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Revisiting decision-making: A case for new legislation?

John Williams*

Introduction

It is trite to say decision-making is part of living, but that does not make it less the case. Daily we make hundreds of decisions, some are trivial but others serious including decisions on medical treatment, social care, and financial matters. For most people, we do not challenge their ability to decide; for example, rarely are people asked whether they possess the capacity to sign a lease or consent to surgery. Much of the discussion of decision-making concentrates on mental capacity. All four nations in the United Kingdom have legislation on mental capacity which builds upon the judicial development of the law. There are two parts to the legislation. First, how do decision-makers determine whether an adult has relevant mental capacity? What test is used? The second imposes duties on the decision-maker where the adult is assessed as lacking mental capacity; on what basis should they decide, assuming it is right to decide for the person?

Although legislation is essential given the powers decision-makers have where an adult is assessed as lacking mental capacity, it addresses only one component of decision-making. One criticism of the legal discourse is the impression that mental capacity is the only factor when deciding if an adult can decide. Herring and Wall recognise an adult can have capacity under the mental capacity legislation, but not be autonomous. Autonomy extends beyond possessing the mental capacity to decide and requires a wider level of capacity outside of mental capacity legislation, although they feature in other legislation and the common law. [1]

Mental capacity legislation across the four nations

Scotland was the first of the four nations to introduce mental capacity legislation using its new-powers under the Scotland Act 1998.[2] The Adults with Incapacity (Scotland) Act 2000 was a 'ground breaking' reform which repealed the previous law based on a 'paternalistic, substitutive, model' and removed all decision-making to curators, tutors, or guardians if the person lacked mental capacity. There was no duty on any of these to consult with the person. The 2000 Act was based on the report and draft Bill published by the Scottish Law Commission which found much of the law to be archaic.[3] The Scottish Executive recognised the need for a new law. They made the case for change in the 1999 Making the Right Move report.[4]

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Jonathan Herring and Jesse Wall, 'Autonomy, Capacity and Vulnerable Adults: Filling the Gaps in the Mental Capacity Act' (2015) 35 Legal Studies 698 <https://www.cambridge.org/core/product/identifier/S026138750000221X/type/journal_article> accessed 28 September 2020.

[2] Margaret L Ross, 'The Adults with Incapacity (Scotland) Act 2000: A Long and Winding Road' (2003) 7 Edinburgh Law Review 226 <https://www.euppublishing.com/doi/abs/10.3366/elr.2003.7.2.226> accessed 28 September 2020.

[3] Scottish Law Commission, 'Report on Incapable Adults (Scots Law Commission No 151)' (1995) <https://www.scotlawcom.gov.uk/files/5013/2758/0994/rep151_1.pdf> accessed 28 September 2020.

In England and in Wales the Mental Capacity Act 2005 followed a report by the Law Commission in 1995 which referred to the legal context as one of '*incoherence, inconsistency and historical accident'*.[5] A Joint Committee of the House of Lords and House of Commons considered a draft bill on mental incapacity and reported in 2003. The Committee concluded new legislation was required but recognised that legislation can only go so far. It also required a change in attitudes which recognises the rights of those lacking mental capacity.[6] The government introduced the Mental Capacity Bill which became law in 2005.

Northern Ireland was the last of the four nations to introduce mental capacity legislation. Of the four nations, Northern Ireland adopted a more radical approach to mental capacity law and mental health law. The Mental Capacity Act (Northern Ireland) 2016 is based on the Bamford review of mental health and learning disability. The Act fuses mental health and mental capacity law for those aged sixteen years and over. The Bamford review recommended that,

> *'... Government should adopt a coherent and coordinated approach to legislative provision. This should be through the introduction of comprehensive provisions for all people who require substitute-decision-making. A single legislative Framework is proposed for interventions in all aspects of the needs of people requiring substitute decision-making, including mental health, physical health, welfare or financial needs'* [7]

This reflects article 12(2) of the Convention on the Rights of Persons with Disabilities which requires state parties to *'recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life*.' The reference to *legal capacity* goes beyond mental capacity.

All three pieces of legislation are welcome, not least because they respond to the human rights deficit under the preceding legal frameworks. The tests for mental capacity vary but are rooted in a functional approach. Principles help ensure greater consistency and the involvement of those whose capacity is being assessed.[8] However, mental capacity is only one, albeit important, aspect of decision-making. To possess legal capacity to decide, yes or no, requires two other elements. Kennedy and Grubb, discussing decision-making in a medical context, said that a decision must be,

1. made by an adult with mental capacity;
2. be real – that is, based upon adequate information; and
3. be voluntary and not made under the undue influence of another.[9]

Despite its medical pedigree, this description of legal capacity has wider application. It is helpful in social care and adult safeguarding. Consent and refusal are important issues in adult safeguarding. In financial abuse cases, the question often arises whether the person, for example, voluntarily transferred their property to a family member. Whether, and if so the extent to which a victim

[4] Scottish Executive, 'Making the Right Moves: Rights and Protection for Adults with Incapacity' (1999) <https://web.archive.org/web/20030310113938/http://www.scotland.gov.uk/rightmoves/docs/mrmm.pdf> accessed 28 September 2020.

[5] Law Commission, 'Mental Incapacity' (1995) 231 Law Com 33, para 2.45

[6] House of Lords and House of Commons Joint Committee on the Draft Mental Incapacity Bill, 'Draft Mental Incapacity Bill', vol 1 (2003).

[7] David Bamford, 'The Bamford Review of Mental Health and Learning Disability (Northern Ireland): A Comprehensive Legislative Framework' (2007) para 8.7.

[8] Penny Letts, 'Mental Capacity Act 2005: The Statutory Principles and Best Interests Test 1' (2005) <http://www.dca.gov.uk/menincap/mcbdraftcode> accessed 29 September 2020; Carolyn Johnston and Jane Liddle, 'The Mental Capacity Act 2005: A New Framework for Healthcare Decision-making' (2007) 33 Journal of medical ethics 94.

[9] Andrew Grubb and others, *Principles of Medical Law* (Oxford University Press 2010), para 8.68.

cooperates with safeguarding and the criminal justice system depends upon their ability, or their legal capacity, to consent. Legal capacity is essential in deciding where an adult wants to live. They may be assessed as having the relevant mental capacity, but are they making a real decision? have they been given the information about the financial implications, the culture of the home, and facilities available? There is no clear and easily accessible legislative framework in any of the four nations that allows for anything other than mental capacity to be considered. A legislative framework is desirable. There is a limit to which the judiciary can develop necessary safeguards. Is new legislation required that looks more holistically at decision-making by those referred to as 'vulnerable adults'? Use of the word 'vulnerable' is fraught with difficulties and raises concerns, particularly if defining it is left to the incremental process of the common law.[10] This point is discussed below.

A new approach to decision-making.

The legislation across the four nations provides clear criteria, safeguards, and definitions when assessing an adult's mental capacity and, if they lack capacity, how decisions are made in their best interests. Understandably, the legislation has not escaped criticism. Wilson's interesting study on the working of the Adults with Incapacity (Scotland) Act 2000 and the Mental Capacity Act 2005 presents a mixed picture. The legislation was favourably received as families and carers can manage decisions for those lacking mental capacity on a legally valid basis. However, Wilson also found that adults lacking mental capacity sometimes resented the powers exercised over them. For some there was a feeling of a lack of empowerment. He notes that the paradigm of disability rights has changed since the Convention on the Rights of Persons with Disabilities.[11] The relationship between the Convention and the legislation in England and Wales, and in Scotland is conflicted, particularly in the light of the interpretation of article 12 by the Committee on the Rights of Persons with Disabilities General Comment No 1. Drawing upon the General Comment No 1 Donnelly argues it may be appropriate to revisit the best interest principle, difficult though that may be. She suggests that using the terminology of respecting the rights of the person would realign decision-making to afford greater recognition of will and preferences, whilst recognising the complexity. This is like a proposal put to the House of Lords and House of Commons Joint Committee but rejected because,

> *'…it would be too onerous on relatives, carers and other informal decision-makers to require an understanding of human rights legislation when determining best interests. The Codes of Practice and any Departmental guidance issued to the general public should explain the relevant human rights considerations.'* [12]

Arguably rights have greater clarity for decision-makers than the rather nebulous term 'best interests'. The rejection of the idea may have more to do with the inaccessible language used in the human rights discourse rather than the complexity of the rights.

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[10] Michael C Dunn, Isabel CH Clare and Anthony J Holland, 'To Empower or to Protect? Constructing the "Vulnerable Adult" in English Law and Public Policy' (2008) 28 Legal Studies 234 <https://www.cambridge.org/core/product/identifier/S0261387500002890/type/journal_article> accessed 30 September 2020.

[11] Sam Wilson, 'Mental Capacity Legislation in the UK; Systematic Review of the Experiences of Adults Lacking Capacity and Their Carers' (2017) 41 BJPsych Bulletin 260 <https://www.cambridge.org/core/services/aop-cambridge-core/content/view/3FCD8AA3BE68B9611BFC650924F6549F/S2056469400003818a.pdf/mental_capacity_legislation_in_the_uk_systematic_review_of_the_experiences_of_adults_lacking_capacity_and_their_carers.pdf> accessed 30 September 2020.

[12] House of Lords and House of Commons Joint Committee on the Draft Mental Incapacity Bill (n 6) para 91.

The Convention's inclusion of supported decision-making resulted in countries reviewing their mental capacity laws through law reform agencies. The Law Commission for England and Wales addressed this in its 2017 report on deprivation of liberty and proposed the introduction of a formally appointed person known as a 'supporter' to assist the person in decision-making. He or she would not be an advocate in the traditional sense. This would build on the second principle in the Mental Capacity Act 2005, namely the requirement to take all practicable steps to help the person decide for him or herself.[13] Although the Commission's recommendations were not adopted in the Mental Capacity (Amendment) Act 2019, the Report identified a need for reform in order to move closer to the expectations of the Convention. However, they recognised that there would be situations where it would be necessary to overrule the ascertainable wishes and feelings of the person. This has been challenging for many countries seeking to implement the provision.[14] The Scottish Law Commission in its 2014 report addressed the implications of *HL v United Kingdom;*[15] it made only passing reference to supported decision-making.[16] More widely, Then *et al.* undertook an international study of law reform agencies that considered supported decision-making. Although they identify a 'noticeable trend' of law reform agencies making recommendations on supported decision-making, no clear model emerges.[17]

A review of mental capacity legislation in England, Wales, and Scotland is necessary. Supported decision-making is one issue that needs addressing, although it is likely that any reforms would recognise the power to overrule wishes and feelings in some cases. Northern Ireland's legislation is more compliant with the Convention and the European Convention on Human Rights.[18] Section 5 Mental Capacity Act (Northern Ireland) gives a significant nod towards supported decision-making, particularly in relation to the provision of information.[19] Whether it meets the full expectations of the Convention is unclear. Of the three pieces of legislation it is the most compatible.

A debate on reforming current legislation would provide a timely opportunity to consider mental capacity as one part of legal capacity. Broadening legislation to include the need for free will and real consent would address some concerns raised by practitioners and others that safeguarding decisions fail to consider them or are unable to do anything when coercion is apparent. Raised awareness of the existence of coercive and controlling behaviour, and the developments in medical law on the duty to provide information, provide a context for this debate.

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[13] Law Commission, ' Mental Capacity and Deprivation of Liberty Law Com No 372' (2017) paras 14.51-56

[14] See Donnelly, Mary. "Deciding in dementia: The possibilities and limits of supported decision-making." *International journal of law and psychiatry* 66 (2019): 101466; Pritchard-Jones, L. G. "Exploring the potential and the pitfalls of the United Nations Convention on the Rights of Persons with Disabilities and General Comment no. 1 for people with dementia." *International journal of law and psychiatry* 66 (2019); Hall, Margaret Isabel. "Situating dementia in the experience of old age: Reconstructing legal response." *International journal of law and psychiatry* 66 (2019): 101468.

[15] *HL v UK* (2005) 40 EHRR 32.

[16] Scottish Law Commission, 'Report on Adults with Incapacity' Scots Law Com No 240' (2014)

[17] Shih Ning Then and others, 'Supporting Decision-Making of Adults with Cognitive Disabilities: The Role of Law Reform Agencies – Recommendations, Rationales and Influence' (2018) 61 International Journal of Law and Psychiatry 64, p 74..

[18] Gerard Lynch, Catherine Taggart and Philip Campbell, 'Mental Capacity Act (Northern Ireland) 2016' (2017) 41 BJPsych Bulletin 353 </pmc/articles/PMC5709686/?report=abstract> accessed 29 September 2020.

[19] Colin Harper, Gavin Davidson and Roy Mcclelland, 'No Longer "Anomalous, Confusing And Unjust": The Mental Capacity Act (Northern Ireland) 2016' (2016), p 63 <http://www.legislation.gov.uk/nisi/1986/595> accessed 2 October 2020.

The inherent jurisdiction

Mental capacity law prior to the introduction of legislation depended on the judges and it is right to say that they did a good job. Much of their thinking on mental capacity and best interests found its way into the legislation. Prior to the legislation the inherent jurisdiction was used to protect those who lacked mental capacity where significant decisions had to be made. In *Re F (1990)*[20] the House of Lords carefully distinguished between the treatment for F's mental health, which was within the Mental Health Act 1983, and her ability to consent to, in this case, sterilisation. Sterilisation was not treatment for a mental disorder so did not fall within the 1983 Act. However, so far as mental capacity was concerned there was a gap in the law. Not to do anything because she could not consent would leave her exposed to harm. Lord Bridge emphasised the importance of the use of the inherent jurisdiction.

> *'It would be intolerable for members of the medical, nursing and other professions devoted to the care of the sick that, in caring for those lacking capacity to consent to treatment they should be put in the dilemma that, if they administer the treatment which they believe to be in the patient's best interests, acting with due skill and care, they run the risk of being held guilty of trespass to the person, but if they withhold that treatment, they may be in breach of a duty of care owed to the patient.'*[21]

The case was a milestone in the law's development of incapacity.[22] Such cases are now decided by the Court of Protection under the Mental Capacity Act 2005; this displaced the use of the inherent jurisdiction in mental capacity matters.

Another case decided before the Mental Capacity Act 2005 was *Re F (2000).*[23] Although its applicability to mental capacity has been overtaken by the 2005 Act, it has wider significance for the use of the inherent jurisdiction. The dilemma for the local authority and for the courts was how, in the absence of mental capacity legislation, to protect a vulnerable and incapacitated adult from abuse. The Court of Appeal held that, in the words of Sedley LJ, 'no humane society would leave her adrift and at risk' because she was eighteen years and no longer within the Children Act 1989. A declaration was granted in favour of the local authority that she should remain in its care with limited family contact. Clearly, that was the right result. But the court identified problems. Although it defended its development of the jurisdiction, it pointed out the limitations of a case-by-case approach. Butler-Sloss LJ said,

> *The assumption of jurisdiction by the High Court on a case-by-case basis does not, however, detract from the obvious need expressed by the Law Commission and by the Government for a well-structured and clearly defined framework for the protection of vulnerable, mentally incapacitated adults, particularly since the whole essence of declarations under the inherent jurisdiction is to meet a recognised individual problem and not to provide general guidance for mentally incapacitated adults. Until Parliament puts in place that defined framework, the High Court will still be required to help out where there is no other practicable alternative.'*[24]

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[20] *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1

[21] n19, p 53.

[22] Alison J Stansfield, AJ Holland and ICH Clare, 'The Sterilisation of People with Intellectual Disabilities in England and Wales during the Period 1988 to 1999' (2007) 51 Journal of Intellectual Disability Research 569.

[23] *Re F (Adult Patient)* [2000] EWCA Civ 3029

[24] n 22, p 9

Sedley LJ noted that although the local authority had the legal power to provide accommodation for F under the old community care law, the power to keep her there relied on 'moral or physical restrictions.' [25] Although the best that could be done in the then circumstances, it shows the weakness of having to rely on the inherent jurisdiction. It also raises the courts understandable unwillingness to assume responsibility for ongoing supervision of the order. In this respect the inherent jurisdiction is more suitable for single medico legal decisions characterized by the 1990 Re F case.[26] As already mentioned, the Mental Capacity Act 2005 would now address the facts of Re F (2000) and, importantly includes safeguards and criteria for intervention. It also provides an infrastructure for decision-making, grounds for challenge, and access to the Court of Protection.

The High Court has continued to develop the inherent jurisdiction beyond mental capacity to include vulnerable people who may need protection not available under legislation. It was recognised in Re F (2000) that the doctrine of necessity, the basis for intervention under the jurisdiction, is not limited to medical emergencies such as that in *Re F (1990).* It has a much wider role to play. Lord Goff in *R v Bournewood NHS Trust* clarified that,

> *The concept of necessity has its role to play in all branches of our law – in contract…in tort…in restitution…and our criminal law.*[27]

Several cases illustrate the use of the inherent jurisdiction where the adult has mental capacity but is vulnerable. In Re *SA (Vulnerable Adult with Capacity: Marriage*)[28] Munby J was asked to use the jurisdiction to protect a deaf and mute young woman who had just become eighteen. Prior to this, measures had been put in place including the wardship jurisdiction to protect her from being forced into a marriage. She had the mental capacity to consent to marriage. She had borderline intellectual disability, was deaf, and had no verbal communication. Munby J held that the inherent jurisdiction could be used despite her mental capacity as she was vulnerable.[29] Her vulnerability was inherent, but also situational as there was the possibility she would be taken to Pakistan by the parents and be forced into a marriage. Bennett J in *Re G (An Adult) (Mental Capacity: Court's Jurisdiction)*[30] faced a similar dilemma. Continued contact with G's father had an adverse effect on her mental health and mental capacity. The judge asked what the situation would have been if G were a child; as she is an adult, she should be no worse off. Another marriage case is *Re SK*.[31] In this case the court used the inherent jurisdiction to provide declaratory relief in order to ascertain whether she had exercised her free will in relation to decisions affecting her civil status and her country of residence. Here the vulnerability was solely situational, unlike *Re SA* and *Re G*, but the jurisdiction was used.[32] In all three cases it was recognised that the jurisdiction could only be fettered by statute. They fell outside the Mental Capacity Act 2005 as the incapacity is for a reason

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[25] n 22, p 12.

[26] John Williams, 'State Responsibility and the Abuse of Vulnerable Older People: Is There a Case for a Public Law to Protect Vulnerable Older People from Abuse?' in Jo Bridgeman, Craig Lind and Heather Keating (eds), *Responsibility, Law and Family* (Ashgate 2008) <http://books.google.com/books?id=d7gg5YMeZu0C&pg=PA81&lpg=PA81&dq=State+responsibility+and+the+abuse+of+vulnerable+older+people:+Is+there+a+case+for+a+public+law+to+protect+vulnerable+older+people+from+abuse?&source=bl&ots=Bui8AG9pBJ&sig=jXFZJvJcUaKZB344w>.

[27] *R v Bournewood Community and Mental Health NHS Trust, Ex p L* [1998] UKHL 24 p. 10

[28] *Re SA (Vulnerable Adult with Capacity: Marriage)* [2005] EWHC 2942 (Fam)

[29] n 27, p.2

[30] *Re G (An Adult) (Mental Capacity: Court's Jurisdiction)* [2004] EWHC 2222 (Fam)

[31] *Re SK [2004]* EWHC 3202 (Fam)

[32] Michael C Dunn, Isabel CH Clare and Anthony J Holland, 'To Empower or to Protect? Constructing the "Vulnerable Adult" in English Law and Public Policy' (2008) 28 Legal Studies 234.

other than impairment of, or disturbance of the functioning of the mind or brain. However, they lacked legal capacity.

Confirmation of the use of the common law doctrine of necessity is found in the Court of Appeal case of *A Local Authority and others v DL*.[33] The local authority was concerned that a son was exercising undue influence and duress over his elderly parents. The parents had mental capacity – there was no impairment in the functioning of the mind or brain. But they were under his control. The son argued that using the inherent jurisdiction regarding people with mental capacity was contrary to article 8 of the European Convention on Human Rights. The local authority argued the Convention required the court to keep the jurisdiction as the common law must develop in order that the positive obligations imposed by the Human Rights Act could be given effect. A new 'Bournewood gap' would be created if this was not the case. The son argued that the cases relied on by the local authority involved either children or incapacitated adults.[34]

In the Court of Appeal McFarlane LJ said that the use of the inherent jurisdiction which adopted a facilitative rather approach was 'on all fours' with the re-establishment of the individual's autonomy of decision-making. This enhanced rather than breached the article 8 of the European Convention on Human Rights. Reliance was placed on *LBL v RYJ and VJ*, a decision of Macur J. She stressed the need to restore autonomy rather than imposing a decision on the person.

> *… I reject what appears to have been the initial contention of this local authority that the inherent jurisdiction of the court may be used in the case of a capacitous adult to impose a decision upon him/her whether as to welfare or finance. I adopt the arguments made on behalf of RYJ and VJ that the relevant case law establishes the ability of the court, via its inherent jurisdiction, to facilitate the process of unencumbered decision-making by those who they have determined have capacity free of external pressure or physical restraint in making those decisions.*[35]

This makes the point, accepted by the Court of Appeal in *A Local Authority v DL*, that the inherent jurisdiction cannot be used to impose decisions; rather it is designed to 'facilitate the process of unencumbered decision-making' by the person. This is an important limitation of the jurisdiction.

On another issue, Macur J said,

> *If I were to have found that her vulnerability was exceptional/greater by reason of her limited intellectual functioning and age, these factors would need to have been considered in reaching my decision concerning capacity. If she is unable to withstand external pressure of "normal/everyday" degree, whether emotional or physical, it seems to me that it would necessarily inform the answer to the question posed at section 3(1)(c) of the [Mental Capacity Act 2005].*[36]

The second quotation raises an interesting point about the relationship between the Mental Capacity Act 2005 and the inherent jurisdiction. It suggests that those matters relevant to the engagement of the inherent jurisdiction, may, in effect, be issues in deciding mental capacity under the Act.[37]

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[33] *A Local Authority and others v DL* [2012] EWCA Civ 253
[34] n 35, para 25.
[35] *LBL v RYJ and VJ* [2010] EWHC (Fam) 2665.
[36] n.37, paras 62 and 64
[37] See 39 Essex Chambers, ' LBL v RYJ & VJ' (22 September 2010) <https://www.39essex.com/cop_cases/lbl-v-ryj-and-vj/> accessed 17 November 2020.

Vulnerability and the inherent jurisdiction

As noted above, Butler-Sloss in *Re F (2000)* whilst supporting the use of the inherent jurisdiction in pre-Mental Capacity Act 2005 capacity decisions, recognised the need for a well-structured and clearly defined framework. The 2005 Act provided structure, in particular the definition of incapacity and the statutory principles. Definitions are an important safeguard against inconsistent use of powers. In the absence of legislation covering vulnerable adults outside of the Act, the courts have developed indicators of vulnerability. Munby J in *Re SA (Vulnerable Adult with Capacity*: *Marriage)*[38] disavowed any attempt to define vulnerable adult for the purpose of the inherent jurisdiction. He summarised the authorities as follows,

> *…the inherent jurisdiction can be exercised in relation to a vulnerable adult who, even if not incapacitated by mental disorder or mental illness, is, or is reasonably believed to be, either: (i) under constraint; or (ii) subject to coercion or undue influence; or (iii) for some other reason deprived of the capacity to make the relevant decision, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent.*[39]

Helpfully he expanded on the terms 'constraint' and 'undue influence'. On constraint he did not feel incarceration was necessary. It is sufficient that there is some 'significant curtailment of the freedom to do those things' free men and women are entitled to do. 'Coercion or undue influence' he illustrates by the case of *Re T (Adult Refusal of Treatment).*[40] Here the will of the person was 'sapped and overborne' by the improper influence of another. He continued,

> *… the many other circumstances that may so reduce a vulnerable adult's understanding and reasoning powers as to prevent him forming or expressing a real and genuine consent, for example, the effects of deception, misinformation, physical disability, illness, weakness (physical, mental or moral), tiredness, shock, fatigue, depression, pain or drugs. No doubt there are others.*[41]

The inherent jurisdiction to protect a vulnerable adult, if mental capacity is unimpaired, was exercisable on an interim basis where there were reasonable grounds to believe that the adult's legal capacity or will to decide was 'sapped and overborne by the improper influence of another'.[42]

In summary, the inherent jurisdiction allows the court to disregard the stated opinion of an adult who has the required mental capacity because he or she is 'vulnerable'. This requires the word 'vulnerable' to do a lot of work if it is to prevent an unacceptable intrusion into the person's private life. Not that in any of the cases cited, the court acted improperly. In *Re F (2000),* the courts faced a legislative lacuna so, as Sedley LJ noted no humane society would leave her adrift and at risk.

Vulnerability in guidance and legislation – 'adults at risk'

In its consultation paper published in 1997, the Lord Chancellor's Department defined a 'vulnerable adult' as a person,

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[38] *Re SA (Vulnerable Adult with Capacity: Marriage)* [2005] EWHC 2942 (Fam)

[39] n.40, para 77.

[40] *Re T (Adult: Refusal of Medical Treatment)* [1992] EWCA Civ 18

[41] n. 40,para 78.

[42] See *Mazhar v Birmingham Community Healthcare Foundation NHS Trust & Ors* [2020] EWCA Civ 1377

> *Who is or may be in need of community care services by reason of disability, age or illness; and is or may be unable to take care or unable to protect him or herself against significant harm or exploitation.*[43]

This definition was incorporated into the protecting vulnerable adults' statutory guidance in Wales and in England.[44] The Law Commission in its Adult Social Care report identified concerns,

> *… that the term vulnerable adult appears to locate the cause of abuse with the victim, rather than placing responsibility with the actions or omissions of others. It can also suggest that vulnerability is an inherent characteristic of a person and does not recognise that it might be the context, the setting or the place which makes a person vulnerable. We, therefore, proposed that the term vulnerable adults should be replaced by adults at risk.*[45]

Responses to the consultation identified the term 'vulnerable adult' as stigmatising, dated, negative, and disempowering.[46] Much of the problem with the definition is its reliance on inherent vulnerability. Vulnerable people are defined 'first and foremost by their inherent vulnerability.'[47]

Although on the recommendation of the Law Commission 'vulnerable adult' was replaced in the Social Services and Well-being (Wales) Act 2014, and the Care Act 2014, the thresholds for adult safeguarding are still predicated on inherent vulnerability. Section 126 of the Welsh legislation specifically adopts the term 'adults at risk'. The English Care Act 2014 does not use the term, but it is used in the statutory guidance.[48] The definition of adult at risk in the Welsh and English legislation requires that, besides experiencing or being at risk of abuse or neglect and the inability to protect self, the person 'has needs for care and support' regardless of whether the authority is meeting those needs.[49] In both nations the inability to protect self must arise out of the need for care and support rather than the abuse or neglect. The effect of this is to restrict adult safeguarding to inherent vulnerability, when for many people they experience harm or the risk of it because of situational vulnerability. Pritchard-Jones summarises the position as follows.

> *Within both pieces of legislation and their supporting documents and instruments, the first conceptual criticism of vulnerability – the idea that the inability to protect oneself from abuse because of a need, which is generated by an impairment or a disability – therefore remains, despite the terminological shift to "adult at risk". Moreover, the fact that the adult has a disability or impairment which generates needs, which then means they are unable to protect themselves, does nothing to*

[43] Lord Chancellor's Department, *Who Decides: Making Decisions on Behalf of Mentally Incapacitated Adults* (Lord Chancellor's ed, HMSO 1997) para 8.7.

[44] See Department of Health, 'No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse'; National Assembly for Wales, 'In Safe Hands' <http://onenewportlsb.newport.gov.uk/stellent/groups/public/documents/policies_and_procedures/cont363383.pdf>.

[45] Law Commission, 'Adult Social Care', vol Law Com 326 (2011) <https://s3-eu-west-2.amazonaws.com/lawcom-prod-storage-11jsxou24uy7q/uploads/2015/03/lc326_adult_social_care.pdf>, para 9.21.

[46] n. 49, para 9.24.

[47] See n. 32

[48] Department of Health and Social Care, 'Care and Support Statutory Guidance' (2020), paras 14.121, 14.29,14.30, and 14.99 <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance> accessed 22nd November 2020.

[49] s.126(1)(b) Social Services and Well-being (Wales) Act 2014 and s.42(1)(a) Care Act 2014.

> *remove the idea that the adult themselves is "to blame" for their abuse, which … was a key concern of the terminology "vulnerable adult.*[50]

This tethering of safeguarding intervention to status partly undermines the improvements in adult safeguarding found in both pieces of legislation. For example, some cases of domestic abuse are excluded from safeguarding because of this; the harm is situational rather than inherent. Robbins argues domestic abuse is already marginalised in social work; the 2014 legislation consolidates this.[51]

The Scottish Adult Support and Protection Act 2007 adopts a different approach when defining 'adults at risk'. Section 3(1) uses the following definition: a person is an adult at risk if they,

> *(a) are unable to safeguard their own well-being, property, or other interests,*
>
> *(b) are at risk of harm, and*
>
> *(c) because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.*

This is a softer approach, although inherent vulnerability still features in deciding the level of vulnerability to harm. Vulnerability is determined by the situational requirements of being unable to safeguard themselves and being at risk of harm.

This brief account of the term 'vulnerable adults' and its transformation into 'adults at risk' identify two issues. First, the term 'vulnerable adults' is demeaning and should have no place in adult safeguarding. As noted above, respondents to the Law Commission's adult social care consultation paper regarded it as stigmatising and demeaning. Whether adult at risk as defined in Welsh and English social care legislation is an improvement is debatable. Second, it is based on the inherent vulnerability of the person; their need for care and support rather than exposure to abuse and neglect triggers safeguarding duties.

Vulnerability is also used extensively in other areas of law. In criminal law, special measures are made available for vulnerable and intimidated witnesses when giving evidence as a victim or a witness. In the case of an adult a witness is vulnerable if the quality of their evidence is likely to be diminished because they are suffering from a mental disorder under the Mental Health Act 1983, have a significant impairment or intelligence and social functioning, or have a physical disability or are suffering from a physical disorder.[52]

Discussion

The above raises several issues concerning adults who are prevented or unable to decide. Inability to decide alone is not a justification for legal intervention unless it is beyond the control of the person and there is a sound human right's compliant reason to justify intervention. Any such intervention must be in accordance with the law.[53] The inherent jurisdiction has successfully been

[50] Laura Pritchard-Jones, '"Adults at Risk": "Vulnerability" by Any Other Name?' (2018) 20 The Journal of Adult Protection 47.

[51] Rachel Robbins and others, 'Is Domestic Abuse an Adult Social Work Issue?' (2016) 35 Social Work Education 131 <https://www.tandfonline.com/doi/abs/10.1080/02615479.2016.1140733> accessed 3 July 2020; Kristin Heffernan, Betty Blythe and Paula Nicolson, 'How Do Social Workers Understand and Respond to Domestic Violence and Relate This to Organizational Policy and Practice?' (2014) 57 International Social Work 698; Sarah Wydall and others, 'Domestic Abuse and Elder Abuse in Wales: A Tale of Two Initiatives' (2018) 48 British Journal of Social Work.

[52] s. 16 Criminal Evidence Act 1999.

[53] Article 8(2) European Convention on Human Rights.

used to intervene where a 'vulnerable adult' needs to have their autonomy restored. As with the courts' work developing the law of mental capacity pre 2005, the judiciary have used the power wisely in the interests of humanity and a need to act. To argue that the cases cannot, in the absence of relevant legislation, be decided under the inherent jurisdiction would be to condemn many adults to abuse and neglect because of a gap in legislation. Whilst the judges have acted with compassion as they did with mental capacity pre-2005, this does not preclude a different way of doing things. The concerns raised in Re F (2000) are compelling. Although made in the context of mental capacity, they are of wider application. Butler-Sloss LJ's call for a 'well-structured and clearly defined framework'[54] equally applies to other adults needing protection. The European Court in HL v UK when discussing article 5 of the European Convention on Human Rights, held that detention based on common law was too arbitrary and lacked sufficient safeguards, such as those found under the Mental Health Act 1983. Legislation was required.[55] This is an equally compelling argument when considering intervening in the private life of adults whose ability to decide has been compromised.

A proposal was put to the Joint Committee of the House of Lords and House of Commons considering the draft Incapacity Bill that its scope should be extended to include inability to make a free choice because of undue influence. Drafting would be complex and would involve safeguards to prevent unnecessary and disproportionate interventions in people's private life. The Committee did not feel confident in recommending such an approach.[56] However, the relatively unchecked ability of the courts to extend the inherent jurisdiction, without the structure referred to by Butler-Sloss LJ, necessitates a reconsideration of this. Yes, drafting legislation would be difficult, but not impossible. Much more is known about undue influence or what is now referred to as coercive or controlling behaviour. It is now a criminal offence in certain circumstances.[57] It is also worth noting that Munby J referred to the case of Re T to support the inclusion of undue influence. There are also statutory definitions, although they cannot be indiscriminately incorporated into legislation. Legislation would ensure a well-structured framework with workable definitions and procedural safeguards.

Definitions are challenging. Munby J's explanation in Re SA is helpful. It is interesting to note that it anticipates vulnerability being inherent and situational, or situational. This distinguishes it from the approach taken in the 2014 reforms of social care law in Wales and in England, which still rely on inherent vulnerability. 'Vulnerable' must be replaced. A new definition could be built around an inability to decide because of:

1. Inherent factors that seriously inhibit decision-making on significant matters. These may include:
    a. Mental incapacity (based on the definitions in the 2005 Act).
    b. Physical disability.
    c. Mental health.
2. Situational factors that seriously inhibit decision-making on significant matters.
    a. Coercive or controlling behaviour.
    b. Curtailment of the freedom to decide.
3. Inherent and situational factors that seriously inhibit decision-making on significant matters.

[54] See n.23
[55] See n.14
[56] n.6, para 270
[57] See s.76 Serious Crimes Act 2015; McMahon, Marilyn, and Paul McGorrery. "Criminalising controlling and coercive behaviour: The next step in the prosecution of family violence?" *Alternative Law Journal* 41, no. 2 (2016): 98-101.

Powers under new legislation would in the case of mental capacity include powers to make decisions, although subject to any commitment to partially or fully implement the Convention on the Rights of Persons with Disabilities right for people to decide. In all other cases the purpose of intervention would be to restore autonomy, a principle taken from the inherent jurisdiction. Donnelly's suggestion that using the terminology of respecting rights would afford greater recognition of will and preferences should be the basis upon which decisions are made under new legislation. It has greater resonance with the Convention on the Rights of Persons with Disabilities.

As discussed, the Convention on the Rights of Persons with Disabilities includes the right to supported decision-making. Information is one of the three components of decision-making. A duty on decision-makers in public authorities to provide information would be a starting point. The duty could also be extended beyond disability and include those whose capacity has been compromised through coercive or controlling behaviour. In identifying the level of information required, legislation could draw upon medical law principles and the guidance given to doctors.[58]

Conclusion

Although in a different context, the Bamford Review[59] highlighted the need for a 'coherent and coordinated' approach to legislation. This principle should apply to adults where it is thought necessary to intervene on their behalf where their decision-making ability has been seriously compromised by inherent and/or situational factors and their human rights are at risk. Such interventions must be carefully structured and ensure that they achieve an appropriate and proportionate human rights-based response. Interventions, as seen in the inherent jurisdiction cases, protect human rights. However, that does not mean that greater protection is not required to achieve clarity of definitions, and procedural and other safeguards. The incremental approach of the common law is no longer a sufficiently robust way of achieving this, despite the good work that has been done by the judiciary. A holistic review of decision-making involving those whose legal capacity has been compromised is needed. Any such legislation could also help align our approach to the Convention on the Rights of Persons with Disabilities, particularly in relation to supported decision-making. It is unlikely that legislation would anticipate all eventualities and the inherent jurisdiction would still have a residual role, but it would be significantly reduced in favour of a clear statutory framework.

[58] Montgomery v Lanarkshire Health Board [2015] UKSC 11; General Medical Council, 'Ethical Guidance for Doctors: Decision Making and Consent.' (2020) <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/decision-making-and-consent>, para 10-13.
[59] See n. 7