prevent serious physical harm to others, then “serious harm” needs to be defined in the legislation. The proposed legislation gives no indication to that defined level of harm”. (Appendix 2)

107. The Committee sought clarification from the Department on how “serious harm” would be defined or interpreted in the Bill, and whether the definition of “serious harm” as set out in the Criminal Justice Order 2008 would apply. The Department advised in a letter dated 3 November 2015:

“Clause 293 clarifies what “harm” means for the purposes of the Bill. “Serious harm” however, is not defined on the basis that whether a particular harm constitutes serious harm will depend on the individual circumstances of each case and the particular context in which the harm is occurring. Guidance and examples will be provided in the Code of Practice. Case law relating to the provisions in the Mental Health (NI) Order 1986 (upon which the prevention of serious harm condition is based) will also be relevant to how the term is interpreted. Both “serious” and “harm” are concepts that will be familiar to the courts.

While it is entirely legitimate for the courts to consider definitions of a particular term where it is used in other statutes, it is important to note that the definition in the Criminal Justice (NI) Order 2008 (2008 Order) has not been expressly applied for the purposes of the Bill nor, we are advised, would it automatically apply. Based on case law, the particular context of the Bill will be of supreme importance if the matter were to be considered by the courts. The Committee will also wish to note that the definition in the 2008 Order is limited to physical harm, whereas harm as defined in clause 293 means harm of any kind”. (Appendix 4)

108. The Committee came to a view that to define “serious harm” on the face of the Bill would be difficult, given the wide variety of scenarios that this Bill addresses.

109. The Royal College of Psychiatrists voiced a concern that given deprivations of liberty will cover a wide range of the population, the process of deprivation of liberty safeguarding may become overly bureaucratic or burdensome, as has been the case with the Mental Capacity Act 2005 in England and Wales. NIC-CY expressed similar concerns, stating that in England and Wales since 2014, 54% of applications have still not been dealt with. The Department's responded as follows:

"The first point to make is that the scheme in the Bill is not modelled on the current scheme in England and Wales. We had the benefit of having a blank sheet, and, for that reason, the scheme that we propose here should avoid many of the difficulties that the scheme in England and Wales encountered, principally because we are fusing together mental health and mental capacity legislation. That is not the case in England and Wales, and there are a lot of awkward interfaces between the two as a result, and that has led to a lot of very difficult cases, which were referred to earlier. We do not have that problem because we are addressing it in the one Bill.

Secondly, we are coming to it after one of the cases referred to earlier, that of Cheshire West. We have dealt with that in this Bill in a very streamlined way, by making the deprivation of liberty a serious intervention under Part 2. All cases are dealt with under that, and they attract the highest level of safeguards, because deprivation of liberty is, obviously, one of the most serious things that you can do in somebody's life. So, we believe that we have had an opportunity to tackle many of the issues. The scheme is not modelled on that in England and Wales". (Appendix 2)

110. The Committee was content with the reassurance from the Department that the scheme under the Bill would not follow the model used in the Mental Capacity Act 2005.

Clauses 35 & 36

111. Stakeholders welcomed the independent advocate safeguard clauses, which require than an independent advocate is in place in the case when an act is

being proposed which is - a deprivation of liberty, a requirement to attend a certain place to receive treatment with serious consequences, the imposition of a community residence requirements, or the provision of compulsory treatment.

112. However, there was concern that access to the independent advocate was restricted to these specific circumstances, with some organisations suggesting that a person should have access to an independent advocate at the time when their capacity is being assessed. This view was put forward by NIAMH, Mindwise and Disability Action. For example, Mindwise stated:

“That role should be expanded to include support and communication with P and then, as an additional safeguard, assisting D in deciding if P lacked capacity”. (Appendix 2)

113. Disability Action made a similar point:

“Disability Action welcomes the fact that the right to independent advocacy has been included in the Bill and that further regulations will be developed. However, there is a strong belief that the provision of independent advocacy should not only relate to serious compulsory interventions but be available at all stages in the process, including prior to the capacity assessment”. (Appendix 2)

114. The Department’s response was that it could not require an independent advocate to be appointed and instructed for every single act under the Bill - for example, the decision to give a person the flu vaccine. Rather, the safeguard of the independent advocate is reserved for serious interventions, so that the Bill is workable and affordable. Departmental officials stated:

“We need to remember that the principles in Part 1 set out steps that must be taken to support an individual before intervening under Part 2. Clause 5 is crucial here: it states that you need to involve people who are likely to help and support a person. At that stage, it is envisaged that the code of practice, for example, would explain that this might involve an advocate, and that would be before a capacity assessment, because the aim is to support the individual as much as possible beforehand so that they make their own decisions. Part 2 covers all acts in connection with a person's care, treatment or personal wel-

fare. We simply could not require an independent advocate to be appointed and instructed under every single act under the Bill. The safeguards need to be proportionate. Overall, the framework needs to be workable and affordable. We have reserved additional safeguards for those serious interventions, and that independent advocate is an additional safeguard. However, that is not to say that an advocate could not be involved for routine interventions, because they should act to help and support the person in the first instance". (Appendix 2)

115. The Committee was content with the Department's approach to this matter.

Clauses 45 - 48

116. These clauses deal with a person's right to apply to the Review Tribunal to have an authorisation reviewed (authorisations are required for certain serious interventions and detention in hospital for examination).

117. The Law Society NI expressed concerns in relation to how the Review Tribunal will operate - for example, whether it will be chaired by a legally qualified person and whether there will be an appeals process. The Department clarified that while the Bill makes some amendments and repeals to the Mental Health (NI) 1986 Order, much of it remains the same. Officials explained:

"I think that there has been a bit of misunderstanding about what the Bill is doing to the review tribunal. The Mental Health Review Tribunal, as it is at the moment, is constituted under Part 5 of and schedule 3 to the 1986 Order. The Bill does not do away with Part 5 in its entirety, in relation to the constitution and set up of the tribunal. Instead, it makes some amendments, and it also makes some repeals. If you look at schedule 8 to the Bill, which deals with amendments, and also at schedule 11, which is repeals, you will see that quite a lot of the provisions in the 1986 Order that relate to the constitution of the tribunal – for example, who sits on the tribunal – remain. Schedule 3 to the 1986 Order will remain, and you will see that it is completely unchanged from the current position. Tribunals will be chaired by a legal person, have a medical person and then another person with relevant expertise, as the Department sees fit. That aspect is not changing in any way. Likewise, provisions

such as article 83 of the 1986 Order set out the ability for the tribunal to make rules. I think that the Law Society was a bit worried that we would be turning it from a judicial into an admin function. That is just not the case; that is not what we intend. It will be the same judicial function as it has always been.

I think that the Law Society also mentioned that there is no right of appeal. If you look at article 83(7) of the 1986 Order, you see that there is a route to the Court of Appeal on a point of law, and we obviously also have the route of judicial review. We are fairly confident that those give any applicant the ability to have their case dealt with, with the appropriate judicial oversight". (Appendix 2)

118. The Committee was satisfied with the clarification provided by the Department.

119. There were concerns in relation to the time periods in which HSC Trusts must refer cases to the Tribunal, as set out in clause 48. The Bill specifies that a person's case must be reviewed every two years in the case of someone over 18, and every one year for an under 18. In relation to adults, Disability Action argued that this automatic review period should be reduced from 2 years to 1 year. Similarly, the Northern HSC Trust advocated that for 16 and 17 years olds, automatic reviews should occur every 3 months, rather than after a year. Disability Action stated:

"It is unthinkable that it would be suitable to leave such an individual for 24 months – someone who does not have an advocate, family member or anybody else to remind them of their legal right to redress at tribunal. That is far too long to wait for an automatic review". (Appendix 2)

120. The Department's response was that two years and one year are the periods already available under the Mental Health (NI) Order 1986 for automatic review. It also clarified that there are various points in the process which a person can make an application to the Tribunal before the two year period - for example within the first 6 months of the authorisation, and within an extension period of the authorisation. There is also a duty on the HSC Trusts in clause 48 to notify the Attorney General if somebody lacks capacity to make an appli-

cation and their nominated person is not doing it on their behalf. Officials explained:

“There are two routes to the tribunal, and that is contained in clauses 45 to 49. The person or their nominated person can apply to the tribunal, and there are various points at which they can make that application. If an authorisation is granted under paragraph 15 of schedule 1, which is authorisation for detention for treatment, a community residence requirement or something of that nature, a person can apply within six months, beginning from the date on which the authorisation is granted. There is also an interim authorisation under paragraph 20 of schedule 1, which is for a short-term assessment period of 28 days; you get to apply to the tribunal during that period as well. If an authorisation is granted under schedule 2, which is the emergency process, you also get an opportunity to apply within that 28-day period. If the authorisation is extended under chapter 6 of Part 2, you get an opportunity again to go to the tribunal. That will be during that extension period, so if your authorisation for six months is extended for six months, you will get another chance within that period to get to the tribunal; both you and your nominated person”. (Appendix 2)

121. The Committee was content that there were sufficient access points in relation to the Tribunal.
122. The Royal College of Nursing suggested that under clause 42 the “responsible person” role could in some cases be a qualified nurse. The Department advised that the regulations have the flexibility to add to the list of people set out in clause 42 (a) and (b). The Committee was content with this approach.
123. The South Eastern HSC Trust and the British Psychological Society had queried the use of the term “medical practitioner” in clause 47, and suggested it be replaced with the term “medical or clinical practitioner”. The Department’s response was that given that tribunal cases involve significant restrictions on a person’s rights, objective medical evidence is required for ECHR compliance. The Committee accepted this explanation.

Clause 62

124. The South Eastern HSC Trust and the NI Rare Disease Partnership expressed concern that an emergency situation only referenced the risk of harm to P, and not the risk of harm to others.

125. The Department's response was that it could not foresee a situation in which not complying with the safeguards would cause a risk of harm to others but not a risk of harm to P, and therefore a reference to "harm to others" is not necessary. The Committee was not entirely convinced by the Department's argument that there would never be situations in which there would be a risk of harm to others but not a risk of harm to P, for example when P is much physically stronger than the person giving them care or treatment. The Committee therefore asked whether the Department would be prepared to consider an amendment to this clause. The Department responded in a letter dated 3 November 2015:

"Clause 62 explains when a situation is an emergency for the purposes of Part 2 of the Bill. It is needed because Part 2 requires additional safeguards to be met where a serious intervention is being proposed. The purpose of most of the additional safeguards is to check that what is being proposed is in the best interests of P. In practical terms, it means that the decision maker must weigh up the risks involved in delaying the intervention to put in place the relevant additional safeguard or to check if it is in place against the risk of harm involved in proceeding without the safeguard in place. This exercise has to be done for each applicable additional safeguard as there may be time to put one or more of the safeguards in place but not others. If the risk of harm involved in delaying the intervention is greater, the situation is an emergency and D can proceed without putting the relevant safeguard in place or checking if it is in place.

It is the Department's view that, given the purpose of the additional safeguards in Part 2 (i.e. to ensure what is being proposed is in the best interests of P), it has to be right that the assessment of risk required by clause 62 (to determine whether the safeguards should be complied with or not) should be focused on any harm that may come to P. The Bill is after all a framework that aims to allow decisions to be made in the best interests of P: decisions that could otherwise be made by P (not by someone else) if P had

capacity. In other words, it is the Department's view that there are limitations on the extent to which the interests of others can justifiably have a bearing on what should be done under this framework.

Notwithstanding the above, the Department would wish to make two related points that are relevant to the Committee's concern about this clause. First, for the purposes of the Bill and clause 62, harm has, after much careful thought, been defined in clause 293 to include any harm to P resulting from that person harming others. This mirrors a similar provision in clause 7 (see subsection (9)). Both of these provisions were modifications made to the Bill to address concerns similar to those raised here by the Committee: modifications that the Department considered could be justified without skewing the underpinning aims of the Bill as explained above. In light of those modifications and looking specifically at the purpose of clause 62, it would be the Department's view that it is difficult to imagine a situation in which not complying with the safeguards (and proceeding with the intervention as an emergency) would create a risk of harm to others but not a risk of harm to P. Indeed to include a reference to harm to others in that clause might imply otherwise. In light of the above, the Department would not support an amendment to this clause to reference harm to others." (Appendix 4)

126. The Committee was content with the Department's explanation.

PART 3

127. The introduction of a system of nominated persons within the Bill was welcomed by stakeholders.

128. However, there were concerns regarding the detail of the proposed system. The Older Person's Commissioner NI queried why if two or more people are contained within the same paragraph of the default list set out in clause 71, why the older or oldest of these people is deemed to be the nominated person. COPNI suggested that given that clauses 78 and 80 give the Tribunal powers to challenge the appointment of an individual as the nominated person, then it could also undertake the role of appointing a suitable person,

when there are two or more people who wish to act as the nominated person. COPNI argued:

“The fact that a person is chosen for that important role, ultimately, on the basis of their age will not ensure that the most appropriate person undertakes the role . . . The commissioner wishes to see a more suitable and reasonable format to decide the nominated person in such circumstances, with a review of a person's particular needs along with the proposed nominated person's experience, availability and care understanding”. (Appendix 2)

129. The Department's response was that there needs to be a clear mechanism in place for the appointment of a nominated person. If someone proved unsuitable, there is a mechanism in the Bill to displace them. The Committee's view was that while the system being proposed by the Department was perhaps “imperfect”, it was a workable approach. Furthermore, the Committee was mindful that when a person has capacity they have the option of appointing whoever they wish as their nominated person. Therefore, the scenario of an older sibling being appointed as the nominated person only will come into play if the person has not already made a nomination.

130. Other stakeholders, including Mencap and the Association for Real Change, queried why only one person could be appointed to the role of nominated person, particularly in the case of separated or divorced parents with shared caring arrangements for an adult child with a learning disability. The Association for Real Change stated:

“One of the simplest but most significant amendments to the proposed nominated persons' list in the draft legislation would be that it explicitly recognises that a person without capacity may be cared for equally by two parental carers who, although their own relationship has ended, continue to share responsibility, including each providing a home for their learning disabled child. There should be no presumption in the legislation that there is only one principal carer and that this one person, by default, then becomes the nominated person”. (Appendix 2)

131. The Department's response was that the approach taken in the Bill was proportionate and workable. In the case of separated parents, it is not that one

parent would not be consulted by the decision maker, because there is a duty under clause 7 to consult people with an interest in P's welfare. The Committee was satisfied that the Department was attempting to take a pragmatic approach to the issue.

132. Caroline Bielanska had suggested that if someone had been found guilty of ill treatment or neglect under clause 256 of the Bill, they should be prevented from being appointed as a nominated person. The Department's view was that people appoint a nominated person when they have capacity, and that respecting personal autonomy is key in the Bill. If down the line that person is not acting in P's best interests, they can be displaced. The Committee was content with the Department's rationale on the matter.

PART 4

133. A range of stakeholders, including the Children's Law Centre, the Association for Real Change, Mencap, COPNI, the Ulster University Law Clinic, NICCY, and the Northern HSC Trust, expressed concern that independent advocates will be commissioned by the Trusts themselves. They argued that this arrangement will call into question whether the advocates are actually independent - given that the person proposing a serious intervention for P will very often also be an employee of the Trust, such as a doctor or social worker. The Law Centre NI suggested that the HSC Board could commission the advocates, rather than the Trusts.

The Law Centre NI stated:

"The commissioner of the service should not be the prime body that is going to be challenged by that service". (Appendix 2)

Similarly, COPNI advised:

"The commissioner takes the view there should be not only perceived independence but clearly demonstrable independence. The point raised by the Law Centre that the commissioning body should not be the body that is subject to challenge is a fair one. The perception of independence is important". (Appendix 2)

A representative from Disability Action made this point based on experience:

“As an independent advocate, I can tell you that it is my full-time job to challenge the trust. My independence comes from the fact that I am not employed by the trust”. (Appendix 2)

134. The Department’s position was that advocates commissioned by the Trusts can be independent, and that they had issued guidance to the Trusts in 2012 on commissioning and delivery standards which focused on independence, in preparation for building capacity in the advocacy sector in advance of the Bill. However, the Committee took the view that the stakeholders had a valid point in relation to independence and the perception of independence. It was not clear why the Trusts, rather than for example, the Health and Social Care Board, had to commission the advocates. The Committee wrote to the Department to ask whether there was any practical reason why the Board could not do the commissioning. The Department’s response dated 3 November 2015 stated:

“The Department does not accept the proposition that the current provisions in the Bill would not allow for the appointment of advocates who could fulfil their role and functions under the Bill in an independent manner. As the Committee may already be aware, the majority of advocacy services are currently being commissioned by the HSC Trusts and delivered by a range of voluntary/community sector organisations. This arrangement allows the HSC Trusts to create services that best meet the specific needs of the local population. The key point, however, is that all of these services are being commissioned and delivered in accordance with Departmental guidance. That guidance was issued by the Department in 2012 to build capacity within the community/voluntary sector and prepare the way for the new statutory right to independent advocacy in the Bill. It sets out a number of principles and standards for both the commissioning and delivery of advocacy services. Independence is one of those standards and is clearly explained in the guidance”. (Appendix 4)

135. The Committee noted the Department’s position that it did not accept that advocates appointed by the Trusts could not operate in an independent manner. In light of the announcement by the Minister for Health, Social Services and

Public Safety in November 2015 of his intention to abolish the Health and Social Care Board, the Committee came to the view that the commissioning of advocates by the Trusts was therefore the most practical arrangement available.

136. The Law Centre proposed that the term “independent advocate” should be changed in the Bill to “independent mental capacity advocate”, so that there is no confusion between general advocacy services and an advocate appointed under this specific legislation. The Law Centre NI argued:

“As members will be aware, there is already extensive independent advocacy work taking place in Northern Ireland. Children in care, people with learning disabilities, people with significant mental health problems, and people with sensory or physical disabilities already receive independent advocacy services. We are concerned that the use of the phrase “independent advocate” in the Bill could lead to misinterpretation of, or confusion about, this very specific statutory role. In England, Wales and Scotland the equivalent term in both the mental health and mental capacity legislation is “independent mental capacity advocate”. The Law Centre feels that this is a better term and proposes an amendment that throughout the Bill “independent advocate” be replaced with “independent mental capacity advocate”, to make it clear that this is a very specific kind of advocacy function that is being carried out. That amendment would have no legal effect on the role, powers, duties and so on of the role.”
(Appendix 2)

137. The Department was initially opposed to the change of terminology because the term “independent mental capacity advocate” is used in the English Mental Capacity Act 2005, and they contended that it would cause confusion if used in Northern Ireland.

138. However, in the Committee’s view, the written evidence it received on the Bill suggested that there was a misunderstanding of the role of the independent advocate in relation to this legislation. Some stakeholders were under the impression that independent advocates provided for by the Bill have a role in giving general support to people who lack capacity, or a role in the best interests decision-making process when the decision does not relate to a deprivation of liberty, compulsory treatment or a community residence requirement. For ex-

ample, a number of organisations suggested that a person themselves should be able to request an independent advocate during the process of having their capacity assessed in the first instance.

139. Furthermore, the Committee was not convinced by the Department's argument that people in Northern Ireland would be confused by the term "independent mental capacity advocate" because it is also used in the English legislation in a slightly different way. Health and social care staff in Northern Ireland will operate according to this Bill and not in accordance with the English legislation.
140. The Committee therefore asked the Department to consider bringing forward amendments to use the term "independent mental capacity advocate" or another term which clearly differentiates between the advocates provided for under this Bill and general advocacy services. The Department's agreed to make amendments to rename "independent advocates" as "independent mental capacity advocates" throughout the Bill.
141. The Law Centre suggested removing the words "as far as reasonable practicable" from clause 84 (3) to ensure that the advocate is always independent of the decision maker. The Law Centre NI stated:
- We are also concerned that clause 84(3) states that a trust must:*
- "have regard to the principle that a person to whom a proposed act would relate should, so far as practicable, be represented by someone who is independent of any person who will be responsible for the act if it is done."*
- This seems to us to be a very weak form of independence. Everywhere else – in medicine, in law and when making public appointments – the independence is not independence as far as practicable: it is independence full stop. Of course, that independence is interpreted in a way that is proportionate. You do not have to be from Outer Mongolia or have no connection with Northern Ireland to be sufficiently independent to make decisions for people in Northern Ireland. Proportionality is already built into independence. To put in the practicability limit is basically to say that it is acceptable for someone to be an independent advocate who is not independent. They should really be called an "independent as far as practicable advocate". We therefore feel that the*

phrase, "as far as practicable" should be deleted. People's fundamental rights and freedoms are being affected; the independence should be full and complete, as human rights law requires". (Appendix 2)

142. The Committee supported the arguments put forward by the Law Centre and asked the Department to consider making the amendment. The Department agreed to make the amendment.
143. The Law Centre also suggested an amendment to clause 85, to allow the regulations to specify that the advocate may obtain a further medical opinion where treatment is being proposed, as is the case with the Mental Capacity Act 2005. The Department's response was that the Mental Capacity Act 2005 does not have sections on second opinions as contained in the Bill. The Committee was content with the Department's rationale on this matter.
144. A variety of stakeholders expressed concern that the role and functions of independent advocates are not clearly set out on the face of the Bill. The Committee noted that clause 85 simply makes reference to regulations about the functions of the independent advocates. Therefore, the Committee asked the Department whether it had considered including some description of the role of the independent advocates on the face of the Bill. The Department's response in a letter dated 3 November 2015 stated:
- "The role of independent advocates under the Bill relates directly to the core purpose of the framework in Part 2 of the Bill: to ensure that the particular decision that needs to be made under that framework in respect of the person who lacks capacity to make it him/herself is in that person's best interests. While the independent advocate is not responsible for making the best interests decision, it is made clear in clause 35 (and clause 53) that an independent advocate must be in place to represent and support the person and be consulted and have his/her views taken into account when the determination of best interests is being made where what is being proposed is, broadly speaking, a compulsory serious intervention. This is repeated in various clauses in Part 4. Regulations will set out what the independent advocates must do to fulfil this role. The Code of Practice will provide further guidance. It is the Department's view that nothing further is required on the face of the Bill". (Appendix 4)*

145. The Committee was content with the Department's explanation.

146. In relation to clause 90, the Committee noted that the way it is drafted implies that it is at the discretion of the person who holds the record to consider whether or not it is relevant to the independent advocate's investigation, and thus whether or not it can be released. The Committee asked the Department for an explanation as to why the independent advocate is not permitted to make this decision in relation to the relevance of the record. The Department's response in a letter dated 3 November 2015 stated:

"As the Committee will be aware, health records or any other record may include a wide range of information, including information about matters that may not be relevant to a particular decision being made under Part 2 and in relation to which an independent advocate may be instructed. The purpose of the limitation in subsection (4) is to ensure that only relevant information is disclosed to the independent advocate. It is the Department's understanding that this is consistent with the Data Protection Act 1998 which requires the data controller (the person who holds the record) to only disclose information where relevant and where required by law to do so." (Appendix 4)

147. The Committee was content with the Department's explanation.

PART 5

Clause 95

148. NICCY and other stakeholders were concerned that the Bill only allows people aged 18 or over to make a Lasting Power of Attorney (LPA), and not 16 and 17 year olds. The Committee asked the Department for clarification on whether consideration was being given to allowing 16 and 17 year olds to make LPAs, given that in general the Bill applies to persons aged 16 and over. The Department advised that this issue was being given further consideration by the Department of Finance and Personnel, however no definitive position was ever provided to the Committee (Appendix 4). The Committee recommends that the Department keeps this issue under review, and reconsider the position as necessary in the future.

Clause 98

149. Caroline Bielanska pointed out that the LPA system as set out in the Bill did not appear to authorise the attorney to maintain others whom the donor would reasonably be expected to wish to provide for - e.g. a spouse, partner or minor children. In contrast, the current EPA regime contains this power. The Committee asked the Department for its view on the matter. In a response dated 3 November 2015, the Department advised that the matter was already provided for in clause 95 (5) (b) (Appendix 4). The Committee was content with the Department's clarification on the matter.

Clause 99

150. The Commissioner for Older People NI suggested that people who have been convicted of a criminal offence of dishonesty should be barred from acting as attorneys. COPNI stated:

"In the proposed legislation, an LPA, in so far as it relates to property and affairs, is revoked in circumstances where an attorney is declared bankrupt. Consideration should also be given for the potential to revoke the LPA where an attorney has been convicted of a criminal offence of dishonesty or sentenced to a prison term of a prescribed period. Given the growth in the prevalence of reported financial abuse and the extended powers introduced by the proposed LPA, it is imperative that older people are adequately protected from persons who may not have their best interests at heart". (Appendix 2)

151. The Committee sought the Departments' view on this suggestion. The Department advised in a letter dated 3 November 2015:

"It is the Department's view that if a person has capacity to make their own decision (including a decision about who should be their attorney) then that decision should be respected. That is the key message of this Bill. Therefore, to amend the Bill as suggested would not align with the Autonomy principle." (Appendix 4)

152. While the Committee recognised COPNI's concerns, it was mindful of the fact that a person should have the right to nominate someone of their choosing to the role of LPA, whether or not that person had past convictions of, for example, fraud or dishonesty. The Committee therefore agreed that it was content with the Department's position that people should have the right to appoint LPAs of their own choosing.

Clause 110

153. This clause will not permit any further EPAs to be made after the Bill comes into effect. The Law Society NI was strongly opposed to this clause for a number of reasons. Experience from England has shown that LPA forms are long and complex, and when legal services are employed it typically costs the client around £500 plus VAT, in addition to the £110 registration fee payable immediately. In their view, this high cost puts people off making LPAs. In contrast, in Northern Ireland, the modest cost of making an EPA (£100), in addition to £115 payable at the later date of registration, is not a barrier to people making an EPA.

154. The Law Society argued that the current EPA system could run alongside the new LPA system created by the Bill. Their concern was that if the only option available to people is an LPA, there will be a low uptake, as opposed to if the EPA option was also available.

155. The Law Society of Northern Ireland stated:

"It is the society's view that EPAs have brought benefits to Northern Ireland and that the current system of EPAs should be retained. Retention of enduring powers of attorney, alongside the new lasting power of attorney, will give the client the maximum flexibility and accessibility to meet their legal needs". (Appendix 2)

156. However, the Department was opposed to allowing future EPAs to be made as it argued that EPAs run contrary to a key principle of the Bill, which is that capacity is issue and time specific. Officials stated:

"It is also important to realise that, in our view, it would not be a viable option to retain the EPA system alongside LPAs. The EPA regime is not in keeping

with the shift in culture that the Bill is trying to bring about. The Bill empowers people to make their own decisions wherever possible. It respects personal autonomy: that is key. This is why capacity is issue- and time-specific under the Bill. Under the EPA regime, there is a presumption that, at some point in the future, a person will lose the capacity to make all future decisions in relation to their property and affairs, at which point the EPA must be registered. However, that runs contrary to the Bill, because you cannot have a blank label of "incapacity" in the Bill.

It is also a key opportunity to create a new, unified system for decision-making in respect of people who lack capacity, by having decision-making within the one statute. We believe that, in practical terms, managing and costing two systems would be unworkable. You would have two statutes and two sets of costs". (Appendix 2)

157. The Committee took the view that abolishing EPAs created too much of a risk that people would simply "do nothing" when faced with the complex and expensive process of making an LPA. It believed that the two systems could run alongside one another, given that it was always the Department's intention that EPAs made before the legislation comes into force would remain valid. The Committee also suggested that the situation could be reviewed within 3 years, if there were unforeseen practical difficulties in terms of running two systems. The Committee asked the Department to make an amendment to the Bill to this effect. The Department responded to the Committee in a letter dated 3 November 2015 as follows:

"The Department remains of the view that the retention of the EPA system alongside the new LPA system is not a viable option. It is at odds entirely with the shift in culture that this Bill is trying to bring about. Under the EPA scheme, the presumption that there is some point at which a person loses capacity to make all future decisions in relation to their property and affairs runs contrary to the Bill's principles. The Bill does not allow blanket labels of incapacity; capacity is issue and time specific. An attorney acting under a lasting power of attorney will therefore not have a blanket power to act. He/she will only have authority to make those specific decisions that the donor is unable to make despite being given all practicable help and support.

In practical terms retaining the EPA scheme alongside the LPA scheme would mean that practitioners would be working from two very different frameworks which will undoubtedly be more bureaucratic and lead to additional costs and indeed confusion for people on the ground. This Bill presents Northern Ireland with an opportunity to create a new unified scheme for decision-making in respect of people lacking capacity. The Department is of the view that replacing the EPA scheme with the wider, more empowering LPA scheme, will deliver better outcomes for those individuals who wish to plan for their future. This was a key recommendation of the Bamford Review and supported by the majority of stakeholders during the Department's extensive consultation process". (Appendix 4)

158. The Committee did not accept the Department's rationale on this issue and agreed to oppose clause 110 and the related Schedule 5.

159. In terms of the complexity of making an LPA, many stakeholders feared that this would put people off, or that it would be all but impossible for someone to complete an LPA themselves without employing costly legal services. COPNI argued that the process should be simplified as much as possible:

"The current EPA form is maybe three or four pages long. If something could be worked out on a similar basis here where it is manageable and where there is an accompanying well-defined and clear guide to the form, that will make life a lot easier for older people and will reduce fees significantly". (Appendix 2)

160. The Department accepted these concerns and the DoJ advised the Committee:

"We met the Law Society on a number of occasions, and we are more than happy to try to make these forms as user-friendly as possible. It is not our intention to create something that is very complex and will put people off applying for LPAs on the basis that the form is too long or too hard to fill in. As you rightly said earlier, there is a blank sheet in front of us. We are not obliged to follow England and Wales, and we really have a good opportunity to create something that will encourage people to take up this important safeguard for their future." (Appendix 2)

161. The Committee was keen to ensure that the forms were kept as short and straightforward as possible, and sought a written Ministerial assurance on this matter. This was subsequently received from the Minister of Justice in a letter dated 23 September 2015 (Appendix 4).

Schedule 4

162. Stakeholders such as the Law Society NI and Caroline Bielanksa voiced concerns in relation to how an LPA would be certified by the “certificate provider”. The Bill does not explicitly require that the certificate provider to witness the donor executing the power of attorney. This could result in the certificate provider signing the document weeks or months after the donor has signed it, and therefore not knowing whether the donor had capacity at the time they signed it. The Law Society NI stated:

“It is noted that the Bill intends to provide an additional safeguard, with the certificate provider being able to explain the form to the person signing it. The society’s view is that this must go further and include a requirement that the certificate provider see the donor to ensure that they fully understand what they are signing and that the LPA is signed by the donor in the presence of that certificate provider.” (Appendix 2)

163. Similarly, COPNI stated:

“There should be a requirement to provide reasonable evidence that an older person has capacity at the time an attorney is appointed. The commissioner is mindful of the need to safeguard and protect the rights and interests of older people during this administrative process.” (Appendix 2)

164. The Committee asked the Department whether it would consider amending the Bill to require the certificate provider to witness the donor executing the power of attorney. The Department’s response of 3 November 2015 advised:

“Schedule 4 does not set out any requirements around the need for a witness generally. It would not be appropriate to include such detail (which is likely to require the signature, address, contact details etc. of the witness) on the face of the Bill. Instead, the Department intends to use the regulation making power under paragraph 1(1)(c) of schedule 4 to achieve this aim.

In light of this approach, paragraph 2(4) cannot, therefore, explicitly require the certificate provider to be the witness (because the requirements around the witness are not yet drafted). However, this is something that we could provide for in the aforementioned regulations and it would be our intention to consult with key stakeholders on this matter in advance of drafting". (Appendix 4)

165. The Committee agreed that it was content that this level of detail should be left to regulations.

166. The Law Society NI and Caroline Bielanksa also flagged up issues in relation to the notification procedure, which requires the donor to name any or no persons they wish to be notified that they are applying to have the instrument registered. In their view this type of process will not act as a safeguard, as any objections will only be speculative, as it will not be known how the attorney will act. In addition, under the Bill the donor can choose for no-one to be notified.

167. The Law Society of Northern Ireland explained:

"Turning now to the proposed form of the LPAs, it is the society's view that the notification provisions in the LPA are essentially worthless. They are intended to be a safeguard, as they are with an EPA, but any objection is by definition speculative, as you cannot know how the attorney will act, and it should be for the court to decide on the available evidence. There are approximately 350,000 LPAs registered every year in England and Wales but only approximately 100 objections. The provisions are therefore disproportionate". (Appendix 2)

168. The Law Society suggested that the Bill be amended so as to require notification to a set list of people after an LPA has been registered - to a spouse or civil partner, cohabitants, children and statutory next of kin. The Committee asked the Department whether it would consider amending the notification process. The Department's response of 3 November 2015 stated:

"The Bill enables the donor to choose a person or persons to be notified before their lasting power of attorney is registered. It is the Department's view that if a person has capacity to make their own decision then that decision should be respected. That is the key message of this Bill. To remove that

freedom of choice from the donor and automatically impose a list of people to be notified would not align with the Autonomy principle. The Department would not, therefore, support the proposed amendment. The Department is also of the view that notification should take place before registration to ensure the Office of Public Guardian has oversight at the earliest opportunity. The Committee may wish to consider this matter in light of concerns raised in relation to clause 99". (Appendix 4)

169. The Committee was content with the Department's rationale on the matter.

PART 6

Clause 116

170. The Committee queried why there is no reference to a decision being made by someone acting under an EPA in relation to clause 116 (5). Such a reference would be required to ensure that a deputy could not make a decision that was inconsistent with a decision made by an attorney acting under an EPA. The Department agreed to make the proposed amendment.

Clause 119

171. Stakeholders queried the fact that the Bill does not give courts the power to obtain financial information from banks or other financial institutions. The Committee wrote to the Department for clarification on the matter. The Department's response dated 10 November 2015 advised:

"The purpose of clause 119 is to allow the court to call for reports to be made that may assist the court during the proceedings under Part 6 of the Bill. DoJ does not consider that the court requires a power under this clause to obtain financial records. Clause 122(2)(k) makes provision for Court Rules to make provision for the conduct of proceedings, including authorising or requiring the production of documents and the provision of information from parties to the proceedings. It is considered that this provision adequately facilitates the production of financial information for the court". (Appendix 4)

172. The Committee was content with the Department's explanation.

PART 7

Clause 124

173. Some stakeholders expressed a concern that the Bill does not appear to give the Public Guardian any powers in relation to EPAs - for example to deal with complaints about EPAs. The Department response to this concern in a letter dated 10 November was:

“The Departments draw the Committee’s attention to paragraph 16 of Schedule 5 to the Bill. Paragraph 16(4) gives the High Court power to direct the Public Guardian to cancel the registration of the enduring power of attorney in a number of circumstances, including if the Court is satisfied that the attorney is unsuitable or that fraud or undue pressure was used to induce the donor to create the enduring power of attorney”. (Appendix 4)

174. The Committee was content with the Department’s clarification on this matter.

Clause 125

175. Stakeholders also pointed out that the Bill does not give the Public Guardian the power to obtain financial information from banks or other financial institutions. The Committee wrote to the Department for clarification on the matter. The Department’s response dated 10 November 2015 advised:

“This clause does not currently give the Public Guardian power to obtain financial information from banks or other financial institutions. DoJ considers that financial information should be provided to the Public Guardian by an attorney or a deputy. A deputy appointed by the court or an attorney who has functions in relation to financial matters will have access to financial records by virtue of their position. If the deputy or the attorney refuses to share these records with the Public Guardian, then there has to be a real concern over the activities of that individual. Such concern could be justification for an application to be made to the Court under Part 6 of the Bill, as clause 112(8) gives the court power to revoke the appointment of a deputy or to vary the powers bestowed upon him or her. The Court also has power to revoke a

lasting power of attorney or terminate the appointment of an attorney if that attorney has behaved in a way which is not in the donor's best interests (see clause 108).” (Appendix 4)

176. The Committee was content with the Department's clarification on this matter.

177. The Committee was keen to ensure that there were no gaps in clause 125 (5), in terms of the Public Guardian being able to access records from a range of facilities. In correspondence dated 24 November 2015, the Department proposed an amendment to clause 125 (5) to address these concerns (Appendix 4). The Committee was content with the Department's proposed amendment.

PART 8

Clauses 132 & 133

178. The Information Commissioner's Office suggested that it would make more sense for the researcher to have to identify and secure the participation of a person willing to act as P's representative before a project is approved. They also suggested that if there is no one whom the researcher can identify to take on this role, such a person should be appointed by the "appropriate body", rather than by the researcher, and that this should be done prior to the approval of this project.

179. The Committee asked the Department if it would consider specifically requiring that the researcher has already identified a person who is prepared to be consulted about whether P should take part in the project as a pre-condition to the project being approved. Alternatively, if the researcher is unable to identify such a person, then the appropriate body should be required to appoint such a person, before it can give approval to the project. The Department's response to this suggestion was outlined in a letter dated 10 November 2015:

“DHSSPS would wish to advise the Committee that the approval safeguard provided for in clause 132 must be met in advance of any research project being commenced. In other words, Part 8 is drafted on the basis that project participants will not be contacted or approached until the research proposal has been approved. It would not therefore be practicable to include in Part 8 the pre-condition for approval suggested by the Information Commis-

sioner's Office. Instead, subsection (7) requires that reasonable arrangements must be in place to ensure the additional requirements in clauses 133 and 135 will be met. To be clear, this means that the researcher in applying for approval will have to describe a clear plan for identifying or appointing consultees in accordance with clause 133 and providing information to and seeking advice from them, otherwise the appropriate body cannot approve the project.

Furthermore, any appointment of a consultee will have to adhere with guidance to be issued by the Department. Examples of such consultees might include other clinical staff, social workers or lay persons not connected with the project. The guidance is also likely to set out the principles to which researchers must adhere when appointing such consultees and provide advice on ways of meeting this requirement in different research settings". (Appendix 4)

180. In light of this further clarification, the Committee was content with the Department's position on this issue.

PART 9

Clause 140

181. The HSC Board stated that it would be helpful if this clause did not restrict the detained person to having to be examined by a "medical practitioner and interviewed by an approved social worker" because this implies that the person is being assessed to see whether they are mentally ill and need to be detained in hospital. The HSCB stated:

"In respect of clause 140, on police powers to detain the person at a hospital, the board took the view that, given the enhanced remit of the Bill to cover the broad range of health and social care interventions, it would be helpful if this clause did not restrict the authority of officers to detain to the narrow focus of being seen by a medical practitioner or an approved social worker. This implies that the person is being assessed for a detained admission for treatment of a mental disorder, when in fact they may require a different type of medical intervention. This stipulation could risk a delay in providing the most appropriate medical intervention. Also, it could delay officers unnecessarily when they

could appropriately hand over responsibility for the supervision of the patient to the health professionals. For example, if the person was experiencing delirium as the result of an infection, the most appropriate response would be treatment for the infection, not an assessment for a mental health disorder".
(Appendix 2)

182. The Department's initial response was that it had put in the requirement for the person to be examined by a "medical practitioner and interviewed by an approved social worker" with the idea that it would give confidence to the police officer that suitably qualified people had examined the person. However, officials acknowledged the point raised by the HSC Board. The Committee then wrote to the Department to ask whether it would be prepared to make an amendment to widen out the type of healthcare professional who could examine the person. The Department's response in a letter dated 10 November stated:

"Having liaised with colleagues in DHSSPS, DoJ would not intend to make such an amendment to extend the categories of professional who could examine and interview the individual in these circumstances. The current draft of clause 140 ties into Schedule 2 of the Bill, which requires a report to be made by a medical practitioner if a person is to be detained in hospital for short period for the purposes of examination (see Schedule 2 paragraph 2(4)). Given that a person taken to a place of safety may be subject to an intervention under Schedule 2 of the Bill, we consider that the current wording of clause 140 assists the operation of Schedule 2". (Appendix 4)

183. The Committee was content with the Department's rationale.

Clause 147

184. This clause provides for a written record to be made of the fact that the person has been detained in a place of safety. NIACRO recommended that the record is not disclosed to employers, given the stigmatising impact of detention in police stations/hospitals.

185. In a letter dated 10 November 2015, the Department advised that detention under a place of safety power would not be disclosed as a result of an applica-

tion for a basic criminal certificate issued by Access NI. However, it may have to be disclosed if an enhanced criminal record certificate is sought. For example, conduct that threatens public safety or which is directed towards certain types of person, for example children, males or females, or older people, might be considered by the PSNI to be relevant information as it may show a dangerous attitude or mind set or a propensity to violence that ought to be disclosed for the purposes of an enhanced criminal record certificate. Such conduct would normally be required to be serious, involving, for example, the use of a weapon against other people (Appendix 4). The Committee was content with the Department's position.

Clause 154

186. The Children's Law Centre suggested that the Bill should place an obligation on the police to record statistics on the use of place of safety powers in relation to young people, and the ultimate disposal of the young person. Representatives stated:

"We suggest, however, that a clause be inserted into the Mental Capacity Bill that places an obligation on the PSNI to record statistics on the use of place of safety powers for young people, including the ultimate disposal of the young person under the place of safety powers because, currently, accurate statistics regarding this power are not available". (Appendix 2)

187. The Committee was of the view that if separate statistics are not collected on young people, there is a risk that such statistics could not be easily extrapolated from the data available. This would not be satisfactory given that the concerns around the use of police stations as a place of safety are particularly acute in terms of young people (see clause 158). The Committee therefore wrote to the Department to ask if it would be prepared to make an amendment to require the collection of statistics on the use of place of safety powers in respect of young people, and the ultimate disposal of those young people.

188. The Department's response dated 10 November 2015 stated:

"DoJ has carefully considered this suggestion and has concluded that clause 154 is wide enough as currently drafted to facilitate the collection of specific

information on age and disposal outcomes. It is also wide enough to allow for the collection of statistics on gender or other relevant characteristics of detained persons. DoJ considers that the collection of these specific statistics is indeed important, but considers that specifying particular statistical breakdowns of data in primary legislation can be inflexible, as areas of particular interest may alter over time. DoJ is happy to work with the PSNI to ensure that relevant information on detained persons is captured". (Appendix 4)

189. The Committee's view was that while clause 254 might "facilitate" the collection of statistics, it did not require it. The Committee wrote again to ask the Department to re-consider its position. The Minister of Justice provided a response dated 18 November 2015 which stated:

"I note the Committee's concern that there is no guarantee within clause 154 that statistics on the numbers of children and young persons detained in police stations and hospitals under the place of safety power will be collected by the PSNI.

Although there is no statutory requirement to do so at present, the PSNI currently collect statistics relating to the age of individuals detained at police stations as a place of safety under the Mental Health (Northern Ireland) Order 1986, and the Department considers that this approach will not change in future. I wish to place on record my Department's intention to work with the PSNI to ensure all relevant statistics are captured once the Bill is introduced, and I am therefore of the view that further amendment to clause 154 as proposed is not required". (Appendix 4)

190. The Committee welcomed the Minister's letter, but came to the view that while it may be the Department's intention that statistics on children are collected, there would be no legislative requirement to do so, and that the Department's priorities could change over time. The Committee therefore agreed its own amendment on the issue.

Clause 158

191. Clause 158 (1) defines a place of safety as a hospital or a police station and clause 158 (2) allows DoJ to amend the definition of a place of safety by regulations.

192. The HSC Board was concerned that the current definition of places of safety would not permit the police to return an individual with dementia to the care home where they reside. The Department clarified that the powers in Part 9 of the Bill are only powers - the police do not have to use them. In a small community, if the person is known to live in a particular care home, the first response would be for the police to take them back there, and not to a place of safety. However, in larger environments, the police would not know a person or where they lived and may have to use the place of safety powers. The Committee was content with the Department's explanation on this matter.

193. NICCY and the Children's Law Centre were opposed to a police station ever being used as a place of safety for a young person. NICCY stated:

"NICCY does not believe that a police station is a suitable place of safety for a young person. The use of a police station as a place of safety is entirely inappropriate in the cases of extremely vulnerable mentally-ill young people and it implies that, in these circumstances, a criminal justice response is appropriate and necessary, which it is not. We want to see police stations being removed from the definition of a place of safety for children and young people."

There are big concerns about moving young people who are really vulnerable and possibly very frightened to a police station. That sends a message to the young person that a criminal justice response is necessary, when, in those circumstances, it is not. A hospital or some alternative health and social care response is the correct provision for a young person who is mentally unwell. Hospitals have protocols in place; they deal with very difficult and unwell young people every day. Just because the young person might be challenging or a big, strapping young man does not mean that they should not have the response that they very clearly need. They are incredibly vulnerable and ill when a place of safety power becomes necessary". (Appendix 2)

194. Mindwise and NIACRO argued that for adults, police stations should only be used as a place of safety in exceptional circumstances, and that referral to hospital should be prioritised.

195. The PSNI made the point that police stations are not currently used as the first port of call for adults or children. The PSNI advised:

“A police station as a place of safety is not the first port of call. Officers on the ground will assess a situation as they find it, and the experience is that, more often than not, people are taken to an emergency department or another medical setting that is more appropriate to meet their needs”. (Appendix 2)

196. The Department acknowledged that police stations or indeed Emergency Departments were not always a suitable place of safety for the individual concerned, but that the Bill had to reflect the current facilities. Officials advised:

“The Bill has had to be crafted around the infrastructure and the physical facilities that are available. One of the stakeholders made reference to the possibility that, if someone is removed to hospital, it could be to a particular suite in the hospital rather than an A&E department. The Bill is crafted in such a way that it just refers to someone being removed to hospital. If the hospital had the capacity and facilities to create a dedicated unit, that would require no amendment to the Bill; it would however, perhaps, require some effort and resources in the hospital”. (Appendix 2)

197. The Department also made the point that it would be problematic to specify in the Bill that police stations should only be used in “exceptional circumstances”.

Officials explained:

“There has been a lot of discussion about using police stations in exceptional circumstances, but the trouble with using words such as “exceptional circumstances” is that they are open to interpretation as well. What we have tried to do, in clause 141, is be really specific about when a person can be detained in a police station. It is obviously:

“for the purpose of enabling the person to be examined by a medical practitioner and interviewed by an approved social worker”,

but there is also that second purpose, which is in clause 141(2)(b):

"for the purpose of preventing harm to that person or other persons while any necessary arrangements are made for the person's care or treatment elsewhere."

We think that that is quite specific, and, hopefully, it should narrow the circumstances in which somebody should arrive in a police station under a place-of-safety power". (Appendix 2)

198. The Committee came to the view that it would not be appropriate to ban a police station ever being used as a place of safety for a young person, if they were at risk of harming themselves or others and the Emergency Department at that time was particularly busy. Similarly, the Committee believed that to specify that police stations should only be used in "exceptional circumstances" could lead to operational difficulties and that officers required some flexibility to be able to make a judgement call on the ground in terms of what was the most suitable place of safety for a particular individual at a particular time.

PART 10

Clauses 165 - 201 and 208 - 235

199. The Committee spent some time discussing the issue of Public Protection Orders (PPOs). PPOs are being introduced for people who are judged to have been not culpable enough at the time of committing the offence to be deserving of a prison sentence; for people who are unfit to plead; and for people who are guilty by reason of insanity. The idea behind PPOs is that if these people pose a danger to the public they cannot be released, even though they are not culpable for their actions.

200. Under a Public Protection Order, the offender is detained in a hospital with the preference being that they receive treatment. However, if they have capacity, they can refuse treatment, but they are then transferred to what is described as "another appropriate establishment", designated as such by DoJ (clause 165).

201. However, Public Protection Orders can only be used if the "detention conditions" set out in clause 166 are met. Specifically, clause 166 (2) (c) requires

that there would be a risk of “serious physical harm to other persons” if the offender was not detained.

202. The Royal College of Psychiatrists advised that the criteria for making a Public Protection Order might not be met, in cases where the person had been found to have committed a rape, when the rape had not resulted in “serious physical harm” to the victim. The implication of this is that the person may be given an absolute discharge (clause 205).

203. The Royal College of Psychiatrists stated:

“ . . . the failure to identify serious psychological harm by focusing only on serious physical harm is indefensible in the 21st century. It is also inconsistent with the approach that is being taken elsewhere and, indeed, the criminal justice legislation.

In the criminal justice legislation, it says "serious harm, whether physical or psychological". In a fairly recent example, we struggled to detain a man who had committed rape, because rape does not cause serious physical harm. It clearly causes very serious psychological harm. This is an archaism in the Northern Ireland mental health legislation that has been carried over and causes us a great deal of anxiety.

The other aspect of that is the use of the word "serious". It has not really been defined in any of the legislation, and that causes us great issues, as well. It is defined in the public protection arrangements for Northern Ireland in a very useful way, and, again, if the code of practice could capture that definition, that would certainly address the issue. Yes, the failure to recognise serious psychological harm is of great concern to us”. (Appendix 2)

204. When the Committee raised this issue with the Department, officials initially advised:

“All the case law relates to article 5 of the European Convention on Human Rights. At the moment, psychological harm is outwith where it tells us we can go when it comes to detaining people on the basis of mental ill health and learning disability. We have to ensure that the Bill is ECHR-compliant. We looked at this area to see how far we can go and do not feel particularly confident as a Depart-

ment that we can go any further than we have, but we appreciate that it is difficult". (Appendix 2)

205. The Committee took the view that the issue was of such importance that it warranted further investigation. It therefore sought its own legal advice on the matter which was considered at its meeting on 16 November. The Committee agreed to seek further clarification on the matter with the Department and held an oral evidence session on 23 November. Officials advised that the Department was considering an amendment to clause 166 after further reflecting on the concerns raised by the Committee.
206. In a letter dated 15 December 2015 the Department advised that it was prepared to make an amendment to clause 166 so that a reference to "psychological harm" is inserted, provided it is of a serious nature (Appendix 4). This means that the detention conditions for a Public Protection Order include the potential of the individual to create a risk of serious physical or psychological harm to other persons. Amendments were also proposed to clauses 167, 170, 178, 183, and 190 which deal with various aspects of PPOs, so that the potential of the individual to create a risk of serious physical or psychological harm to other persons must be considered. Similarly, an amendment was proposed to clause 230, which provides an explanation of the "prevention of serious harm condition" for the purposes of clauses 228 and 229, so that the potential of the individual to create a risk of serious physical or psychological harm to other persons must be considered.
207. Again, on a related issue, the Department proposed amendments to clauses 282 and 293 in Part 15 of the Bill. It proposed to amend clause 282, which deals with the provision of special accommodation for persons that require care or treatment in conditions of special security for the protection of other persons, so to allow for the detention of individuals who might pose a risk of serious physical or psychological harm. The Department also proposed amendments to clause 293, which provides a definition of "harm" for the purposes of the Bill, so that the potential of the individual to create a risk of serious psychological harm is included within the scope of the definition. The Committee supported the proposed amendments.
208. Furthermore, the Department proposed a range of additional amendments to Part 10 to clarify what is meant by "harm" in various clauses, in terms of whether it means physical or psychological or both. This resulted in the Department propos-

ing amendments to clauses 163, 173, 196, 209, 213, 216, 219, 220, and 234. The Committee supported the proposed amendments.

209. On the same theme, the Department proposed a range of amendments to Part 9 of the Bill which deals with the power of police to remove a person to a place of safety. These amendments clarify that the potential of the individual to create a risk of serious “physical or psychological harm” to themselves must be considered. The Committee supported the proposed amendments.

Clauses 202-207

210. The Children’s Law Centre queried whether “unfitness to be tried” would apply to children under 16 and to 16 and 17 year olds. The PPS was concerned that the Bill does not include the procedure for unfitness to be tried in the Magistrates’ Court. The Department’s response was that the English Law Commission has been carrying out a review looking at reform of the law on unfitness to be tried and was due to publish its findings in autumn 2015. The Department advised that it needed to consider the outcome of that piece of work before reforming the law around unfitness to be tried in Northern Ireland. In December 2015 the Committee wrote to the Department to ask for an update on whether the English Law Commission had published its report. In a letter dated 4 January 2016 the Department advised:

“At the date of this response, DoJ can confirm that the Law Commission has not as yet published a final report containing recommendations to government on the law relating to unfitness to plead or the defence of insanity”. (Appendix 4)

211. The Department advised the Committee in June 2015 that it intended to make an amendment to clause 205. Clause 205 of the Bill provides powers to deal with persons who are found to be unfit to be tried or not guilty by reason of insanity. In such cases the court must make one of a number of disposals as provided by clause 205(2). One of these disposals is a supervision and treatment order. Clause 205(8) of the Bill provides that the DoJ must make regulations about supervision and treatment orders (STOs). However, the Depart-

ment advised that its intention was to remove this provision at Consideration Stage and instead make provision for such orders on the face of the Bill.

212. In a letter dated 24 November 2015, the Department advised that it had taken a decision to rename “Supervision and Treatment Orders” as “Supervision and Assessment Orders”, and therefore any references within the Bill would be amended to reflect this change (Appendix 4). This change of terminology requires amendments to clauses 205, 206, 241, 242, and 247. The Department confirmed that it was still its intention to remove the regulation-making power at clause 205(8), which would have allowed for the introduction of these orders through secondary legislation, and had instead drafted a new Schedule 7A which sets out the detail of the proposed scheme for Supervision and Assessment Orders (Appendix 4).
213. The Department provided oral evidence to the Committee on its proposals on the re-named Supervision and Assessment Orders on 30 November. The Department explained that it had not been possible to provide these clauses in the Bill as introduced because of the timescales involved. While the Committee took the view that this was not an ideal approach to legislation, it was content in principle that clause 205 (8) would be removed from the face of the Bill, and that Supervision and Assessment Orders should be dealt with on the face of the Bill. However, the Committee agreed to note the detail of the proposed new Schedule 7A, given that it had not had the opportunity to seek written or oral evidence from stakeholders.
214. During an evidence session on 23 November, the Committee raised the issue of the availability of restraining orders for individuals found unfit to plead. The Department agreed to examine that matter further and in a letter dated 15 December 2015 advised:
- “At the Committee session on 30 November, the issue of the availability of restraining orders for individuals found unfit to plead was discussed. The DOJ has considered the matter and has concluded that a restraining order is not currently available under Article 7 of the Protection from Harassment (Northern Ireland) Order 1997 (“the 1997 Order”) when an individual has been found unfit to plead. This is a similar position to the one in England and Wales, highlighted by recent decision of the Court of Appeal (E&W) in the case of R. v*

Chinegwundoh, which held that a finding of unfitness was neither a conviction nor an acquittal, so no power was available to make a restraining order under the Protection from Harassment Act 1997.

Therefore, new clause 207A - set out at Annex B to this letter - amends Articles 7 and 7A of the 1997 Order, in order to allow the courts to sentence an individual to a restraining order where that individual has been found unfit to plead". (Appendix 4)

215. The Committee supported the proposed amendment.

Arrangements for under 16s and 16 & 17 year olds

216. The Children's Law Centre and NICCY queried how facilities such as the Juvenile Justice Centre, which has residents who are under and over 16 will operate two systems in practice (i.e. the Mental Capacity Bill and the Mental Health (NI) Order 1986 as amended). The Department's response was that if the question of welfare or treatment arises for an under 16 detained in a criminal justice setting, then the law that relates to under 16s applies. The process is to look at whether the individual is competent to consent themselves, or whether a parent or somebody with parental responsibility can consent on their behalf. If there is a disagreement, then the matter might go to court. For young people who are 16 and over Part 2 of the Bill is applied. The Committee was content with the Department's explanation on this matter.

217. The Children's Law Centre queried whether the remand powers in clauses 160-164 would work in practice for 16 and 17 years olds, given that there are no forensic inpatient treatment facilities for young people in Northern Ireland. Similarly, NICCY queried whether the other court disposals available under Part 10 could be applied to 16 and 17 year olds, given that there are no forensic inpatient treatment facilities for young people in Northern Ireland. The Department's response was that it was hard to argue against the need for such a facility, but that it was a question of affordability. The Committee was content with the Department's explanation on this matter.

PART 11

218. The Northern Ireland Association of Mental Health suggested that the Bill should include a duty that for all patients transferred to other parts of the UK, the Northern Ireland HSC Trust should have a responsibility for ongoing monitoring of the patient. The Southern HSC Trust stated that it was aware of some consultants doing this sort of follow-up, but it is based on good practice rather than a statutory requirement. The Department's response was that once an individual is transferred to another jurisdiction then the Act would no longer apply - the legislation of the receiving jurisdiction would apply. There are rights to review within the legislation of the other jurisdictions. The Committee acknowledged that difficulties could arise for families when an individual was transferred to another jurisdiction for treatment, in terms of both information on the patient's care, treatment and current condition, and in relation to making an application to a tribunal or court if required. However, the Committee took the view that those were not issues best dealt with through this Bill.

Clause 252

219. The Southern HSC Trust suggested that the Bill should be used to agree procedures in statute for the transfer of patients between Northern Ireland and the Republic of Ireland - for example, the roles and responsibilities of the social workers, GPs, police and ambulance staff. The Department's response was that clause 252 does contain regulation making powers in connection with any removal of a person to a country that is not part of the UK. However, at the moment the Republic of Ireland has different legislation than Northern Ireland, so it is not possible to make provisions under Part 11 of the Bill in the same way as is being made for England, Scotland and Wales. The Committee accepted the Department's rationale on this matter.

PART 12

Clause 254

220. This clause deals with 16 and 17 year olds who are in-patients in a hospital for the purpose of receiving assessment or treatment of a mental disorder. The

clause places a duty on the hospital to ensure that, subject to the person's needs, the person's environment is suitable having regard to their age. In terms of deciding what constitutes a suitable environment, a hospital must consult a person with knowledge or experience.

221. Some stakeholders argued that this clause should be more tightly worded so that it requires hospitals never to allow a 16 or 17 year to be admitted onto an adult ward. This point was made by the Children's Law Centre and by NICCY. In their view, this practice has risks in terms of the young person's safety and their social and emotional well-being. NICCY stated:

"The admission of children to adult wards is an issue of serious concern, and the risks to the safety of children and the potentially detrimental impact on their social and emotional well-being are significant. We recommend an amendment to this clause to place an unequivocal duty on hospital managers to ensure that all children and young people under 18 will never be placed on adult psychiatric wards and will receive treatment in age and developmentally appropriate settings". (Appendix 2)

222. However, the RQIA stated that having flexibility to allow under 18s onto adult wards has been used in some cases when a child is transitioning into adult services. The RQIA advised:

"Last year, I noted a situation where a 17-year-old said, "I do not want to go from Londonderry to Beechcroft". If it is for a short period, they would go into an adult ward. It has happened in that way . . . Where a child is on an adult ward, the circular from the Department is helpful because it specifies what must be in place. That register comes to us, and we can then choose to go out and look at that situation to afford additional assurance that all the provision that can be made in that short period is made for their protection". (Appendix 2)

223. The Department's response on the issue was that it did not wish to be too prescriptive in the legislation, in order to allow for situations such as no children's beds being available or if the only children's bed available was far from the child's home. If the Bill barred 16 and 17 year olds from being admitted into

adult wards, this could result in a child not being admitted anywhere, even though it was in their best interests.

224. The Committee sought further information from the Department in relation to the number of 16 and 17 year olds detained in adult psychiatric wards, the length of stay, and the reasons why an adult ward, rather than a children's ward had been selected. The Department's response dated 13 October 2015 advised that in 2013-2014 no children under 18 were detained under the Mental Health (NI) Order 1986 in an adult psychiatric ward. During 2014-2015 there were six detentions involving children aged 16 and 17 and one of a child under 16. No information was available on the length of stay or the reasons why an adult ward was selected rather than a children's ward in individual cases (Appendix 4). The Committee was disappointed that the Department could not provide this level of detail, and it subsequently wrote back to the Department to request this information again, which was then provided in a letter dated 3 November 2015 (Appendix 4).

225. The Committee was concerned that these figures did not tally with those provide by the RQIA during the evidence session on 5 October 2015 (Appendix 2). The RQIA had advised that in 2014-2015, there were 22 young people aged 16 or 17 who were detained in adult wards. The Committee subsequently wrote to the RQIA to seek clarification on the matter and responses were provided dated 23 and 30 October 2015 (Appendix 4).

226. In terms of the central issue of whether the Bill should be amended to prevent 16 and 17 year olds from ever being admitted to an adult ward, the Committee took the view that in a small number of cases, this could result in the child not being admitted to any hospital ward, and therefore not receiving the treatment they require. The Committee believed that the ultimate priority has to be meeting the treatment needs of the child and in some instances this could necessitate admitting them onto an adult ward.

Clause 255 and Schedule 8

Principle of applying the amended 1986 Order to under 16s

227. Schedule 8 restricts the application of Part 2 of the Mental Health (NI) Order 1986 to children under 16, with a number of amendments.

228. A range of stakeholders were concerned that the 1986 Order, as amended, will continue to apply to children under 16 who have been compulsorily admitted to hospital. Stakeholders expressed different views on their preferred alternative. The NIHRC stated:

“The commission is disappointed that the 1986 Order will continue to apply to children under 16 who have been compulsorily admitted to a hospital. As set out in our submission, the commission recommends that a separate project be developed to consider a bespoke legal framework governing the capacity of children under the age of 16”. (Appendix 2)

229. The RQIA advocated that a review of the Children (NI) Order 1995 is made a priority:

“Schedule 8 to the Bill makes provision for independent advocates for children and to require persons making decisions to have a child's best interests as their primary consideration. While RQIA welcomes the introduction of these safeguards, we have some concern that children under 16 are excluded from accessing the same range and extent of safeguards as are enshrined in the Bill for over-16s, for instance, the offences of ill-treatment and neglect. We note that a review of the Children (Northern Ireland) Order 1995 is planned, but we are not clear about the timeline for that. We would like to see a priority given to the legislative provision for the rights and needs of young children and young people as vested in the 1995 Order”. (Appendix 2)

230. NICCY and the Children's Law Centre recommended that all under 16s should be included within the scope of the Bill and questioned the Department's rationale for their exclusion. NICCY argued:

“The Northern Ireland Commissioner for Children and Young People (NICCY) has consistently expressed concerns about the exclusion of under-16s from the Mental Capacity Bill. Their exclusion means that vulnerable children will not enjoy equal access to the protections and safeguards that over-16s, who come within the scope of the Mental Capacity Bill, will enjoy. The Department's rationale for the exclusion of under-16s is that a lack of capacity cannot

be determined in a child as being as a result of a mental illness or learning disability or as a result of their developmental immaturity. We now know that, for the purposes of the new offence at clause 256 of the Bill, the Department is proposing to measure capacity in under-16s, as this offence will apply to all age groups. If the Department is proposing to assess capacity in under-16s, NICCY sees no reason why under-16s should be excluded from the scope of the rest of the Bill". (Appendix 2).

231. Other stakeholders suggested different ages from which the Bill should apply, for example, the Probation Board NI proposed an age limit of 14.

232. Department officials explained their rationale on the issue of under 16s in the following terms:

"I do not wish to oversimplify, but there appear to be two camps: one says that the Bill should apply to children otherwise they will be less protected than adults; the other argues that the Bill should not apply to children because it would alter the fundamental role that parents play in making decisions in respect of their children. We did not have to go too far into the provisions of the Bill to find support for the latter argument. As you know, Part 1 contains what is called the presumption of capacity. Under current law, that is the starting point for adults. For them, it is presumed that they have capacity, and that means that, legally, there is no one else who can give consent on behalf of an adult. Hence, the need for the Bill: to ensure that adults are protected when they are unable to make decisions for themselves. For children, however, the position is very different. They are gaining capacity, during which time – indeed, until they become an adult – there will always be a parent or someone acting in that role to protect them and to act, where necessary, in their best interests. Applying the presumption of capacity in Part 1 to children would radically change the nature of the existing protective regime for children. Take, for example, an intelligent 10-year-old who refuses life-sustaining treatment. To comply with Part 1, the starting point would be for the doctor to assume that that child had capacity to make the decision for themselves, unless it is established otherwise. In other words, it would be doubtful whether any parent could lawfully step in and give the necessary consent. To develop the scenario in a different direction, if it were established that the child lacked capacity,

as defined in Part 1 – there are issues with that too – the role of parents would be further displaced, as under Part 2 it would be the doctor, not the parents, making the best-interest decision on behalf of their child. That is an extreme example but a real one that parents and those working in the health and social care sector would face if the Bill applied to children. The implications are just as real at the other end of the spectrum, the more routine end, for things that some of us as parents do on a daily basis, like washing or dressing our younger kids, making decisions about after-school care or whether they should go to the dentist.

It was clear to us that a change of that scale would require a careful analysis and full and open debate as it touches on one of the most fundamental societal issues: the concept of parental responsibility and when a person becomes an adult in the eyes of the law. Not only would such work go beyond not only the current scope of the Bill, which is about mental, not legal, capacity, and beyond the Department of Health's remit, but it would be a huge undertaking on top of the challenges presented by the novel approach that we are already taking in the Bill by fusing mental health and mental capacity law.

It was also clear that agreement on what changes, if any, should be made to existing law around capacity and consent in relation to children was very unlikely within the time frame that we were working to. For example, a key question would be this: if 16 is not the right age threshold in the Bill, what should it be? Some people suggested that it should be 14, others 12, and even 10 years was suggested. Indeed, some argued in the opposite direction that it should be higher and set at 18 years in line with what is proposed in the Republic of Ireland's capacity Bill and the current age of legal capacity here.

In light of all that, the Department adopted what it considers a balanced and pragmatic approach. We decided to stick with the most commonly used age threshold of 16 and bring forward a Bill in the current mandate introducing necessary protections for the many in our society who are unable to make decisions for themselves. At the same time, we are bringing in further protections for children subject to the Mental Health Order, reflecting the consensus on what is perhaps at the heart of the debate: the need to ensure that children are protected". (Appendix 2)

233. The Committee recognised that the issue of capacity in under 16s is a complex one and that at present there is no consensus among stakeholders on how best to approach the matter. The Committee understood that the DHSSPS had proposed in January 2014 to undertake a separate project to assess the emerging capacity of children in relation to health and welfare decisions. It therefore wrote to the DHSSPS to seek an update on the project. The Department's response of 3 November 2015 advised:

"Resources within the Department have been focused during the current Assembly mandate on securing the introduction of the Mental Capacity Bill for those currently without legislative safeguards and, at the same time, strengthening the existing protective framework that is already in place for children (of which the Mental Health Order is part). It therefore remains the Department's position that the separate project to consider the issue of emerging capacity in children in a health and welfare context is a matter to be taken forward in the next Assembly mandate". (Appendix 4)

234. The Committee recommends that the separate project on the emerging capacity of children should be taken forward as a priority in the next mandate.

Extension of disregard provision

235. A range of stakeholders advised that during the consultation on the draft Bill, the Department had indicated that it was considering amending the 1986 Order to provide that the disregard principle would be extended for under 16s to include a period for treatment. However, this is not included in the Bill as introduced.

236. Stakeholders argued that having to declare a period of detention for treatment can have a detrimental impact on young people with regard to employment, travel and insurance purposes, and that young people feel stigmatised by it. The Children's Law Centre explained:

"Basically, if I am detained when I am 14 or 15, even if it is only for one day into the treatment period, I am stuck with that for the rest of my life, if I am asked about it. You will not be asked about it in every situation, but it can have an effect. The biggest example would be if you were going to America. You have to

apply under section 212 of the US Immigration and Nationality Act for a visa to travel there and you can be denied a visa on the basis that you have detained for treatment for a mental illness. So, somebody who is 40, for example, and who has never had another detention since the age of 15, will have to declare that and may or may not get in. It depends on the situation. The knock-on effect that we have seen is that various people have encountered courses or employment opportunities that have been tricky, to say the least, to be able to take up because of a short detention in childhood". (Appendix 2)

237. The NIHRC advised that a blanket requirement to declare a period of detention for treatment, no matter how short, could raise issues of proportionality. The NIHRC explained:

"It is not a very good comparator, but the Department of Justice here has brought in the filtering mechanism for criminal records. That was brought in to ensure compliance with the European Court of Human Rights judgement in MM v UK. It seems to me that, in terms of proportionality, if they adopt a blanket approach of saying that you are always required to declare it, regardless of how short it was or the circumstances, that could possibly raise a compatibility issue down the line, with challenges brought". (Appendix 2)

238. The Department's response to the issue was that it had sought legal advice on the matter which suggested that it proceeds cautiously. Officials also made the following point:

"However, it seemed to us that there might be a question around having a special rule beyond that detention for assessment where there is no equivalent special rule, such as where a child is being treated for a very serious physical condition on a long-term basis, for example. So, it gave rise to some questions in our mind and some additional thinking. We think that it is something that needs to be thought about very carefully, and we need to be clear about what the impact might be on the ground". (Appendix 2)

239. The Committee was not clear from the Department's response on the issue whether it was opposed to extending the disregard provision on policy grounds or on legal grounds. It therefore wrote to the Department to ask that it provide more information on its position and its response dated 3 November

2015 is at Appendix 4. The Committee also agreed to commission its own research on the matter from Assembly Research Services (Appendix 5).

240. The Department's response stated that it was against the extension of the disregard provision on a number of counts. Firstly, on the basis of its legal advice, which the Department summarised as follows:

"The Department has sought legal advice on this matter. The advice confirmed that extending the disregard as suggested would be within competence: the fact that the application of the exemption, in a certain set of circumstances, may involve an excepted matter (armed forces) or a reserved matter (civil aviation or firearms and explosives), does not prevent the provision from being a transferred matter. However, that advice also stated that the Department should proceed with caution on this matter and carefully consider the consequences of an extended disregard provision in consultation with medical professionals". (Appendix 4)

241. Secondly, the Department was concerned about having a rule to allow disregard of detention for treatment of a mental illness, but not having an equivalent rule for a child treated for a very serious physical condition on a long-term basis. Thirdly, the Department pointed out that the criteria for detention for treatment are significantly narrower than those for assessment, and require that the patient is suffering from either mental illness or severe mental impairment as defined at Article 3(1) of the Mental Health (NI) Order 1986. Fourthly, the Department argued that there is a balance to be struck between protecting the rights of the individual and protecting others and the individual themselves for harm.

242. The Committee also took note of some of the key points contained in the Assembly Research paper. Members noted that the existing disregard provision for assessment is unique to Northern Ireland, and does not exist in the rest of the United Kingdom or the Republic of Ireland, and that therefore in some regards Northern Ireland was already more progressive on this issue.

243. The Committee also considered the circumstances where disclosures about detention are required which would include when a person is applying to adopt a child, those working with vulnerable adults, and those wishing to apply for a

firearm. In those cases the Committee would regard such a disclosure as being required for legitimate reasons, especially where there could be a risk to others.

244. On the basis of all the evidence received, the Committee concluded that it would not be in favour of an amendment to the Bill to extend the disregard provision to periods for treatment for under 16s.

Independent advocates

245. The RQIA queried whether under 16s would be able to access an independent advocate by means of the Bill outside hospital, when for example, their admission to a psychiatric hospital is being considered. NICCY and the Children's Law Centre argued that children should be able to request an advocate at any time, both in the community prior to the consideration of detention, and on discharge from hospital. NICCY also expressed concern that the independent advocates would be commissioned by the HSC Trusts, and the impact this has on the perceived independence of the advocates. The Children's Law Centre argued that children should be able to choose their own advocate if they have built up a relationship of trust previously with an individual advocate or a particular service provider.

246. NICCY made the following points:

"NICCY has concerns regarding the perceived independence of the advocates, their ability to challenge decisions made by trusts as employees of the trusts, and the impact that this will have on young people's confidence in the service and their willingness to avail themselves of it.

NICCY wishes to see independent advocacy being available to all children who require it, both under the Mental Capacity Bill and the Mental Health Order, when they require it and at their request, both in the community prior to the consideration of detention and on discharge and in a hospital setting. Children should be able to choose their advocate". (Appendix 2)

247. The Department's position was that under the Bill, independent advocates are only required for under 16s who are inpatients in hospital for assessment or treatment (both voluntary and detained patients), and when certain serious

treatments are being proposed for the child such as ECT. In terms of the choice of advocate, the Department stated that it would be very difficult to guarantee a young person the choice of advocate within the Bill, because practical issues need to be considered, such as the advocate being on holiday. The Department acknowledged the importance of continuity of relationships, but stated that the matter could be addressed in the code of practice.

248. The Committee was content with the Department's approach in terms of the situations in which independent advocates would be made available to under 16s. It also recognised the difficulties in relation to the Bill providing the young person with their own choice of advocate, and accepted that this issue could be better dealt with in the code of practice.

249. In terms of the commissioning of the advocates, the Committee took the view that the stakeholders had a valid point in relation to independence and the perception of independence. It was not clear why the Trusts, rather than for example, the Health and Social Care Board, had to commission the advocates. The Committee wrote to the Department to ask whether there was any practical reason why the Board could not do the commissioning. The Department's response of 3 November 2015 stated:

"The Department does not accept the proposition that the current provisions in the Bill would not allow for the appointment of advocates who could fulfil their role and functions under the Bill in an independent manner. As the Committee may already be aware, the majority of advocacy services are currently being commissioned by the HSC Trusts and delivered by a range of voluntary/community sector organisations. This arrangement allows the HSC Trusts to create services that best meet the specific needs of the local population. The key point, however, is that all of these services are being commissioned and delivered in accordance with Departmental guidance. That guidance was issued by the Department in 2012 to build capacity within the community/voluntary sector and prepare the way for the new statutory right to independent advocacy in the Bill. It sets out a number of principles and standards for both the commissioning and delivery of advocacy services. Independence is one of those standards and is clearly explained in the guidance". (Appendix 4)

250. The Committee noted the Department's position that it did not accept that advocates appointed by the Trusts could not operate in an independent manner. In light of the announcement by the Minister for Health, Social Services and Public Safety in November 2015 of his intention to abolish the Health and Social Care Board, the Committee came to the view that the commissioning of advocates by the Trusts was the most practical arrangement available.

Under 16s on adult wards

251. NICCY advocated that Schedule 8, Article 3D, is amended to place a duty on a hospital manager to ensure that no one under 16 is ever placed on an adult psychiatric ward. The Department's response was that it did not wish to be too prescriptive in the legislation, to allow for situations such as no children's beds being available or if the only children's bed available was far from the child's home. The arguments put forward on all sides were similar as those in relation to clause 254, which deals with the same issue in terms of 16 and 17 year olds.

252. The Committee's position was that in a small number of cases, if under 16s were prevented from being admitted onto an adult ward, this could result in the child not being admitted to any hospital ward, and therefore not receiving the treatment they require. The Committee believed that the ultimate priority has to be meeting the treatment needs of the child and in some instances this could necessitate admitting them onto an adult ward.

Access to education

253. NICCY and the Children's Law Centre expressed concern that the Bill does not contain any access to educational provisions for children and young people. The Department's position was that there is existing legislation on this matter coming under the remit of the Department of Education. The Department advised that Article 86 of the Education Order (Northern Ireland) 1998 governs the provision of education to children who, by reason of illness, may not receive suitable education unless arrangements are made for them otherwise than at school (Appendix 4).

254. Given the concerns expressed on this issue, the Committee wrote to the Department of Education to seek clarification on the provisions that exist for children who following re-integration back into the classroom setting, need to catch up with missed classwork. The Department of Education's response dated 5 November 2015 is at Appendix 4. The Committee noted the information provided.

RQIA access to records of 16 and 17 year olds detained in adult wards

255. The RQIA advised the Committee that under the 1986 Order at present, the HSC Trusts are required to maintain a register of all persons under 18 who are receiving medical treatment for a mental disorder as inpatients in hospital in an adult ward. A DHSSPS circular requires the Trusts to send that register to the RQIA so that they can do unannounced inspections to review the effectiveness of the safeguarding provisions put in place by the Trusts.

256. However, the amendments to the 1986 Order will mean that the children recorded in the register by the Trusts will be under 16. As a result, the RQIA will not receive information in relation to 16 and 17 year olds being treated in adult wards. The RQIA suggested that the Bill be amended to require the Trusts to notify the RQIA of any 16 or 17 year old accommodated in an adult psychiatric facility. The Committee believed this was a sensible approach and asked the Department if it would be prepared to make such an amendment. The Department provided a proposed amendment, which was agreed by the Committee.

Access to the Review Tribunal

257. The Children's Law Centre argued that under 16s should be able to apply to the Review Tribunal during the assessment period, rather than after six weeks. They also argued that an under 16 should be able to make multiple applications to the Review Tribunal, rather than just every six months. The Department's response was that it believes there are enough access points to the Tribunal to have the person's case reviewed and that current scheme is ECHR compliant.

258. For clarification, the Committee wrote to the Department for information on the access points. The Department provided this information in a letter dated 27 October 2015 (Appendix 4). The Committee noted the information provided.

PART 13

Clause 256

259. This clause creates a new offence of ill-treatment or wilful neglect of somebody who lacks capacity in relation to any or all matters concerning his or her care. While stakeholders welcomed the new clause, there were a number of concerns in relation to the detail of it.

260. The offence applies to a person who has the care of P, is an attorney under an LPA, or is a deputy appointed by the court. Stakeholders pointed out that someone acting as an attorney under an EPA should also be covered under the offence. The Department agreed to make this amendment.

261. The Bill places a maximum sentence, on summary conviction, of 6 months. This compares to 12 months under the Mental Capacity Act 2005 for a similar conviction. The Commissioner for Older People NI argued that a 12 month maximum sentence should also apply in Northern Ireland. The COPNI representative stated:

“Evidently, there is a need for a uniform approach, and it is imperative that older people are equally protected. The judiciary in this jurisdiction should have enhanced scope to sentence perpetrators appropriately. As such, an extension of the current maximum sentence on summary conviction in the Bill would ensure that sentencing powers in this jurisdiction mirror those in England and Wales”. (Appendix 2)

262. During an oral evidence session, the Department of Health’s initial response was that custodial sentences for the Magistrates’ Court are limited to six months, and the Bill cannot conflict with that. The DoJ then clarified that while the general principle is that the maximum for the Magistrates’ Court is six months, there are offences for which the sentence can be longer - for example criminal damage carries a maximum sentence of 24 months. The Committee wrote to the Department to ask if it would consider making an amendment to

change the maximum sentence on summary conviction to 12 months. The Department's response in a letter dated 10 November stated:

"Following the evidence session on 19 th October, it is now DHSSPS's understanding that although the maximum penalty in Northern Ireland on summary conviction is normally limited to 6 months, this can be increased in exceptional circumstances. The Committee will wish to be aware that, in such cases, Article 29 of the Magistrates' Courts (NI) Order 1981 will apply. This gives the offender the option to ask for a jury trial, with concomitant implications for costs and court time. In light of the above, the Department considers it necessary to liaise further with DoJ and the Court Service to understand the circumstances in which a maximum penalty greater than 6 months can be specified and the full implications of doing so, before providing a final response on this matter to the Committee. In the meantime we note the Committee's views and will endeavour to update the Committee as soon as possible." (Appendix 4)

263. In a further letter dated 26 November, the Department set down its position as follows:

"We are advised that, while section 154(1) of the Criminal Justice Act 2003 raises the maximum penalty on summary conviction in England and Wales from 6 to 12 months, this provision remains uncommenced. The direct equivalent in Northern Ireland remains imprisonment for a term not exceeding 6 months or a fine not exceeding the statutory maximum or both.

As mentioned in our previous letter, in exceptional cases in Northern Ireland, a maximum sentence greater than 6 months on summary conviction can be specified for a new offence. There should be specific and strong policy grounds for doing this and Article 29 of the Magistrates' Courts (Northern Ireland) Order 1981 will apply. This gives the defendant the option to ask for a jury trial, with concomitant escalations in cost and court time that may not be warranted by the seriousness of the alleged offence and may not attract the higher penalty. This right, however, can be removed for individual offences if deemed appropriate, although this would require an amendment to Article 29(1) of the Magistrates' Courts (Northern Ireland) Order 1981.

It is also worth noting that the clauses 256 and 257 in the Bill are hybrid offences (where trial is explicitly allowed for in either Magistrates' Court or Crown Court, depending on the seriousness of the individual case) meaning that the higher penalties of the Crown Court would be available for any deserving case.

Based on the above analysis, the Department is not prepared to bring forward the requested amendment at this time. Raising the maximum custodial sentence could result in lower level cases, where the penalty may be a fine or a very short custodial sentence, being unnecessarily elevated from the Magistrates' to the Crown Court, incurring significant additional public expenditure". (Appendix 4)

264. The Committee wrote back to the Department to ask why the provision in the Criminal Justice Act 2003, which raises the maximum penalty on summary conviction in England and Wales from six to 12 months, has not been commenced. The Department's response dated 4 January 2016 stated:

"The Departments do not hold any information as to why the provisions in the Criminal Justice Act 2003, which raised the maximum penalty on summary conviction in England and Wales from 6 to 12 months, have not been commenced as it is a decision for the Secretary of State for Justice". (Appendix 4)

265. The Committee took the view that given a maximum sentence of five years is provided for on conviction on indictment, a six month maximum sentence on summary conviction was sufficient.

266. The Children's Law Centre and the NIHRRC pointed out the offence of ill-treatment or neglect of someone who lacked capacity as contained in the Mental Capacity Act 2005 has been recognised as being flawed on a number of counts. Firstly, it has been difficult to bring prosecutions because it requires proof that the person lacked capacity at the particular time of the offence. Secondly, there could be a situation where two patients, one with capacity and one without, could be subject to the same ill-treatment, but a prosecution could only be brought in respect of the patient who lacked capacity. The NIHRRC advised that a new offence has been introduced in England and Wales to create an offence for an individual who has the care of another person by

virtue of being a care worker to ill-treat or wilfully neglect that person. This offence is set out in clauses 20-25 of the Criminal Justice and Courts Act 2015, and the NIHRC argued that these provisions should be included in the Mental Capacity Bill.

267. The Committee wrote to the Department to ask whether it regarded such an amendment as desirable in policy terms, and secondly whether it believed it would be within the scope of the Bill. The Department's response of 10 November stated:

"It is DHSSPS's view that such an offence would be outwith the scope of the Mental Capacity Bill which is creating a legislative framework for persons who lack capacity. The introduction of an offence of wilful neglect and other legislative developments in other parts of the UK were acknowledged in the course of consultation on new adult safeguarding policy. The policy consultation paper also outlined and sought views on recommendations for legislative change made by COPNI. The response to consultation made it clear that more time was needed to consider and reconcile views on the COPNI proposals; those who responded weren't always in agreement with what was proposed by the Commissioner. On that basis, it is not possible to implement legislative change to potentially strengthen safeguards for adults at risk in the current mandate. This is the position taken consistently by both DHSSPS and DOJ, which jointly developed, consulted on and published the adult safeguarding Policy". (Appendix 4)

268. The Committee accepted the Department's rationale on this issue.

269. The Children's Law Centre and NICCY welcomed the fact that the new offence created by clause 256 would apply to people of all ages. However, they queried how the Department intends to establish a lack of capacity in under 16s, given that they are excluded from the majority of the rest of the Bill. NICCY stated:

"While the assessment of a lack of capacity in under-16s on a case-by-case basis is welcome, it raises significant questions about the rationale for the exclusion of under-16s from the scope of the remainder of the civil provisions of the Mental Capacity Bill. It appears that, for the purposes of this offence under

the Bill, the capacity of under-16s can and will be assessed. If the Department is proposing to assess capacity in under-16s, we can see no reason why under-16s should be excluded from the scope of the capacity-based civil provisions of the Bill". (Appendix 2)

270. The Department responded in a letter dated 27 October 2015 as follows:

" . . . mental capacity in adults is distinct from child competence, not least because children are in the process of gaining capacity whereas for adults, capacity is assumed. This is reflected in the existing common law formulated by the courts which includes a competence test for children under 16 (known as Gillick competence) and will presumably apply for the purposes of determining whether an offence has been committed under this clause. However, there is also nothing preventing the courts from adopting aspects of the capacity test in the Bill for this purpose if appropriate - appropriate, that is, having regard to the existing principles of the common law". (Appendix 4)

271. The Committee noted the Department's response.

Clause 257

272. This clause creates a new offence relating to forgery and false statements.

The Bill places a maximum sentence, on summary conviction, of six months. This compares to 12 months under the Mental Capacity Act 2005 for a similar conviction. The Commissioner for Older People NI argued that a 12 month maximum sentence should also apply in Northern Ireland. The Committee wrote to the Department to ask if it would consider making an amendment to change the maximum sentence on summary conviction to 12 months. The Department's response in a letter dated 10 November 2015 was the same as its response to clause 265 - it wished to take further time to consider the implications of permitting trial by jury. In a further letter dated 26 November, the Department set down its position as follows:

"We are advised that, while section 154(1) of the Criminal Justice Act 2003 raises the maximum penalty on summary conviction in England and Wales from 6 to 12 months, this provision remains uncommenced. The direct equiva-

lent in Northern Ireland remains imprisonment for a term not exceeding 6 months or a fine not exceeding the statutory maximum or both.

As mentioned in our previous letter, in exceptional cases in Northern Ireland, a maximum sentence greater than 6 months on summary conviction can be specified for a new offence. There should be specific and strong policy grounds for doing this and Article 29 of the Magistrates' Courts (Northern Ireland) Order 1981 will apply. This gives the defendant the option to ask for a jury trial, with concomitant escalations in cost and court time that may not be warranted by the seriousness of the alleged offence and may not attract the higher penalty. This right, however, can be removed for individual offences if deemed appropriate, although this would require an amendment to Article 29(1) of the Magistrates' Courts (Northern Ireland) Order 1981.

It is also worth noting that the clauses 256 and 257 in the Bill are hybrid offences (where trial is explicitly allowed for in either Magistrates' Court or Crown Court, depending on the seriousness of the individual case) meaning that the higher penalties of the Crown Court would be available for any deserving case.

273. *Based on the above analysis, the Department is not prepared to bring forward the requested amendment at this time. Raising the maximum custodial sentence could result in lower level cases, where the penalty may be a fine or a very short custodial sentence, being unnecessarily elevated from the Magistrates' to the Crown Court, incurring significant additional public expenditure". (Appendix 4)*

274. The Committee wrote back to the Department to ask why the provision in the Criminal Justice Act 2003, which raises the maximum penalty on summary conviction in England and Wales from six to 12 months, has not been commenced.

275. The Department's response dated 4 January 2016 stated:

"The Departments do not hold any information as to why the provisions in the Criminal Justice Act 2003, which raised the maximum penalty on summary conviction in England and Wales from 6 to 12 months, have not been commenced as it is a decision for the Secretary of State for Justice". (Appendix 4)

276. The Committee took the view that given a maximum sentence of two years is provided for on conviction on indictment, a six month maximum sentence on summary conviction was sufficient.

Clause 261

277. Clause deals 261 with the offence of obstruction by refusing to allow a visit or refusing to produce a document and it has a maximum sentence of three months. The Commissioner for Older People NI argued that this should be increased to six months, as is the case for obstructing police in their duties. It also argued that the Bill should allow for a prosecution on indictment to the Crown Court. The Committee wrote to the Department to ask for its rationale in terms of how it had approached this clause. The Department's response of 10 November 2015 advised:

“DHSSPS’s rationale is largely based on the existing penalty associated with the offence of obstruction in Article 125 of the Mental Health (NI) Order 1986. That offence also provides for a maximum sentence on summary conviction of 3 months imprisonment and excludes prosecution on indictment”. (Appendix 4)

278. The Committee was content with the Department's explanation.

PART 14

Clause 272

279. Clause 272 and Schedule 9 give effect in Northern Ireland to the Convention on the International Protection of Adults, which is about recognising and enforcing protective measures taken in relation to adults under the law of other countries. Alex Ruck Keene raised concerns with the Committee about the impact which this has had in England and Wales, which means that the court had to enforce a measure taken in respect of an adult from anywhere in the world if the adult has an “impairment or insufficiency of his personal faculties”. The Department's response was that if it limited the scope to just countries that had ratified the Convention on the International Protection of Adults, that

would only allow arrangements to be made with Scotland. England and Wales have not ratified the Convention as yet, and the Republic of Ireland has not signed up to it at all.

280. The Law Society was concerned that LPAs and EPAs are not classed as protective measures for the purposes of the Convention. It argued that this would be beneficial, so that a court is able to make declarations as to enforceability and recognition of foreign powers of attorney from states that are not Convention states.

281. The Committee commissioned a research paper on the issues (Appendix 5) and held a further oral evidence session with the Department on 23 November. The Committee questioned the Department on a range of issues including whether it was the intention that the Convention would be ratified in Northern Ireland, the reasons for the delay in ratification of the Convention in England and Wales, and the requirement of courts in Northern Ireland to recognise protective measures made by countries who had not signed up to the Convention.

282. The Department clarified that it was its intention that the Convention would be ratified in Northern Ireland, but that the process for doing so lay in the hands of the Foreign and Commonwealth Office and the Ministry of Justice. Officials advised:

“Incorporating the convention into our law is one of the many steps that have to be taken before ratification can happen, but it is a necessary first step. This is a complex area of law so it will take time to work out all the implications and ensure that all the necessary systems are in place to support its implementation. Secondary legislation will be required, including court rules. That work will be taken forward during the implementation phase of the project, and a significant lead-in time will be required for that . . . The first step is to give the convention effect in domestic law, which is what the Bill would do. It is a cross-cutting issue, so the decision to ratify would require Executive approval, but that is certainly the intention because we are taking the first step in the process.” (Appendix 2)

283. The Committee noted the information provided.

PART 15

Clause 278

284. The NI Social Worker Training Programme pointed out that this clause refers to “justice of the peace”. It was their understanding that this office was replaced in April 2005 by the office of the Lay Magistrate. The Department accepted that this was an error and brought forward an amendment to make the correction.

285. The Southern HSC Trust and the NI Approved Social Worker Training Programme suggested an amendment to clause 278 (2) to permit an “approved social worker” to accompany the medical practitioner and constable when entering a premises. The Department’s response was that it could see merit in the suggestion and it proposed an amendment which was supported by the Committee.

286. The Southern HSC Trust and the NI Social Worker Training Programme also queried whether this clause allowed for a warrant to be granted for the objective of “assessing the premises”, and not just for removing the person from the premises. These organisations were also not clear on whether warrants would be granted to allow a Trust to enter a person’s home if the social worker believes that the individual lacks capacity and are being ill-treated, or that they lack capacity and are living alone and not attending to their health needs. The Committee wrote to the Department seeking clarification on these matters. The Department’s response of 10 November 2015 stated:

“The Department does not understand the suggestion around the assessment of premises but would advise that concerns about a person’s living conditions will clearly be relevant for the purposes of clause 278. Clause 278 originates from Article 129 of the Mental Health (NI) Order 1986 which contains provision similar to the second suggestion made by Southern HSC Trust and the NI Approved Social Worker Training Programme. The Department is currently liaising with Counsel to clarify clause 278 so that its effect and scope is clearer on the face of the Bill”. (Appendix 4)

287. The Department proposed an amendment which was supported by the Committee.

Clause 280

288. The Southern HSC Trust and the NI Approved Social Worker Programme were concerned that this clause does not require the PSNI to support medical practitioners and social workers in bringing a person to hospital for detention. The Committee wrote to the Department seeking clarification on this matter. The Department's response of 10 November stated:

"It should be noted that clause 280 only covers individuals who are being removed from any place, or being taken to or detained in any place, under Part 9 of the Bill, or individuals being taken to or detained in any place under Part 10 of the Bill. In relation to Part 9, the individual will always be accompanied by a PSNI officer. In relation to individuals who are subject to Part 10, it is envisaged that these patients will be conveyed between healthcare and justice settings by a range of different professionals, as is currently the case. The HSC Trusts are currently responsible for transferring prisoners subject to transfer to direction orders from a healthcare setting to court hearings. Where there are risks involved in transporting a patient, a police officer will transport the patient along with a member of healthcare staff if necessary. When patients are sent to prison from Court, the Prisoner Escorting and Court Custody Service (PECCs) will transport the prisoner to prison, unless this happens in a 'special' court sitting i.e. a Saturday or Bank Holiday (with the exception of Laganside Court where PECCs do provide this service).

PECCs staff are also responsible for transporting prisoners who are returning from an external healthcare facility to prison, although on occasions they may be accompanied by Trust nursing staff depending on the capacity of the prisoner". (Appendix 4)

289. The Committee was content with the Department's explanation.

Clause 283

290. Clause 283 deals with the panels which will consider applications to authorise detentions and extensions of Public Protection Orders made without restrictions. Given the seriousness of the decisions these panels will be taking, in terms of the impact on an individual's liberty, the Committee was concerned that clause 283 does not specify quorum requirements, but simply states that the panel has three members. The Committee also queried the fact that the clause states that provision for cases where the panel cannot reach a unanimous decision will be provided for in the regulations. The Committee therefore wrote to the Department advising that it favoured a quorum of three being specified on the face of the Bill, and to ask for its views on the suggestion that for cases where the panel cannot reach a unanimous decision, for the decision to be taken on a majority vote (i.e. 2 to 1).

291. In terms of the quorum issue, the Department proposed an amendment to clarify that all 3 panel members must be in attendance during proceedings of the panel, which included when a decision is to be made. This was supported by the Committee.

292. In relation to the majority vote issue, in a letter dated 26 November, the Department responded as follows:

"We discussed the Committee's proposal with professional colleagues who have identified a number of issues. For example, it is possible that the panel member in the minority may be the one with the most relevant expertise and experience. In the Department's view, this casts doubt on whether a 'one size fits all' approach would work particularly given that the cases coming before the panel will be wide ranging.

In light of this, the Department is not minded to bring forward the requested amendment and remains of the view that dealing with this matter in regulations is the most prudent approach (as already provided for in subsection (4)(d))". (Appendix 4)

293. The Committee wrote to the Department to ask it for information on the expected composition of the panels, in terms of the expertise and experience which panel members will be required to have. The Committee also requested information on the Department's current thinking on how cases would be dealt

with where the panel cannot reach a unanimous decision. The Department's response of 4 January 2016 stated:

"The exact composition of the Trust panels will vary depending on the type of case requiring authorisation but, at this stage, we would anticipate there being a mixture of expert and lay panel members. The expertise and experience of those members (which we intend to address in regulations made under clause 283(3)) will necessarily reflect the needs of the person in respect of whom an authorisation is being sought and the nature of the intervention being proposed. For example, where major surgery is being proposed, a panel member with surgical expertise will be required. In other cases, a consultant psychiatrist may need to be on the panel if a particularly serious treatment for a mental disorder is involved; or a social worker if for example the issue is whether an elderly person should be moved from his/her home in circumstances amounting to a deprivation of his/her liberty.

The Department would wish to advise the Committee that it intends to consult further with professional colleagues on how to deal with cases where a unanimous decision cannot be reached. This work will inform any regulations to be made under clause 283(4). Current thinking, based on initial consultations, is that while a majority vote may be appropriate in some cases, it may not in others and the Department remains of the view that dealing with this and other procedural issues in regulations is the most prudent approach given the wide scope of this Bill". (Appendix 4)

294. The Committee took the view that it is not ideal that such matters should be left to regulations. However, given the number of unknown factors at this stage in terms of the composition of panels, and the complexity of cases they may be dealing with, the Committee agreed that it would not be feasible to specify the procedures on the face of the Bill.

Clause 285

295. The Committee questioned why clause 285 only seems to consider the past behaviour of the individual - either they have been violent in the past, or other people have been afraid of them in the past. Situations where the individual is

threatening future violence against others do not seem to have been included in the clause. The Department's response of 10 November stated:

"DHSSPS would wish to advise the Committee that clause 285 is a qualifying provision and must be viewed together with the operative provisions in the Bill, of which there are many. For example, clause 24(2)(c) which read with clause 25(5)(a) and (b), requires that detention is a proportionate response to the likelihood of harm to P, or of physical harm to other persons and the seriousness of the harm concerned. For that purpose a predictive judgement is therefore required and future actions can be considered". (Appendix 4)

296. The Committee was content with the Department's clarification on this issue.

Clause 288

297. The Committee was concerned that clause 288 gives the Department substantial powers to amend, repeal, or modify primary legislation passed by the Assembly by way of secondary legislation. The Committee recognised that the Department does need some flexibility given the size and complexity of the Bill, however, it was not prepared to support clause 288 as drafted. The Committee asked the Department to provide it with examples of the types of scenarios in which it might require powers to amend the Act. In a letter dated 10 November, the Department provided the following information:

"The types of scenarios that clause 288 would cover include, for example:

Amendment of the Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003 to align the Regulation and Quality Improvement Authority's role with the requirements of the Bill.

Transitional arrangements in respect of children turning 16 years of age.

Consequential amendments to include (but not limited to): Health and Personal Social Services (NI) Order 1972; The Registered Homes (NI) Order 1992; The Industrial Relations (NI) Order 1987; The Child Support (NI) Order 1991; The Pensions (NI) Order 1995; The Adoption (NI) Order 1987". (Appendix 4)

298. The Committee requested that the Department prepared a more limited version of clause 288 for its consideration.

299. In a letter dated 26 November, the Department advised:

“In light of recent correspondence, the Department anticipates that the Committee will indicate, in its final report, that it regards clause 288 (as introduced) as too wide, that it is only prepared to allow powers that we can establish are needed and that it has accordingly asked the Departments to bring forward amendments to address its concerns.

As requested, therefore, draft amendments to clause 288 for the Committee’s consideration can be found in Annex A of my separate letter of today’s date on Departmental amendments.

The effect of making these amendments will be to reduce the powers conferred by the Bill, which the Departments thought prudent to include in order to deal with the ‘unknown unknowns’ given the size and complexity of this Bill. This change of approach will of course increase the risk of needing a further Bill to supplement the Mental Capacity Act (if enacted).

The Committee will also wish to note that there may be further powers required to amend Part 11 as there are still proposed amendments outstanding on this matter. As Part 11 regards transfers to other jurisdictions, a subordinate legislation power to amend Part 11 would allow the Departments to respond to legislative changes in other jurisdictions within the United Kingdom without the requirement of another Bill. Finally, the Departments may also need to revisit the amendments to clause 288 in light of any non-departmental amendments passed at consideration stage”. (Appendix 4)

300. The Committee wrote to the Department to ask for clarification on what powers it had conceded through the proposed amendments to replace clause 288. The Committee also requested information on the purpose of the proposed amendment to clause 290 and how and when those powers would be expected to be used. The Department’s response dated 4 January 2016 stated:

“The main effect of the proposed amendments to clause 288 is to remove the power in subsection (2) to amend or modify other primary legislation in regulations, for all but one of the purposes listed in subsection (1): consequential.

Similar powers to amend the Bill once enacted are now restricted to Part 11 only (see new clause 253(7) in the list of departmental amendments). For completeness, subsection (3) is replaced by new clause 58A which has the same effect. As previously advised, this change of approach will increase the chance of a further Bill being required in the future to supplement or amend the Act.

The residual power to amend other primary legislation in consequence of the Bill once enacted is provided for in the amendment to clause 290. It will be used to, for example, amend and substitute references to the “Mental Health (NI) Order 1986” in other primary legislation with the “Mental Capacity Act”, where appropriate. Some examples include:

The Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003;

The Jobseeker’s Allowance Regulations (NI) 1996;

Justice Act (NI) 2015;

Human Trafficking and Exploitation (Criminal Justice and Support for Victims) Act (NI) 2015;

Transport Act (NI) 2011;

Goods Vehicles (Licensing of Operators) Act (NI) 2010;

Charities Act (NI) 2008; and

The Marriage (NI) Order 2003”. (Appendix 4)

301. The Committee supported the Department’s decision to remove clause 288 from the Bill, and the related amendments to clauses 289, 290, 294 and new clause 58A. The Committee believed that these changes provide the Department with more appropriate powers in terms of being able to amend the Act and other legislation as a consequence of the Bill coming into operation.

Clause 293

302. The Law Centre suggested amending the definition of “deprivation of liberty” to reflect that it refers to a person who is under continuous supervision and not

free to leave. The Department's response was that it had purposely framed the definition around Article 5 of the Human Rights Convention to ensure that the Bill remains compliant with Article 5, should case law develop. However, the code of practice will contain details of what a deprivation of liberty might entail in a range of situations. The Committee was content with the Department's rationale on this matter.

COSTS ASSOCIATED WITH THE BILL

303. The introduction of the Bill will require a substantial change to both practice and culture across the health and social care and justice sectors. This change will come at a significant financial cost in a number of areas including staff training, additional staffing, costs associated with Legal Aid for cases brought under the legislation, and the establishment and operation of the Review Tribunal and the Office of the Public Guardian.

304. Figures in the Explanatory and Financial Memorandum (EFM) estimated financial implications to both DHSSPS and DOJ in the range of £75.8 to £129.2 million for the first year of implementation, followed by £68 to £102.7 million for recurrent costs. The EFM also stated that the departmental estimates had not been finalised:

“DHSSPS and DoJ will further refine the estimated costs through, for example, changing existing practices, getting better value from resources already deployed and reallocating current priorities. Crucially, commencement of the Bill can be delayed or phased, pending the resolution of financial issues”.

305. Given the high level of estimated costs referred to in the EFM and the uncertainty as to how the Bill would be funded, the Committee commissioned five Assembly Research papers on a number of areas (Appendix 5). The key points from these papers are set out below.

Assessing the Costs

306. This paper looked at, amongst other issues, the available headline financial information regarding the Bill. It flagged up the significant reliance in the Bill

on the use of secondary legislation to fully implement the provisions. This means that much of the detail regarding the implementation of the Bill is relatively unformulated at this stage, and therefore associated costs are made more difficult to predict.

Training Costs

307. The EFM stated that given that the introduction of the legislation will require a significant change to practice and culture across the HSC, the estimated costs of the Bill are based on the assumption that the entire HSC workforce will need to receive training.
308. The paper referred to the House of Lords Select Committee's report on the Mental Capacity Act 2005. This was a post-legislative scrutiny report which was published in 2014 and made significant recommendations regarding training and awareness for healthcare professionals. The research paper also pointed to a Care Quality Commission report on the Mental Capacity Act 2005, which highlighted that awareness and understanding of the Act among staff was not widespread. These reports both point to the importance of staff training when a new legislative framework is introduced, which obviously has significant cost implications. This theme also emerged during the Departments' consultation on the draft Bill. In its report on the consultation responses, the DHSSPS noted that "*more than half of the responses in relation to implementation commented on the need for training*".
309. The DHSSPS provided two potential costs for training in the EFM - £21.58 million for a new legislation training programme or alternatively, £4.08 million if training was subsumed into existing provision. The research paper highlighted that these were two separate stand-alone figures, rather than a range, whereby the costs may fall at any point along a continuum.
310. Training costs for DoJ in terms of the criminal justice elements of the Bill are quoted as £75,000 for year 1, and £15,000 for years 2 & 3. The research paper pointed out that these figures appear to be very low, and raised the question of whether they cover training for the PSNI.

Deprivation of liberty assessment costs

311. One element of the pre-implementation costs associated with the Bill is the assessment of existing populations within care homes or other supported settings in terms of whether people are being deprived of their liberty.
312. In the EFM, the DHSSPS provided two scenarios in terms of estimating the costs of deprivation of liberty assessments. The first was based on staff performing three assessments per day, amounting to £4.88 million. The second estimate was based on four assessments per day, amounting to £3.71 million. However, the DHSSPS confirmed to the researcher that after engagement with HSC Trusts, three assessments per day was the more likely option at the higher cost of £4.88 million.
313. Further to this information, the DHSSPS then advised that the above figures were based on the assumption that the entire existing population within care homes or other supported settings would need to be assessed. However, as of June 2015, the DHSSPS was of the view that the entire population would not require assessment, but rather the number would be somewhere in the range of 3,800 - 16,000 people.
314. As well as this uncertainty in terms of the number of assessments required, the research paper pointed out that the cost-per-assessment was still relatively unknown because the assessment structure will only be defined by regulations following the enactment of the Bill.

DHSSPS Recurring Costs

315. The DHSSPS has estimated its recurring costs as somewhere between £64 million and £91 million per year. These estimates include costs associated with supporting a person to make a decision; routine interventions; serious interventions; and very serious interventions. They are based on two fundamental factors - the number of interventions and the staff resource required to undertake the intervention.
316. The research paper examined the assumptions which these estimates rely on. In terms of the projected number of assessments, questions were asked around why the DHSSPS was relying on a figure of 5% of people in Northern

Ireland having a learning disability; the reliance on Scottish data in terms of compulsory treatment; the reliance on data from England and Wales in terms of deprivation of liberty detentions; and the exclusion of demographics as a relevant consideration.

317. In relation to staff time needed to undertake interventions, the research paper queried why the DHSSPS had excluded the data received from the Belfast HSC Trust in terms of calculating its estimates.

DoJ Recurring Costs

318. The DoJ has estimated its recurring costs as somewhere between £4 million and £11 million per year. These estimates include costs associated with general criminal justice; protection order service provision; training; Review Tribunal; legal aid; and the Office of the Public Guardian.

319. The research paper examined the assumptions which these estimates rely on. It pointed out that the DoJ was working on the basis of the current prison population figures, in terms of healthcare provision for mentally disordered individuals and the transfer of prisoners to Great Britain for specialist provision. It also flagged up that the legal aid costs associated with the Review Tribunal were based on a wide projection of between 25% and 75% of interventions resulting in an action in the Review Tribunal.

320. In terms of the Office of the Public Guardian, the yearly running costs have been estimated as between £1.4 million and £1.8 million. In addition, the set-up costs are estimated at £1.25 million. The research paper provided comparative data on the Office of the Public Guardian in England and Wales in terms of its workforce and its approach to fees and income.

Committee consideration of costs

321. In view of the issues raised in the research papers and the significant costs associated with the Bill, the Committee held an evidence session on 2 November 2015 with officials from DHSSPS, DOJ and NICTS. The key objectives were to ascertain the accuracy of the Departments' costings, to assess

whether these costs were likely to be affordable in terms of implementing the Bill, and to identify any areas within the Bill which could be amended in order to reduce costs. The Hansard of the evidence session can be found at Appendix 2.

322. In terms of the accuracy of the costings provided in the EFM, officials advised that they were in the process of refining them and planned to have a more robust statement of costs by the end of 2015. A letter was subsequently received from the Department dated 14 January 2016 (Appendix 4). The Department advised that the estimated costs had been reduced as follows:

“We are now working on the basis of a range of £76.4m to £84.7m for year one implementation costs; and £68.6m to £76.9m for recurrent costs (across DHSSPS and DoJ).

For DHSSPS specifically, the year one figure from phase two of the costings exercise is estimated at £71.8m, with recurrent costs estimated at £64m. This reduction has been mainly achieved by challenging and then reducing the assumptions made by HSC Trusts in calculating the amount of staff time that will be required under the new legislation.

DoJ costs have been revised upwards from £4m - £11m to an estimated £4.4m - £13m. This revision in costs is mainly due to an increase in the estimated number of individuals subject to the interventions and authorisations within the Bill. As a consequence of this increase, there will be a corresponding increase in numbers eligible to apply to the Review Tribunal and for legal aid. Review Tribunal costs have also been revised to now include an estimate for travel and subsistence for panel and staff members, which have been calculated on current average costs. The costs to the Review Tribunal of defending judicial reviews are also now included in the revised estimates.

A further phase of the costings exercise is well under way and more reductions in estimates can be expected, as we are now subjecting the staff costs to further rigorous analysis, including use of recent comparative information with other jurisdictions”.

323. On the issue of whether the overall cost of implementing the Bill could be reduced, the Department stated that there was the potential to undertake a staged implementation. However, that notion came with the following caveat:

“As I imagine the Committee has gathered by now, a lot of the Bill hangs together as a piece, so to work through what bits are more of a priority than others would probably be quite complex to do. We would probably need to have fairly extensive consultation if we were to break up the Bill in that way”. (Appendix 2)

324. The affordability of the Bill as a whole was of key concern to the Committee, given the current and future financial climate. Officials provided the following response to that issue:

“On the Bill’s affordability, it will have to be bid for as part of a comprehensive spending review bid. The outcome of that is unknowable. It is difficult to say where we will be by the time that we get to that stage . . . There are options in the event that the financial situation is not resolved through the CSR, which is a possibility. Again, decisions are required at a political level that go beyond us. We will give policy advice about what we think, but, given the other pressures on the health service at the minute, any financial question has to be decided on in the round”. (Appendix 2)

325. The Committee was seriously concerned about the lack of certainty around whether the monies will be allocated by the relevant Departments in order to allow the Bill to be implemented. Given that the Bill is introducing mental capacity legislation to Northern Ireland for the first time, and fusing it with reformed mental health legislation, the Committee believed it was unsatisfactory that the funding arrangements had not been put in place for such a significant change to the law.

Clause by Clause Consideration

326. The Committee undertook its clause-by-clause consideration of the Bill on 11 January 2016. Information on the Committee’s deliberations on the individual clauses in the Bill, which sets out the context of the decisions reached by the Committee, can be found in the previous section of this report. Details of the Department’s proposed amendments can be found in the correspondence dated 4 January 2016 in Appendix 4.

327. Clause 1- Principles: capacity

Agreed: the Committee is content with Clause 1 as drafted.

328. Clause 2 - Principle: best interests

Agreed: the Committee is content with Clause 2 as drafted.

329. Clause 3 - Meaning of “lacks capacity”

Agreed: the Committee is content with Clause 3 as drafted.

330. Clause 4 - Meaning of “unable to make a decision”

Agreed: the Committee is content with Clause 4 subject to the amendment proposed by the Department to ensure that references to enabling a person to make a decision, or helping a person to make a decision, are read as enabling the person to do the things in clause 4 (1) (a) to (d).

331. Clause 5 - Supporting person to make decision

Agreed: the Committee is content with Clause 5 subject to the amendment proposed by the Department to amplify what is said in clause 5 (2) in a way that brings out the point that help and support must be given to enable the person to communicate his or her decision.

332. Clause 6 - Compliance with section 1(2)

Agreed: the Committee is content with Clause 6 as drafted.

333. Clause 7 - Best interests

Agreed: the Committee is content with Clause 7 subject to the amendments proposed by the Department: to change reference to “independent advocate”

to “independent mental capacity advocate”; and to make reference to an attorney acting under EPA to be a relevant person.

334. Clause 8 - Compliance with section 2

Agreed: the Committee is content with Clause 8 as drafted.

335. Clause 9 - Protection from liability for acts in best interests of person lacking capacity

Agreed: the Committee is content with Clause 9 subject to the amendment proposed by the Department to change reference to “independent advocate” to “independent mental capacity advocate”.

336. Clause 10 - General limitations on section 9

Agreed: the Committee is content with Clause 10 as drafted.

337. Clause 11 - Advance decisions: effect on section 9

Agreed: the Committee is content with Clause 11 as drafted.

338. Clause 12 - Acts of restraint: condition that must be met

Agreed: the Committee is content with Clause 12 as drafted.

339. Clause 13 - Formal assessment of capacity

Agreed: the Committee is content with Clause 13 as drafted.

340. Clause 14 - Section 13: formal capacity assessments and statements of incapacity

Agreed: the Committee is content with Clause 14 subject to the technical amendment proposed by the Department.

341. Clause 15 - Nominated person: need to have in place and consult

Agreed: the Committee is content with Clause 15 as drafted.

342. Clause 16 - Second opinion needed for certain treatment

Agreed: the Committee is content with Clause 16 subject to the technical amendment proposed by the Department.

343. Clause 17 - Second opinion needed for continuation of medication

Agreed: the Committee is content with Clause 17 as drafted.

344. Clause 18 - Second opinion: relevant certificates

Agreed: the Committee is content with Clause 18 subject to the amendments proposed by the Department: to ensure that the doctor must examine P and any relevant health records before providing a certificate; to clarify that the doctor providing the second opinion should be independent of the doctor providing the treatment; and technical amendments.

345. Clause 19 - Treatment with serious consequences: objection from nominated person

Agreed: the Committee is content with Clause 19 as drafted.

346. Clause 20 - Meaning of “treatment with serious consequences”

Agreed: the Committee is content with Clause 20 as drafted.

347. Clause 21 - Section 19: the prevention of serious harm condition

Agreed: the Committee is content with Clause 21 subject to the amendment proposed by the Committee consequential to the Committee amendment to clause 22 as follows:

Clause 21, page 13, line 10

Leave out ‘section 19’ and insert ‘sections 19 and 22’

348. Clause 22 - Resistance etc by P to provision of certain treatment

Agreed: the Committee is content with Clause 22 subject to the amendments proposed by the Committee which together would require that the prevention of serious harm condition, as set out in clause 21, would have to be met in the event of P resisting the act as follows:

Clause 22, page 13, line 38

Leave out from ‘(and’ to the end of line 39 and insert -

‘; and (b) the prevention of serious harm condition (as well as the conditions of section 9(1)(c) and (d), and any other conditions that apply under this Part) is met.’

Clause 22, page 13, line 40

Leave out ‘This section’ and insert ‘Subsection (2)(a)’

Clause 22, page 14, line 1

Leave out '(2)' and insert '(2)(a)'

Clause 22, page 14, line 3

At end insert-

'(5) See section 21 for the prevention of serious harm condition.'

349. Clause 23 - Meaning of “subject to an additional measure”

Agreed: the Committee is content with Clause 23 subject to the amendment proposed by the Department to include supervision and assessment orders as an “additional measure” for the purpose of the Bill.

350. Clause 24 - Deprivation of liberty

Agreed: the Committee is content with Clause 24 as drafted.

351. Clause 25 - Section 24: definitions

Agreed: the Committee is content with Clause 25 as drafted.

352. Clause 26 - Taking person to a place for deprivation of liberty

Agreed: the Committee is content with Clause 26 as drafted.

353. Clause 27 - Permission for absence

Agreed: the Committee is content with Clause 27 as drafted.

354. Clause 28 - Requirements to attend for certain treatment

Agreed: the Committee is content with Clause 28 subject to the technical amendments proposed by the Department.

355. Clause 29 - Duty to revoke requirement where criteria no longer met

Agreed: the Committee is content with Clause 29 as drafted.

356. Clause 30 - Community residence requirements: authorisation etc

Agreed: the Committee is content with Clause 30 as drafted.

357. Clause 31 - Meaning of “community residence requirement”

Agreed: the Committee is content with Clause 31 subject to the technical amendments proposed by the Department.

358. Clause 32 - Duty to revoke community residence requirements where criteria no longer met

Agreed: the Committee is content with Clause 32 as drafted.

359. Clause 33 - Duties in relation to people subject to community residence requirements

Agreed: the Committee is content with Clause 33 as drafted.

360. Clause 34- Community residence requirements: further provision

Agreed: the Committee is content with Clause 34 as drafted.

361. Clause 35 - Independent advocate: need to have in place and consult

Agreed: the Committee is content with Clause 35 subject to the amendments proposed by the Department to change reference to “independent advocate” to “independent mental capacity advocate”.

362. Clause 36 - Section 35: relevant acts

Agreed: the Committee is content with Clause 36 subject to the technical amendment proposed by the Department.

363. Clause 37 - First extension of period of authorisation

Agreed: the Committee is content with Clause 37 as drafted.

364. Clause 38 - Subsequent extensions

Agreed: the Committee is content with Clause 38 as drafted.

365. Clause 39 - Sections 37 and 38: extension reports

Agreed: the Committee is content with Clause 39 subject to the technical amendment proposed by the Department.

366. Clause 40 - Extension of period where responsible person not of the requisite opinion

Agreed: the Committee is content with Clause 40 as drafted.

367. Clause 41 - Meaning of “measure”, “authorised measure” and “the criteria for continuation”

Agreed: the Committee is content with Clause 41 as drafted.

368. Clause 42 - Meaning of “the responsible person”

Agreed: the Committee is content with Clause 42 as drafted.

369. Clause 43 - Extension reports: further provision

Agreed: the Committee is content with Clause 43 subject to the amendments proposed by the Department: to change reference to “independent advocate” to “independent mental capacity advocate”; and the technical amendment.

370. Clause 44 - Effect of extension on authorisation where authorised measure unused etc

Agreed: the Committee is content with Clause 44 as drafted.

371. Clause 45 - Right to apply to Tribunal

Agreed: the Committee is content with Clause 45 as drafted.

372. Clause 46 - Applications: visiting and examination

Agreed: the Committee is content with Clause 46 as drafted.

373. Clause 47 - Power of certain persons to refer case to Tribunal

Agreed: the Committee is content with Clause 47 as drafted.

374. Clause 48 - Duty of HSC trust to refer case to Tribunal

Agreed: the Committee is content with Clause 48 subject to the technical amendments proposed by the Department.

375. New Clause 48A - References etc to Tribunal: persons formally detained under the Mental Health Order

Agreed: the Committee is content with the amendment proposed by the Department to insert a new Clause 48A.

376. Clause 49 - Duty of HSC trust to notify the Attorney General

Agreed: the Committee is content with Clause 49 subject to the technical amendment proposed by the Department.

377. Clause 50 - Powers of Tribunal in relation to authorisation under Schedule 1

Agreed: the Committee is content with Clause 50 as drafted.

378. Clause 51 - Powers of Tribunal in relation to authorisation under Schedule 2

Agreed: the Committee is content with Clause 51 subject to the technical amendment proposed by the Department.

379. New Clause 51A - Sections 50 and 51: additional powers of Tribunal

Agreed: the Committee is content with the amendment proposed by the Department to insert a new Clause 51A.

380. Clause 52 - Medical reports: involvement of nominated person

Agreed: the Committee is content with Clause 52 subject to the amendment proposed by the Department to change reference to “independent advocate” to “independent mental capacity advocate”.

381. Clause 53 - Medical reports: involvement of independent advocate

Agreed: the Committee is content with Clause 53 subject to the amendments proposed by the Department to change reference to “independent advocate” to “independent mental capacity advocate”.

382. Clause 54 - Sections 52 and 53: meaning of “emergency”

Agreed: the Committee is content with Clause 54 subject to the amendment proposed by the Department to change reference to “independent advocate” to “independent mental capacity advocate”.

383. Clause 55 - Provision of information

Agreed: the Committee is content with Clause 55 as drafted.

384. Clause 56 - Ways in which information must be provided

Agreed: the Committee is content with Clause 56 as drafted.

385. Clause 57 - Failure by person other than D to take certain steps

Agreed: the Committee is content with Clause 57 as drafted.

386. Clause 58 - Part 2 not applicable where other authority for act

Agreed: the Committee is content with Clause 58 subject to the technical amendment proposed by the Department.

387. New Clause 58A - Power to make further provision

Agreed: the Committee is content with the amendment proposed by the Department to insert a new Clause 58A.

388. Clause 59 - Disregards of certain detention

Agreed: the Committee is content with Clause 59 subject to the technical amendments proposed by the Department.

389. Clause 60- “Serious intervention”

Agreed: the Committee is content with Clause 60 as drafted.

390. Clause 61 - Acts that are “part of” serious interventions

Agreed: the Committee is content with Clause 61 as drafted.

391. Clause 62 - Meaning of “emergency” in relation to safeguard provisions

Agreed: the Committee is content with Clause 62 as drafted.

392. Clause 63 - Section 62: definitions etc

Agreed: the Committee is content with Clause 63 subject to the amendment proposed by the Department to change reference to “independent advocate” to “independent mental capacity advocate”.

393. Clause 64 - Failure by persons other than D to take steps to ensure safeguard met

Agreed: the Committee is content with Clause 64 as drafted.

394. Clause 65 - References to treatment “likely” to be treatment with serious consequences

Agreed: the Committee is not content with Clause 65 as drafted.

395. Clause 66 - Interpretation of Part 2: general

Agreed: the Committee is content with Clause 66 subject to the technical amendment proposed by the Department.

396. Clause 67 - Nominated person

Agreed: the Committee is content with Clause 67 as drafted.

397. Clause 68 - Appointment of nominated person

Agreed: the Committee is content with Clause 68 as drafted.

398. Clause 69 - Revocation of appointment

Agreed: the Committee is content with Clause 69 as drafted.

399. Clause 70 - Resignation

Agreed: the Committee is content with Clause 70 as drafted.

400. Clause 71 - Default nominated person

Agreed: the Committee is content with Clause 71 as drafted.

401. Clause 72 - Section 71: the list

Agreed: the Committee is content with Clause 72 as drafted.

402. Clause 73 - Section 71: persons to be disregarded

Agreed: the Committee is content with Clause 73 as drafted.

403. Clause 74 - Section 71: meaning of “carer”

Agreed: the Committee is content with Clause 74 as drafted.

404. Clause 75 - Declaration that particular person not to be nominated person

Agreed: the Committee is content with Clause 75 as drafted.

405. Clause 76 - Notice declining to be a person’s nominated person

Agreed: the Committee is content with Clause 76 as drafted.

406. Clause 77 - Formalities for documents under Part 3

Agreed: the Committee is content with Clause 77 subject to the amendment proposed by the Department to clarify the nature of information that may be disclosed to the nominated person and to align the language used in the Bill with the Data Protection Act 1998.

407. Clause 78 - Application to Tribunal for appointment of nominated person

Agreed: the Committee is content with Clause 78 subject to the amendments proposed by the Department to: insert a reference to an attorney under an enduring power of attorney in the list of qualifying persons who may apply to the Tribunal for appointment of a nominated person; and the technical amendment.

408. Clause 79 - Tribunal’s power to appoint nominated person

Agreed: the Committee is content with Clause 79 as drafted.

409. Clause 80 - Tribunal's power to disqualify person from being default nominated person

Agreed: the Committee is content with Clause 80 as drafted.

410. Clause 81 - Revocation of Tribunals' appointment where P regains capacity

Agreed: the Committee is content with Clause 81 as drafted.

411. Clause 82 - Duties in relation to nominated person: supplementary

Agreed: the Committee is content with Clause 82 as drafted.

412. Clause 83 - Determining who is nominated person

Agreed: the Committee is content with Clause 83 as drafted.

413. Clause 84 - Independent advocates

Agreed: the Committee is content with Clause 84 subject to the amendments proposed by the Department to: leave out the words "so far as practicable" which will strengthen the principle that HSC Trusts must have regard to when commissioning and instructing an advocate for the purposes of the Bill; and to change references from "independent advocate" to "independent mental capacity advocate".

414. Clause 85 - Functions of independent advocates: provision of support etc

Agreed: the Committee is content with Clause 85 subject to the amendments proposed by the Department to change references from "independent advocate" to "independent mental capacity advocate".

415. Clause 86 - Request for independent advocates to be instructed

Agreed: the Committee is content with Clause 86 subject to the amendments proposed by the Department to: change references from "independent advocate" to "independent mental capacity advocate"; and the technical amendment.

416. Clause 87 - Steps to be taken before independent advocate may be required

Agreed: the Committee is content with Clause 87 subject to the amendments proposed by the Department to: change references from "independent advocate" to "independent mental capacity advocate"; and to clarify the nature of

information that may be disclosed to an independent advocate and aligns the language used in the Bill with the Data Protection Act 1998.

417. Clause 88 - Right to declare that no independent advocated to be instructed

Agreed: the Committee is content with Clause 88 subject to the amendments proposed by the Department to change references from “independent advocate” to “independent mental capacity advocate”.

418. Clause 89 - Instruction of independent advocate

Agreed: the Committee is content with Clause 89 subject to the amendments proposed by the Department to change references from “independent advocate” to “independent mental capacity advocate”.

419. Clause 90 - Powers of independent advocates

Agreed: the Committee is content with Clause 90 subject to the amendments proposed by the Department to change references from “independent advocate” to “independent mental capacity advocate”.

420. Clause 91 - Right of person to discontinue involvement of independent advocate

Agreed: the Committee is content with Clause 91 subject to the amendments proposed by the Department to change references from “independent advocate” to “independent mental capacity advocate”.

421. Clause 92 - Continuing duty of trust in relation to independent advocate

Agreed: the Committee is content with Clause 92 subject to the amendments proposed by the Department to change references from “independent advocate” to “independent mental capacity advocate”.

422. Clause 93 - Formalities for declarations under Part 4

Agreed: the Committee is content with Clause 93 as drafted.

423. Clause 94 - Power to adjust role of independent advocate

Agreed: the Committee is content with Clause 94 subject to the amendments proposed by the Department to change references from “independent advocate” to “independent mental capacity advocate”.

424. Clause 95 - Lasting powers of attorney

Agreed: the Committee is content with Clause 95 as drafted.

425. Clause 96 - Restrictions on scope of lasting power of attorney

Agreed: the Committee is content with Clause 96 as drafted.

426. Clause 97 - Relationships between advance decisions and lasting powers of attorney

Agreed: the Committee is content with Clause 97 as drafted.

427. Clause 98 - Scope of lasting powers of attorney: gifts

Agreed: the Committee is content with Clause 98 as drafted.

428. Clause 99 - Appointment of attorneys: requirements as respects attorneys

Agreed: the Committee is content with Clause 99 as drafted.

429. Clause 100 - Appointment of two or more attorneys

Agreed: the Committee is content with Clause 100 as drafted.

430. Clause 101 - Appointment of replacement attorneys

Agreed: the Committee is content with Clause 101 as drafted.

431. Clause 102 - Appointment of two or more replacements for a single initial appointee

Agreed: the Committee is content with Clause 102 as drafted.

432. Clause 103 - Replacement attorneys: position where two or more initial appointees

Agreed: the Committee is content with Clause 103 as drafted.

433. Clause 104 - Revocation of lasting power etc by donor or on donor's bankruptcy

Agreed: the Committee is content with Clause 104 as drafted.

434. Clause 105 - Revocation etc: events relating to the attorney

Agreed: the Committee is content with Clause 105 as drafted.

435. Clause 106 - Protection of attorney and others if no power created or power revoked

Agreed: the Committee is content with Clause 106 as drafted.

436. Clause 107 - Reliance on authority of attorney in relation to treatment etc

Agreed: the Committee is content with Clause 107 as drafted.

437. Clause 108 - Powers of court as to lasting powers of attorney

Agreed: the Committee is content with Clause 108 as drafted.

438. Clause 109 - Powers of court as to operation of lasting powers of attorney

Agreed: the Committee is content with Clause 109 as drafted.

439. Clause 110 - Enduring powers of attorney

Agreed: the Committee is not content with Clause 110 as drafted.

The Committee agreed to formally register opposition to clause 110 with the Bill Office.

440. Clause 111 - The court's power to make declarations

Agreed: the Committee is content with Clause 111 as drafted.

441. Clause 112 - the court's power to make decisions and appoint deputies: general

Agreed: the Committee is content with Clause 112 as drafted.

442. Clause 113 - Section 112 powers: care, treatment and personal welfare

Agreed: the Committee is content with Clause 113 subject to the technical amendment proposed by the Department.

443. Clause 114 - Section 112 powers: property and affairs

Agreed: the Committee is content with Clause 114 as drafted.

444. Clause 115 - Appointment of deputies

Agreed: the Committee is content with Clause 115 subject to the technical amendments proposed by the Department.

445. Clause 116 - Restrictions on deputies

Agreed: the Committee is content with Clause 116 subject to the amendment proposed by the Department to make reference to an EPA, so that a deputy may not be given a power to make a decision on behalf of P that is inconsistent with a decision made by an attorney acting under an EPA.

446. Clause 117 - Reliance on authority of deputy in relation to treatment etc

Agreed: the Committee is content with Clause 117 as drafted.

447. Clause 118 - Interim orders and directions

Agreed: the Committee is content with Clause 118 as drafted.

448. Clause 119 - Power to call for reports

Agreed: the Committee is content with Clause 119 as drafted.

449. Clause 120 - Powers of Public Guardian or Court Visitor in respect of reports under section 119(2)

Agreed: the Committee is content with Clause 120 as drafted.

450. Clause 121 - Applications to the court

Agreed: the Committee is content with Clause 121 subject to the amendments proposed by the Department to: ensure that the donor of, or an attorney under, an enduring power of attorney can apply to the court under Part 6 without leave; and technical amendments.

451. New Clause 121A - Duty to notify Attorney General

Agreed: the Committee is content with the amendment proposed by the Department to insert a new Clause 121A.

452. Clause 122 - Rules of court

Agreed: the Committee is content with Clause 122 subject to the technical amendments proposed by the Department.

453. Clause 123 - The Public Guardian

Agreed: the Committee is content with Clause 123 as drafted.

454. Clause 124 - Functions of the Public Guardian

Agreed: the Committee is content with Clause 124 as drafted.

455. Clause 125 - Further powers of the Public Guardian

Agreed: the Committee is content with Clause 125 subject to the amendment proposed by the Department to ensure that all providers of care in Northern

Ireland are covered by the clause, and thus required to provide the Public Guardian with P's records.

456. Clause 126 - Duty to notify the Public Guardian

Agreed: the Committee is content with Clause 126 as drafted.

457. Clause 127 - Notifications under section 126: procedure and effect

Agreed: the Committee is content with Clause 127 subject to the technical amendments proposed by the Department.

458. Clause 128 - Court Visitors

Agreed: the Committee is content with Clause 128 as drafted.

459. Clause 129 - Powers of Court Visitors

Agreed: the Committee is content with Clause 129 as drafted.

460. Clause 130 - Research

Agreed: the Committee is content with Clause 130 as drafted.

461. Clause 131 - Section 130: supplementary

Agreed: the Committee is content with Clause 131 subject to the amendment proposed by the Department to require the designation of any other regulations relating to clinical trials that are not to be treated as research for the purpose of Part 8, to be done by regulations subject to negative resolution.

462. Clause 132 - Approval of research projects

Agreed: the Committee is content with Clause 132 as drafted.

463. Clause 133 - Requirement to consult nominated person, carer etc

Agreed: the Committee is content with Clause 133 subject to the amendment proposed by the Department to make reference to an attorney under an enduring power of attorney in the list of people who can be consulted about P's involvement in a research project.

464. Clause 134 - Section 133: exception for urgent treatment

Agreed: the Committee is content with Clause 134 as drafted.

465. Clause 135 - Additional safeguards

Agreed: the Committee is content with Clause 135 as drafted.

466. Clause 136 - Loss of capacity during research project: transitional cases

Agreed: the Committee is content with Clause 136 as drafted.

467. Clause 137 - Power of police to remove person from public place to place of safety

Agreed: the Committee is content with Clause 137 subject to the amendments proposed by the Department to clarify that the potential of the individual to create a risk of serious “physical or psychological harm” to himself must be considered.

468. Clause 138 - Information to be given on removal

Agreed: the Committee is content with Clause 138 as drafted.

469. Clause 139 - Search of person on exercise of power to remove

Agreed: the Committee is content with Clause 139 subject to the technical amendments proposed by the Department.

470. Clause 140 - Power of police to detain in hospital a person removed from a public place

Agreed: the Committee is content with Clause 140 as drafted.

471. Clause 141 - Power to detain in police station a person removed from a public place

Agreed: the Committee is content with Clause 141 subject to the amendment proposed by the Department to clarify that the potential of the individual to create a risk of serious “physical or psychological harm” to himself must be considered.

472. Clause 142 - Sections 140 and 141: the detention conditions

Agreed: the Committee is content with Clause 142 subject to the amendments proposed by the Department to clarify that the potential of the individual to create a risk of serious “physical or psychological harm” to himself must be considered.

473. Clause 143 - Transfer from one place of safety to another

Agreed: the Committee is content with Clause 143 subject to the amendments proposed by the Department to clarify that the potential of the individual to create a risk of serious “physical or psychological harm” to himself must be considered.

474. Clause 144 - Maximum period of detention under Part 9

Agreed: the Committee is content with Clause 144 as drafted.

475. Clause 145 - Duty to inform certain persons where power of removal or transfer used

Agreed: the Committee is content with Clause 145 subject to the technical amendments proposed by the Department.

476. Clause 146 - Section 145: meaning of “the required information”

Agreed: the Committee is content with Clause 146 subject to the technical amendments proposed by the Department.

477. Clause 147 - Record of detention to be kept

Agreed: the Committee is content with Clause 147 as drafted.

478. Clause 148 - Responsibilities of the appropriate officer

Agreed: the Committee is content with Clause 148 as drafted.

479. Clause 149 - Review of detention

Agreed: the Committee is content with Clause 149 as drafted.

480. Clause 150 - Access to legal advice

Agreed: the Committee is content with Clause 150 as drafted.

481. Clause 151 - Searches of person following removal of place of safety

Agreed: the Committee is content with Clause 151 as drafted.

482. Clause 152 - Searches and examination to ascertain identity

Agreed: the Committee is content with Clause 152 as drafted.

483. Clause 153 - Intimate searches

Agreed: the Committee is content with Clause 153 subject to the technical amendment proposed by the Department.

484. Clause 154 - Annual records

Agreed: the Committee is content with Clause 154 subject to the amendments proposed by the Committee which together would require that separate statistics are collected for young people detained in hospital and police stations under these powers, and their ultimate disposal as follows:

Clause 154, page 84, line 5

At end insert-

'(c) the number of children detained under this Part in hospitals;

(d) the number of children detained under this Part in police stations;

(e) final disposals in respect of children detained as mentioned in paragraphs (c) and (d).

Clause 154, page 84, line 8

At end insert-

'(3) In this section "children" means persons under 18.'

485. Clause 155 - Principles applying for purposes of Part 9

Agreed: the Committee is content with Clause 155 subject to the technical amendment proposed by the Department.

486. Clause 156 - Reasonable belief etc

Agreed: the Committee is content with Clause 156 as drafted.

487. Clause 157 - Power of constable to use reasonable force

Agreed: the Committee is content with Clause 157 as drafted.

488. Clause 158 - Definitions for purposes of Part 9

Agreed: the Committee is content with Clause 158 subject to the technical amendment proposed by the Department.

489. Clause 159 - Relationship of Part 9 to other provisions

Agreed: the Committee is content with Clause 159 as drafted.

490. Clause 160 - Remand to hospital

Agreed: the Committee is content with Clause 160 as drafted.

491. Clause 161 - Section 160: meaning of “accused person”

Agreed: the Committee is content with Clause 161 as drafted.

492. Clause 162 - Section 160: the medical report condition

Agreed: the Committee is content with Clause 162 as drafted.

493. Clause 163 - Section 160 - the treatment condition

Agreed: the Committee is content with Clause 163 subject to the amendments proposed by the Department to: clarify that the potential of the individual to create a risk of serious “physical or psychological harm” to himself must be considered; and the technical amendment.

494. Clause 164 - Effect of remand to hospital

Agreed: the Committee is content with Clause 164 as drafted.

495. Clause 165 - Public protection orders with and without restrictions

Agreed: the Committee is content with Clause 165 as drafted.

496. Clause 166 - Section 165: the detention conditions

Agreed: the Committee is content with Clause 166 subject to the amendments proposed by the Department to: clarify that the potential of the individual to create a risk of serious “physical or psychological harm” to other persons must be considered; and the technical amendment.

497. Clause 167 - Section 165: the restriction condition

Agreed: the Committee is content with Clause 167 subject to the amendments proposed by the Department to clarify that the potential of the individual to create a risk of serious “physical or psychological harm” to other persons must be considered.

498. Clause 168 - Further provision about making of public protection orders

Agreed: the Committee is content with Clause 168 as drafted.

499. Clause 169 - Effect of public protection orders

Agreed: the Committee is content with Clause 169 as drafted.

500. Clause 170 - Power to direct the ending of restrictions under a public protection order

Agreed: the Committee is content with Clause 170 subject to the amendment proposed by the Department to ensure that that the potential of the individual to create a risk of serious physical or psychological harm to other persons must be considered.

501. Clause 171 - Effect of ending of restrictions under a public protection order

Agreed: the Committee is content with Clause 171 as drafted.

502. Clause 172 - Hospital direction when passing custodial sentence

Agreed: the Committee is content with Clause 172 as drafted.

503. Clause 173 - Conditions for giving hospital direction

Agreed: the Committee is content with Clause 173 subject to the amendments proposed by the Department to: ensure that that the potential of the individual to create a risk of serious physical or psychological harm to other persons must be considered; and the technical amendment.

504. Clause 174 - Effect of hospital directions

Agreed: the Committee is content with Clause 174 as drafted.

505. Clause 175 - Interim detention orders

Agreed: the Committee is content with Clause 175 as drafted.

506. Clause 176 - Effect of interim detention orders

Agreed: the Committee is content with Clause 176 as drafted.

507. Clause 177 - Detention under a public protection order without restrictions

Agreed: the Committee is content with Clause 177 as drafted.

508. Clause 178 - Discharge from detention by responsible medical practitioner

Agreed: the Committee is content with Clause 178 subject to the amendment proposed by the Department to ensure that that the potential of the individual to create a risk of serious physical or psychological harm to other persons must be considered.

509. Clause 179 - First extension of period of order

Agreed: the Committee is content with Clause 179 as drafted.

510. Clause 180 - Subsequent extensions

Agreed: the Committee is content with Clause 180 as drafted.

511. Clause 181 - Sections 179 and 180: extension reports

Agreed: the Committee is content with Clause 181 as drafted.

512. Clause 182 - Extension of period where responsible person not of the requisite opinion

Agreed: the Committee is content with Clause 182 as drafted.

513. Clause 183 - The criteria for continuation

Agreed: the Committee is content with Clause 183 subject to the amendment proposed by the Department to ensure that that the potential of the individual to create a risk of serious physical or psychological harm to other persons must be considered.

514. Clause 184 - Extension reports: further provision

Agreed: the Committee is content with Clause 184 as drafted.

515. Clause 185 - Permission for absence

Agreed: the Committee is content with Clause 185 as drafted.

516. Clause 186 - Transfers between hospitals etc

Agreed: the Committee is content with Clause 186 as drafted.

517. Clause 187 - Effect of custodial sentence

Agreed: the Committee is content with Clause 187 as drafted.

518. Clause 188 - Detention under a public protection order with restrictions

Agreed: the Committee is content with Clause 188 as drafted.

519. Clause 189 - Discharge from detention by Department of Justice

Agreed: the Committee is content with Clause 189 as drafted.

520. Clause 190 - Power to recall person who has been conditionally discharged

Agreed: the Committee is content with Clause 190 subject to the amendment proposed by the Department to ensure that that the potential of the individual

to create a risk of serious physical or psychological harm to other persons must be considered.

521. Clause 191 - Reports by responsible medical practitioner

Agreed: the Committee is content with Clause 191 as drafted.

522. Clause 192 - Direction for person to attend for purposes of justice etc

Agreed: the Committee is content with Clause 192 as drafted.

523. Clause 193 - Permission for absence

Agreed: the Committee is content with Clause 193 as drafted.

524. Clause 194 - Transfers between hospitals etc

Agreed: the Committee is content with Clause 194 as drafted.

525. Clause 195 - Detention under a hospital direction

Agreed: the Committee is content with Clause 195 subject to the technical amendment proposed by the Department.

526. Clause 196 - Transfer to prison etc of person detained in hospital under a hospital direction

Agreed: the Committee is content with Clause 196 subject to the amendments proposed by the Department to: impose a duty on, rather than grant a power to, the DoJ, to direct that a prisoner be returned from hospital if that prisoner can no longer be detained in hospital; to clarify that the potential of the individual to create a risk of serious physical or psychological harm to himself must be considered; and technical amendments.

527. Clause 197 - Section 196: meaning of "release date"

Agreed: the Committee is content with Clause 197 as drafted.

528. Clause 198 - Duties and powers to release from detention

Agreed: the Committee is content with Clause 198 subject to the amendment proposed by the Department to clarify that the right to apply to, and the powers of, the Sentence Review Commissioners apply to that individual.

529. Clause 199 - Reports by responsible medical practitioner

Agreed: the Committee is content with Clause 199 as drafted.

530. Clause 200 - Permission for absence etc

Agreed: the Committee is content with Clause 200 as drafted.

531. Clause 201 - Transfers between hospitals

Agreed: the Committee is content with Clause 201 as drafted.

532. Clause 202 - Procedure where question of fitness to be tried arises

Agreed: the Committee is content with Clause 202 as drafted.

533. Clause 203 - Finding that the accused did the act or made the omission charged

Agreed: the Committee is content with Clause 203 as drafted.

534. Clause 204 - Procedure in relation to finding of insanity

Agreed: the Committee is content with Clause 204 as drafted.

535. Clause 205 - Powers to deal with person unfit to be tried or not guilty by reason of insanity

Agreed: the Committee is content with Clause 205 subject to the amendments proposed by the Department to reflect the decision to rename "Supervision and Treatment Orders" as "Supervision and Assessment Orders" and to take account of new Schedule 7A which provides for these Orders, rather than them being dealt with through regulations.

536. Clause 206 - Remission for trial where person no longer unfit to be tried

Agreed: the Committee is content with Clause 206 subject to the amendments proposed by the Department to reflect the decision to rename "Supervision and Treatment Orders" as "Supervision and Assessment Orders".

537. Clause 207 - Power to make order where the accused did the act or made the omission charged

Agreed: the Committee is content with Clause 207 as drafted.

538. New Clause 207A - Power to make restraining order following finding of unfitness to plead etc

Agreed: the Committee is content with the amendment proposed by the Department to insert a new Clause 207A.

539. Clause 208 - Power to transfer person serving custodial sentence etc to hospital

Agreed: the Committee is content with Clause 208 as drafted.

540. Clause 209 - Conditions for transfer under section 208

Agreed: the Committee is content with Clause 209 subject to the amendments proposed by the Department to: clarify that the potential of the individual to create a risk of serious physical or psychological harm to himself must be considered; and the technical amendment.

541. Clause 210 - Effect of transfer under section 208

Agreed: the Committee is content with Clause 210 as drafted.

542. Clause 211 - Transfer of civil prisoner or immigration detained to hospital

Agreed: the Committee is content with Clause 211 as drafted.

543. Clause 212 - Detention in hospital on removal under section 211

Agreed: the Committee is content with Clause 212 subject to the technical amendment proposed by the Department.

544. Clause 213 - Duration of direction under section 211

Agreed: the Committee is content with Clause 213 subject to the amendments proposed by the Department to: impose a duty on, rather than grant a power to, the DoJ, to direct that a prisoner be returned from hospital if that prisoner can no longer be detained in hospital; to clarify that the potential of the individual to create a risk of serious physical or psychological harm to himself must be considered; and technical amendments.

545. Clause 214 - Transfer to hospital of person remanded by magistrates' court

Agreed: the Committee is content with Clause 214 as drafted.

546. Clause 215 - Detention in hospital on removal under section 214

Agreed: the Committee is content with Clause 215 subject to the technical amendment proposed by the Department.

547. Clause 216 - Duration of direction under section 214

Agreed: the Committee is content with Clause 216 subject to the amendments proposed by the Department to: clarify that the potential of the individual to create a risk of serious physical or psychological harm to himself must be considered; and the technical amendment.

548. Clause 217 - Transfer of certain other detainees to hospital

Agreed: the Committee is content with Clause 217 as drafted.

549. Clause 218 - Detention in hospital on removal under section 217

Agreed: the Committee is content with Clause 218 subject to the technical amendment proposed by the Department.

550. Clause 219 - Duration of direction under section 217

Agreed: the Committee is content with Clause 219 subject to the amendments proposed by the Department to: impose a duty on, rather than grant a power to, the DoJ, to direct that a prisoner be returned from hospital if that prisoner can no longer be detained in hospital; to clarify that the potential of the individual to create a risk of serious physical or psychological harm to himself must be considered; and technical amendments.

551. Clause 220 - Conditions for transfer to hospital under section 211, 214 or 217

Agreed: the Committee is content with Clause 220 subject to the amendments proposed by the Department to: clarify that the potential of the individual to create a risk of serious physical or psychological harm to himself must be considered; and the technical amendment.

552. Clause 221 - General provisions about hospital transfer directions

Agreed: the Committee is content with Clause 221 subject to the technical amendment proposed by the Department.

553. Clause 222 - Right to apply to Tribunal

Agreed: the Committee is content with Clause 222 subject to the technical amendment proposed by the Department.

554. Clause 223 - Meaning of “a qualifying person”

Agreed: the Committee is content with Clause 223 as drafted.

555. Clause 224 - Applications: visiting and examination

Agreed: the Committee is content with Clause 224 as drafted.

556. Clause 225 - Power of certain persons to refer case to Tribunal

Agreed: the Committee is content with Clause 225 as drafted.

557. Clause 226 - Duty of HSC trust to refer case to Tribunal

Agreed: the Committee is content with Clause 226 subject to the technical amendments proposed by the Department.

558. Clause 227 - Duty to notify the Attorney General

Agreed: the Committee is content with Clause 227 subject to the technical amendment proposed by the Department.

559. Clause 228 - Powers of Tribunal as to public protection order without restrictions

Agreed: the Committee is content with Clause 228 subject to the technical amendment proposed by the Department.

560. Clause 229 - Powers of Tribunal as to public protection order with restrictions

Agreed: the Committee is content with Clause 229 as drafted.

561. Clause 230 - Sections 228 and 229: the prevention of serious harm condition

Agreed: the Committee is content with Clause 230 subject to the amendment proposed by the Department to ensure that the potential of the individual to create a risk of serious psychological harm to other persons must also be considered in addition to serious physical harm.

562. New Clause 230A - Sections 228 and 229: additional powers of Tribunal etc

Agreed: the Committee is content with the amendment proposed by the Department to insert a new Clause 230A.

563. Clause 231 - Effect of conditional discharge

Agreed: the Committee is content with Clause 231 as drafted.

564. Clause 232 - Applications and reference to Tribunal where person recalled

Agreed: the Committee is content with Clause 232 subject to the technical amendment proposed by the Department.

565. Clause 233 - Application to Tribunal where person has not been recalled

Agreed: the Committee is content with Clause 233 as drafted.

566. Clause 234 - Powers of Tribunal as to hospital directions and hospital transfer directions

Agreed: the Committee is content with Clause 234 subject to the amendments proposed by the Department to: clarify that the potential of the individual to create a risk of serious physical or psychological harm to himself must be considered; and the technical amendment.

567. New Clause 234A - Additional powers of Tribunal

Agreed: the Committee is content with the amendment proposed by the Department to insert a new Clause 234A.

568. Clause 235 - Section 234: procedure where prevention of serious harm condition is not met

Agreed: the Committee is content with Clause 235 as drafted.

569. Clause 236 - Provision of information

Agreed: the Committee is content with Clause 236 as drafted.

570. Clause 237 - Ways in which information must be provided

Agreed: the Committee is content with Clause 237 as drafted.

571. Clause 238 - Section 22 may apply to person detained under Part 10

Agreed: the Committee is content with Clause 238 as drafted.

572. Clause 239 - Absence without permission

Agreed: the Committee is content with Clause 239 as drafted.

573. Clause 240 - Effect of court order or direction on previous authority for hospital detention

Agreed: the Committee is content with Clause 240 as drafted.

574. Clause 241 - Appeals: general

Agreed: the Committee is content with Clause 241 subject to the amendment proposed by the Department to reflect the decision to rename “Supervision and Treatment Orders” as “Supervision and Assessment Orders”.

575. Clause 242 - Appeals against orders made on finding of unfitness to plead etc

Agreed: the Committee is content with Clause 242 subject to the amendment proposed by the Department to reflect the decision to rename “Supervision and Treatment Orders” as “Supervision and Assessment Orders”.

576. New Clause 242A - Hospital directions: case stated by magistrates’ court

Agreed: the Committee is content with the amendment proposed by the Department to insert a new Clause 242A.

577. Clause 243 - Requirements as to written evidence

Agreed: the Committee is content with Clause 243 as drafted.

578. Clause 244 - Interpretation of part 10: children

Agreed: the Committee is content with Clause 244 as drafted.

579. Clause 245 - Interpretation of Part 10: impairment of or disturbance in the functioning

Agreed: the Committee is content with Clause 245 as drafted.

580. Clause 246 - Interpretation of Part 10: references to disorder

Agreed: the Committee is content with Clause 246 as drafted.

581. Clause 247 - Interpretation of Part 10: general

Agreed: the Committee is content with Clause 247 subject to the amendments proposed by the Department to: reflect the decision to rename “Supervision and Treatment Orders” as “Supervision and Assessment Orders” and to take account of new Schedule 7A, which provides for these Orders; and the technical amendment.

582. Clause 248 - Removal of detained persons from Northern Ireland to England or Wales

Agreed: the Committee is content with Clause 248 subject to the amendments proposed by the Department as a consequence of the amendments to clause 252; and the technical amendment.

583. Clause 249 - Removal of detained persons from Northern Ireland to Scotland

Agreed: the Committee is content with Clause 249 subject to the amendments proposed by the Department as a consequence of the amendments to clause 252; and the technical amendment.

584. New Clause 249A - Removal of certain persons detained under Part 10 to England or Wales

Agreed: the Committee is content with the amendment proposed by the Department to insert a new Clause 249A.

585. New Clause 249B - Removal of certain persons detained under Part 10 to Scotland

Agreed: the Committee is content with the amendment proposed by the Department to insert a new Clause 249B.

586. Clause 250 - Persons removed from England or Wales to Northern Ireland

Agreed: the Committee is content with Clause 250 subject to the technical amendment proposed by the Department.

587. Clause 251 - Persons removed from Scotland to Northern Ireland

Agreed: the Committee is content with Clause 251 subject to the technical amendment proposed by the Department.

588. New Clause 251A - Persons to be detained under Part 10 after removal from England and Wales

Agreed: the Committee is content with the amendment proposed by the Department to insert a new Clause 251A.

589. New Clause 251B - Persons to be detained under Part 10 after removal from Scotland

Agreed: the Committee is content with the amendment proposed by the Department to insert a new Clause 251B.

590. Clause 252 - Removal from Northern Ireland: power to make further provision

Agreed: the Committee is content with Clause 252 subject to the amendment proposed by the Department to take account of the new powers in relation to Part 10 transfers from Northern Ireland created through the new clauses 249A and 249B.

591. Clause 253 - Persons transferred to Northern Ireland: power to make further provision

Agreed: the Committee is content with Clause 253 subject to the amendment proposed by the Department to take account of the new powers in relation to Part 10 transfers from Northern Ireland created through the new clauses 251A and 251B.

592. New Clause 253A - Interpretation of Part 11

Agreed: the Committee is content with the amendment proposed by the Department to insert a new Clause 253A.

593. Clause 254 - In-patients under 18: duties of hospital managers

Agreed: the Committee is content with Clause 254 as drafted.

594. Clause 255 - Amendments of Mental Health Order: children etc

Agreed: the Committee is content with Clause 255 as drafted.

595. Clause 256 - Ill-treatment or neglect

Agreed: the Committee is content with Clause 256 subject to the amendments proposed by the Department to: extend the application of the offence to individuals detained under Parts 9 & 10 of the Bill; to insert a reference to an attorney under an EPA in the list of people by whom the offence could be committed; and to ensure alignment with the consent requirements for the equivalent offence under the Mental Health Order and minimise the potential for vexatious prosecutions.

596. Clause 257 - Forgery, false statements etc

Agreed: the Committee is content with Clause 257 as drafted.

597. Clause 258 - Unlawful detention of persons lacking capacity etc

Agreed: the Committee is content with Clause 258 subject to the amendments proposed by the Department to: extend the application of the offence to indi-

viduals detained under Parts 9 & 10 of the Bill; to ensure alignment with the consent requirements for the equivalent offence under the Mental Health Order and minimise the potential for vexatious prosecutions; to clarify that the offence does not interfere with the common law offence of false imprisonment; and the technical amendment.

598. Clause 259 - Assisting person to breach community residence requirement

Agreed: the Committee is content with Clause 259 subject to the amendment proposed by the Department to ensure that a person can only be found guilty under this clause if they know that the person they are assisting is liable to be detained under the Bill.

599. Clause 260 - Assisting persons to breach community residence requirement

Agreed: the Committee is content with Clause 260 subject to the amendment proposed by the Department to ensure that a person can only be found guilty under this clause if they know that the person they are assisting is subject to a community residence requirement; and a technical amendment.

600. Clause 261 - Obstruction

Agreed: the Committee is content with Clause 261 as drafted.

601. Clause 262 - Offences by bodies corporate

Agreed: the Committee is content with Clause 262 subject to the amendment proposed by the Department to ensure alignment with the consent requirements for offences by bodies corporate as set out in the Interpretation Act (NI) 1954 and to minimise the potential for vexatious prosecutions.

602. Clause 263 - Renaming of Mental Health Review Tribunal

Agreed: the Committee is content with Clause 263 as drafted.

603. Clause 264 - Visiting etc powers of medical practitioners in connection with the Tribunal

Agreed: the Committee is content with Clause 264 as drafted.

604. Clause 265 - Power to make regulations about dealing with money and valuables

Agreed: the Committee is content with Clause 265 subject to the amendments proposed by the Department to: ensure that any regulations may not permit the relevant authority to do anything inconsistent with a decision concerning P's property and affairs made by an EPA; and a technical amendment.

605. Clause 266 - Contravention of regulations under section 265

Agreed: the Committee is content with Clause 266 subject to the technical amendments proposed by the Department.

606. Clause 267 - Expenditure

Agreed: the Committee is content with Clause 267 as drafted.

607. Clause 268 - Payment for necessary goods and services

Agreed: the Committee is content with Clause 268 as drafted.

608. Clause 269 - Appointment of approved social workers

Agreed: the Committee is content with Clause 269 as drafted.

609. Clause 270 - Miscellaneous functions of HSC trusts

Agreed: the Committee is content with Clause 270 subject to the technical amendments proposed by the Department.

610. Clause 271 - Direct payments in place of provision of care services

Agreed: the Committee is content with Clause 271 subject to the amendment proposed by the Department to ensure that references to attorney in the direct payment provisions in the Bill include attorneys under an EPA.

611. Clause 272 - International protection of adults

Agreed: the Committee is content with Clause 272 as drafted.

612. New Clause 272A - Review of law relating to advance decisions

Agreed: the Committee is content with the amendment proposed by the Department to insert a new Clause 272A.

613. Clause 273 - Family relationships etc

Agreed: the Committee is content with Clause 273 as drafted.

614. Clause 274 - Voting rights

Agreed: the Committee is content with Clause 274 subject to the technical amendment proposed by the Department.

615. Clause 275 - Relationship of Act with law relating to murder etc

Agreed: the Committee is content with Clause 275 as drafted.

616. Clause 276 - Codes of practice

Agreed: the Committee is content with Clause 276 subject to the amendments proposed by the Department to: change the reference from “independent advocate” to “independent mental capacity advocate”; and technical amendments.

617. Clause 277 - Effect of code

Agreed: the Committee is content with Clause 277 subject to the amendments proposed by the Department to: change the reference from “independent advocate” to “independent mental capacity advocate”; and to insert a reference to an attorney under an EPA in the list of people that must have regard to any relevant code of practice.

618. New Clause 277A - Provision of information by HSC trusts and the Department

Agreed: the Committee is content with the amendment proposed by the Department to insert a new Clause 277A.

619. New Clause 277B - Provision of facilities by HSC trusts and the Department

Agreed: the Committee is content with the amendment proposed by the Department to insert a new Clause 277B.

620. Clause 278 - Warrants

Agreed: the Committee is content with Clause 278 subject to the amendments proposed by the Department to: allow an approved social worker to accompany a constable, as well as a medical practitioner to enter premises when a warrant issued under clause 278 is executed; and technical amendments.

621. Clause 279 - Warrants: people liable to be detained under 1983 Act or 2005 Order

Agreed: the Committee is content with Clause 279 subject to the technical amendments proposed by the Department.

622. Clause 280 - Provisions as to custody, detention etc

Agreed: the Committee is content with Clause 280 subject to the technical amendment proposed by the Department.

623. Clause 281 - Retaking of persons escaping from legal custody

Agreed: the Committee is content with Clause 281 subject to the technical amendment proposed by the Department.

624. Clause 282 - Special accommodation

Agreed: the Committee is content with Clause 282 subject to the amendments proposed by the Department to: remove the words “from serious physical harm”, to allow for the detention of individuals who might pose a risk of serious psychological harm to other persons; and the technical amendment.

625. Clause 283 - Panels constituted to decide applications: general provision

Agreed: the Committee is content with Clause 283 subject to the amendments proposed by the Department to: provide that all panel members must be in attendance during the proceedings of the panel, which includes when a decision is to be made; and technical amendments.

626. Clause 284 - Protection for acts done in pursuance of Part 9 or 10

Agreed: the Committee is content with Clause 284 subject to the technical amendment proposed by the Department.

627. Clause 285 - Risk of serious physical harm to others

Agreed: the Committee is content with Clause 285 as drafted.

628. Clause 286 - Medical practitioners who may make certain medical reports

Agreed: the Committee is content with Clause 286 as drafted.

629. Clause 287 - Documents appearing to be duly made

Agreed: the Committee is content with Clause 287 as drafted.

630. Clause 288 - Power to make further provision

Agreed: the Committee is not content with Clause 288 as drafted.

The Committee agreed to formally register opposition to clause 288 with the Bill Office.

631. Clause 289 - Regulations

Agreed: the Committee is content with Clause 289 subject to the amendments proposed by the Department to: require that regulations made under clause 36 (4) (b) which relates to deprivation of liberty are subject to the draft affirmative procedure; require that regulations made under clauses 252 and 253 that amend this Act are subject to the draft affirmative procedure; that regulations made under clause 265 (2) which contain any provision that creates an offence are subject to the draft affirmative procedure; require that regulations made under clause 290 (3) which amend Northern Ireland legislation or an Act of Parliament are subject to the draft affirmative procedure; require that the regulation making power at paragraph 14 of Schedule 7A will be subject to the draft affirmative procedure; and technical amendments.

632. Clause 290 - Consequential amendments and repeals

Agreed: the Committee is content with Clause 290 subject to the amendment proposed by the Department linked to the removal of clause 288.

633. Clause 291 - Persons “unconnected with” a person

Agreed: the Committee is content with Clause 291 as drafted.

634. Clause 292 - Meaning of “mental disorder”

Agreed: the Committee is content with Clause 292 as drafted.

635. Clause 293 - Definitions for purposes of Act

Agreed: the Committee is content with Clause 293 subject to the amendments proposed by the Department to: ensure that the potential of the individual to create a risk of serious psychological harm is included within the scope of the definition; change reference from “independent advocate” to “independent mental capacity advocate”; and technical amendments.

636. Clause 294 - Commencement

Agreed: the Committee is content with Clause 294 subject to the amendments proposed by the Department to: give the Departments the power to make

transitional, transitory or saving provision by regulations in connection with the commencement of the Bill; and technical amendments.

637. Clause 295 - Short title

Agreed: the Committee is content with Clause 295 as drafted.

638. Schedule 1 - Authorisation by panel of certain serious interventions

Agreed: the Committee is content with Schedule 1 subject to the amendments proposed by the Department to: change the reference from “independent advocate” to “independent mental capacity advocate”; and technical amendments.

639. Schedule 2 - Authorisation of short-term detention in hospital for examination etc

Agreed: the Committee is content with Schedule 2 subject to the amendments proposed by the Department to: change the reference from “independent advocate” to “independent mental capacity advocate”; restrict the timeframe within which the examination required for the admission report must be done; limit the types of errors that can be corrected under paragraph 20 to include administrative errors only; and technical amendments.

640. Schedule 3 - Extension of panel of period of authorisation

Agreed: the Committee is content with Schedule 3 subject to the amendments proposed by the Department to: change the reference from “independent advocate” to “independent mental capacity advocate”; and technical amendments.

641. Schedule 4 - Lasting powers of attorney: formalities

Agreed: the Committee is content with Schedule 4 subject to the technical amendments proposed by the Department.

642. Schedule 5 - Existing enduring powers of attorney

Agreed: the Committee is not content with Schedule 5 subject to the amendment proposed by the Department.

The Committee agreed to formally register opposition to Schedule 5 with the Bill Office.

643. Schedule 6 - Property and affairs: supplementary provisions

Agreed: the Committee is content with Schedule 6 as drafted.

644. Schedule 7 - Extension by panel of public protection order without restrictions

Agreed: the Committee is content with Schedule 7 as drafted.

645. New Schedule 7A - Supervision and Assessment Orders

Agreed: the Committee noted the amendment proposed by the Department to insert a new Schedule 7A.

646. Schedule 8 - Amendments of Mental Health Order

Agreed: the Committee is content with Schedule 8 subject to the amendments proposed by the Department to: repeal of Part 6 of the Mental Health (NI) Order 1986 which sets out the functions of the RQIA under that Order; address the dual registration problem relating to private mental health hospitals; ensure that the duty to maintain a register of people receiving medical treatment for mental disorder as in-patients in hospital applies to people under 18; repeal Article 128 of the Mental Health (NI) Order 1986 which will no longer be required once the Bill is commenced; amend references to “place of safety” to “appropriate place” in Article 129 of the Mental Health (NI) Order 1986; remove paragraph 67 on the basis that the amendment of existing provisions will be dealt with after Royal Assent in conjunction with the drafting of an Order in Council and the drafting of regulations under Part 11 of the Bill; and technical amendments.

647. Schedule 9 - International protection of adults

Agreed: the Committee is content with Schedule 9 subject to the technical amendment proposed by the Department.

648. Schedule 10 - Consequential amendments

Agreed: the Committee is content with Schedule 10 subject to the technical amendments proposed by the Department.

649. Schedule 11 - Repeals

Agreed: the Committee is content with Schedule 11 subject to the amendments proposed by the Department: in relation to Schedule 8

amendments; in relation to new clause 277A; and an amendment made on the basis that the amendment of existing provisions will be dealt with after Royal Assent in conjunction with the drafting of an Order in Council and the drafting of regulations under Part 11 of the Bill.

650. Long Title

Agreed: the Committee is content with the Long Title of the Bill as drafted.

Links to Appendices

Appendix 1 - Minutes of Proceedings can be viewed [here](#).

Appendix 2 - Minutes of Evidence can be viewed [here](#).

Appendix 3 - Written submissions can be viewed [here](#).

Appendix 4 - Correspondence from the Department of Health, Social Service and Public Safety and the Department of Justice and other organisations can be viewed [here](#).

Appendix 5 - Research Papers can be viewed [here](#).

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Kathryn Aiken
Northern Ireland Assembly
Parliament Buildings
Ballymiscaw
Stormont
Belfast BT4 3XX

Telephone: 028 90 520481

Email: committee.hssps@niassembly.gov.uk

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