SCOTTISH LAW COMMISSION
(Scot Law Com No 151)

Report on Incapable Adults

Report submitted under section 3(2) of the Law Commissions Act 1965

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The Scottish Law Commission was set up by section 2 of the Law Commissions Act 1965 for the purpose of promoting the reform of the law of Scotland. The Commissioners are:

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Scottish Law Commission

Item 17 of our Fourth Programme of Law Reform

Judicial Factors, Powers of Attorney and Guardianship of the Incapable

To: The Right Honourable the Lord Rodger of Earlsferry, QC
Her Majesty's Advocate

We have the honour to submit our Report on Incapable Adults.

(*Signed*) C K DAVIDSON, *Chairman*
E M CLIVE
W A NIMMO SMITH
N R WHITTY

KENNETH F BARCLAY, *Secretary*
14 July 1995

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Part 1 Introduction

Background to the report

1.1 This report follows on our Discussion Paper No. 94 *Mentally Disabled Adults: Legal Arrangements for Managing their Welfare and Finances* which we published in September 1991. In August 1993 we published another Discussion Paper No. 96 *Mentally Disordered and Vulnerable Adults: Public Authority Powers* and have subsequently received many comments on it. That paper was concerned with rationalising the powers public bodies such as local authorities, the Mental Welfare Commission and the police enjoy in order to protect the mentally disabled or those suspected of being mentally disabled. These issues are sufficiently different from those in this present report to justify a separate report. We intend to produce a report following on Discussion Paper No. 96 in the near future.

1.2 Over the last two decades there has been renewed interest in the problems of the mentally disabled. In 1988 the Scottish Health Service Planning Council published a report on *Scottish Health Authorities Review of Priorities for the Eighties and Nineties*[1] which placed services for old people with dementia in the highest category followed by community care for the mentally ill and the mentally handicapped. This assessment of priority was accepted by the then Secretary of State for Scotland. The greater awareness of the needs of the mentally disabled is in part due to the increasing number of elderly people suffering from dementia and similar mentally disabling conditions. The incidence of dementia increases with age. It has been estimated that dementia affects some 3% of the population aged between 65 and 69 years old, but around 20% of those aged 80 or over[2]. The number of people aged 80 or over has risen considerably over the last 15 years from 113,700 in 1977[3] to 175,000 in 1992[4]. The number is expected to rise still further over the next few years[5] due to demographic trends and advances in medicine.

1.3 Another factor is the changing attitudes of society and those professionally caring for the mentally disabled. The policy of care in secure institutions has over the years been replaced by one of providing appropriate support and care so that the mentally disabled can so far as possible live in the community. As the White Paper *Caring for People: Community Care in the Next Decade and Beyond* states:[6]

> "Community care means providing the services and support which people who are affected by problems of ageing, mental illness, mental handicap or physical or sensory disability need to be able to live as independently as possible in their own homes, or in "homely" settings in the community. The Government is firmly committed to a policy of community care which enables such people to achieve their full potential".

The White Paper was implemented by the National Health Service and Community Care Act 1990 which came into force fully in April 1993. Local authorities now charge elderly people for most of the services supplied to them. Private and local authority homes also levy substantial residence charges. This leads to complex financial decisions having to be taken to meet the charges, perhaps by realising assets such as dwellinghouses. These decisions will have to be taken in conjunction with decisions about personal welfare and treatment.

1.4 There is also a greater awareness of the rights of the mentally disabled. The philosophy that lies behind the new approach is one of minimum intervention in their lives, consistent with providing proper care and protection and maximum help to enable individuals to realise their full potential and make the best use of the abilities they have. The United Nations *Declaration on the Rights of Mentally Retarded Persons*[7] encapsulates the new approach and is worth quoting in full:-

> "Article I The mentally retarded person has, to the maximum degree of feasibility, the same basic rights as other human beings.

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1. Edinburgh HMSO.
2. Data on Dementia, Scottish Action on Dementia, October 1986.
3. Registrar General Scotland, *Annual Report 1977*, HMSO, Table N 2.3.
4. Registrar General Scotland, *Annual Report 1993*, HMSO, Table N 2.4.
5. 245,000 in 2016. *Annual Report 1993*, Table N 2.4.
6. Cm 849 (1989), para 1.1.
7. 1971 UN General Assembly 26th Session, Resolution 2856.

Article II The mentally retarded person has a right to proper medical care and physical therapy and to such education, training, rehabilitation and guidance as will enable him to develop his ability and maximum potential.

Article III The mentally retarded person has a right to economic security and to a decent standard of living. He has a right to perform productive work or to engage in any other meaningful occupation to the fullest possible extent of his capabilities.

Article IV Whenever possible, the mentally retarded person should live with his own family or with foster parents and participate in different forms of community life. The family with which he lives should receive assistance. If care in an institution becomes necessary, it should be provided in surroundings and other circumstances as close as possible to those of normal life.

Article V The mentally retarded person has a right to a qualified guardian when this is required to protect his personal wellbeing and interests.

Article VI The mentally retarded person has a right to protection from exploitation, abuse and degrading treatment. If prosecuted for any offence, he shall have a right to due process of law with full recognition being given to his degree of mental responsibility.

Article VII Whenever mentally retarded persons are unable, because of the severity of their handicap, to exercise all their rights in a meaningful way or should it become necessary to restrict or deny some or all of these rights, the procedure used for that restriction or denial of rights must contain proper legal safeguards against every form of abuse. This procedure must be based on an evaluation of the social capability of the mentally retarded person by qualified experts and must be subject to periodic review and to the right of appeal to higher authorities."

1.5 In the twenty or so years since the United Nations declaration many countries have enacted legislation embodying its principles. These include Alberta (Dependent Adults Act 1976), United States of America (Uniform Guardianship and Protective Proceedings Act, finalised for adoption by states in 1982), Queensland (Intellectually Handicapped Citizens Act 1985), Victoria (Guardianship and Administration Board Act 1986), Northern Territory, Australia (Adult Guardianship Act 1988), New Zealand (Protection of Personal and Property Rights Act 1988) and West Germany (Betreuungsgesetz 1990). In preparing our discussion paper and this report we have been greatly helped by material from these and other countries. Our discussion paper contained much comparative material to illustrate the different approaches taken on particular issues. Since then we have also benefitted from the comparative and international material, and views on policy, presented at the Council of Europe's Third European Conference on Family Law, which devoted a day to discussion of legal topics relating to incapacitated adults[1]. This wealth of material is not reproduced here for reasons of space and we merely set out succinctly our recommendations for reform of the law of Scotland in this area. We believe that our recommendations are very much in line with recent developments in other countries and with internationally accepted principles.

1.6 The Law Commission for England and Wales has been conducting an examination of the law relating to mentally incapacitated adults along very similar lines to ours. It has published many consultation papers[2] and a report[3]. We have been in close touch with Commissioners and staff of the Law Commission throughout and have had many useful and constructive discussions with them. The general approach of our report is much the same as that of the Law Commission's report. However, there are many differences between the two sets of recommendations and draft Bills. This is partly due to the different responses that each Commission received on consultation, but other factors are the differences in the existing law and court structure between the two jurisdictions.

The present law in outline

1.7 Scottish law has a number of methods which enable decisions to be made or action taken on behalf of adults who are incapable of deciding or acting themselves. In the personal welfare field guardians under the 1984 Act, tutors-dative and tutors-at-law may be appointed by the courts and doctors and other health-care professionals have authority to give incapable patients treatment which is in their best interests to receive. For property and financial affairs there are curators bonis and tutors-at-law appointed by the courts, attorneys appointed by the individuals whose affairs they deal with, many statutory schemes limited to particular property or people in particular situations, and *negotiorum gestio.*

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1. The Conference was held at Cadiz from 20-22 April 1995. A member of this Commission attended the conference as a Rapporteur on one of the topics at the invitation of the Council of Europe.
2. *Mentally Incapacitated Adults and Decision-Making: An Overview*, No. 119, published April 1991; *Mentally Incapacitated Adults and Decision-Making: A New Jurisdiction*, No. 128 (1993): *Mentally Incapacitated Adults and Decision-Making: Medical Treatment and Research*, No. 129 (1993): *Mentally Incapacitated and Other Vulnerable Adults: Public Law Protection*, No. 130 (1993).
3. *Mental Incapacity*, Law Com No. 231, March 1995.

1.8 **Mental health guardians.** A guardian under the Mental Health (Scotland) Act 1984 (a "mental health guardian") may be appointed to an adult by the sheriff on application by a mental health officer (or occasionally a relative of the adult) of the local authority in whose area the adult lives. The application is supported by two medical reports specifying the form of mental disorder the adult is suffering from and stating that the disorder is such as to warrant guardianship, and a recommendation from the mental health officer that guardianship is necessary in the interests of the welfare of the adult[1]. The mental health guardian may be the local authority or any person chosen, or accepted as suitable, by the local authority[2]. In practice most guardians are the local authority or its Director of Social Work. The powers of a mental health guardian are statutory and three in number; power to require the adult to reside at a specified place, power to require the adult to attend for treatment or training, and power to require access to be given to doctors, mental health officers and others[3].

1.9 **Tutors-dative and tutors-at-law.** Tutors-dative have been recently revived in order to provide a more personal type of guardianship[4]. They are appointed by the Court of Session after consideration of two medical certificates of incapacity. Centuries ago tutors-dative were appointed to act on behalf of incapable adults in all aspects of their lives. In modern practice tutors-dative are granted personal welfare powers only[5]. The appointment of a tutor-dative is not intimated to the Mental Welfare Commission or local authority and these bodies have no statutory duties to visit those subject to tutory. Tutors-at-law are also appointed by the Court of Session using a similar procedure to that used for tutors-dative. Tutors-at-law, like tutors-dative, were common centuries ago but became obsolescent. Recently, after a gap of over 100 years, a tutor-at-law has been appointed[6]. A tutor-at-law has full power over the personal welfare and financial affairs of the adult. The tutor-at-law can only be the nearest male relative. He is entitled to be appointed by virtue of his relationship unless his unsuitability is established. A tutor-at-law supersedes any tutor-dative or curator bonis who has previously been appointed.

1.10 **Medical treatment.** Patients who are unconscious or otherwise temporarily incapable of giving consent may, on the basis of necessity, be given treatment which is necessary and which cannot reasonably be postponed until capacity is recovered[7]. The 1984 Act also contains special provisions on urgent treatment for patients who are detained under that Act[8]. In 1989 in the case of *Re F (Mental Patient: Sterilisation*[9]) the House of Lords clarified the law of England and Wales relating to the treatment of permanently incapacitated patients. Treatment could be given to such patients in their best interests, ie to save their lives or to secure improvement or prevent deterioration in their physical or mental health. The House of Lords' decision would probably be followed in Scotland.

1.11 **Curators bonis.** A curator bonis ("curator" for short) may be appointed to a person who is of unsound mind and incapable of managing his or her affairs or giving instructions for their management[10]. The application for a curator is by way of petition to the Court of Session or the sheriff court. Usually one or more of the incapable adult's relatives will petition, but anyone with an interest may do so[11]. The local authority must, and the Mental Welfare Commission may, petition if no-one else is doing so and a curator is necessary[12]. The petition is supported by two medical certificates to the effect that the grounds for appointment are established. On appointment the curator takes over the management and administration of the incapable adult's affairs completely and acts under the supervision of the Accountant of Court, an official of the Court of Session. The curator must submit an initial inventory and annual accounts of transactions thereafter to the Accountant of Court for audit.

1.12 **Attorneys.** An attorney is a person appointed by another (the granter) under a contract of mandate or agency to deal with some or all aspects of the granter's property and financial affairs. The contract may take the form of a document setting out the powers conferred on the attorney, but oral contracts are also competent. The powers conferred are usually very wide, especially where the purpose of the contract is to enable the attorney to manage the granter's property and financial affairs after the latter's incapacity. All powers of attorney granted since 31 December 1990 continue to be effective after the granter's incapacity unless the contract contains provisions to the contrary[13].

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1. 1984 Act, ss 37 and 38.
2. 1984 Act, s 37(2).
3. 1984 Act, s 41(2).
4. See Adrian Ward's articles in 1987 SLT (News) 69 and 1992 SLT (News) 325. None of the recent tutor-dative cases have been reported except *Chapman Petrs* 1993 SLT 955.
5. *Chapman Petrs* 1993 SLT 955, but see *Queen Petr* 1992 mentioned in Adrian Ward's article *Tutors to Adults: Some Developments* 1992 SLT (News) 325.
6. *Britton v Britton's CB* 1992 SCLR 947.
7. Mason and McCall-Smith, *Law and Medical Ethics*, (4th edn) p 220; NHS Scotland, *A Guide to Consent to Examination, Investigation, Treatment or Operation* (1992), page 5.
8. S 102.
9. [1990] 2 AC 1.
10. Walker, *Judicial Factors*, p 22.
11. *Mason* (1852) 14 D 761 (adult's solicitor).
12. 1984 Act, ss 92 and 93.
13. Law Reform (Miscellaneous Provisions) (Scotland) Act 1990, s 71.

1.13 **Statutory schemes.** There are a number of schemes regulated by primary or subordinate legislation. The following are the more common.

(a) The Department of Social Security may appoint a person to claim, receive and deal with any Social Security benefit on behalf of an incapable adult. The application for appointment is made on a prescribed form and medical evidence of the adult's incapacity may be asked for[1].

(b) The managers of a hospital may look after money and valuables belonging to in-patients who have been certified by the doctor in charge as being incapable of managing and administering their property and affairs. The managers may manage amounts up to £5,000 for a particular patient; beyond this sum the consent of the Mental Welfare Commission must be obtained[2].

(c) Government departments[3] and industrial and provident societies[4] may at their discretion pay funds due to a mentally incapable person to an individual who is looking after that person.

1.14 ***Negotiorum gestio.*** *Negotiorum gestio* is a doctrine whereby one person (the *gestor* or manager) may manage the affairs of another who is absent or incapacitated, without there being any official appointment or contract of mandate. It is based on a sort of legally presumed mandate[5]. It is not limited to urgent or immediate acts of administration. Management by a *gestor* may continue for many years[6]. *Negotiorum gestio* enables a relative or a friend of an incapable adult to manage the adult's property and financial affairs, and recover outlays, without the expense of having a curator appointed.

What's wrong with the present law?

1.15 Each existing method briefly described in the previous section suffers from various defects and is in need of reform. There are however more general criticisms, that the present law is fragmented, archaic and fails to provide an adequate remedy in many common situations.

1.16 The powers of a mental health guardian are fixed by statute[7] and cannot be added to or varied to suit the needs and capabilities of the adult under guardianship. Where, as is commonly the case, the guardian is the local authority or the director of social work, the functions have to be delegated, but it is often unclear which person concerned with the welfare of the adult is actually exercising the guardianship powers[8]. The procedure for appointing a mental health guardian takes some time but there is no power to make an interim appointment to deal with an urgent situation. Other criticisms are that the local authority mental health officer exercises effective control over guardianship since any application must contain his or her recommendation[9], the welfare ground for appointment ("necessary in the interests of the welfare of the patient") is vague and "necessary" is too high a standard.

1.17 Because tutory dative is a recently revived post of considerable antiquity the powers and duties have to be gathered from centuries old cases. It is not clear how far they remain authoritative today in a society with a different outlook and values and different procedures. The local authority and Mental Welfare Commission do not have the same statutory duties in relation to adults subject to tutory as they do in relation to adults under mental health guardianship. Yet the powers of a tutor may be far greater than those of a guardian. Tutors-dative can be appointed only by the Court of Session.

1.18 Tutors-at-law are another recently revived type of guardian whose functions are therefore somewhat uncertain. The fact that the post may be held only by the nearest male relative is incompatible with modern notions of sexual equality. Furthermore, relationship should be only one of a number of factors that should be considered in selecting a suitable person to deal with the personal welfare and financial affairs of an incapable adult.

1.19 A curator bonis takes over the management of the adult's whole estate. The curator's powers are not tailored to the needs and abilities of the adult. There is uncertainty as to the correct balance between conserving the estate and spending it for the adult's benefit, and as a result many curators adopt a conservative approach. Curatory, which is an appointment that lasts until recalled, may be imposed on adults whose needs could be met by a short-term order limited to a particular area of need. Curatory is expensive and the problem of high initial and running costs is particularly acute with small estates.

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1. Social Security (Claims and Payments) Regulations 1987, reg 33, SI 1987/1968.
2. 1984 Act, s 94.
3. Mental Health Act 1983, s 142.
4. Industrial and Provident Societies Act 1965, s 22.
5. Bell, *Principles*, para 540.
6. *Fernie v Robertson* (1871) 9 M 437.
7. 1984 Act, s 41.
8. See Mental Welfare Commission *Annual Report* 1987, p 24 and *Annual Report* 1989, paras 12.5 and 12.19.
9. 1984 Act, s 37(3).

1.20 The main defect of attorneys is that they are unsupervised. Once the granter becomes incapable there may be no one with sufficient interest to monitor and if necessary challenge the attorney's actings. The court's powers are limited to superseding the attorney by the appointment of a curator[1]. A contract of mandate or agency conferring a power of attorney continues in effect after the granter's incapacity by virtue of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990[2]. Contracts may therefore confer continuing powers inadvertently through the granter's failure to exclude the statutory provision or to consider carefully whether a continuing power ought to be granted.

1.21 Hospital management of certified in-patient's funds is too informal. A patient's right to deal with his or her own affairs can be taken away by a single doctor certifying incapacity without any court hearing and without any appeal. Many patients could manage their affairs if more help and advice were available to them. Some managers adopt a negative attitude and fail to claim benefits and spend money on behalf of patients so as to enhance their quality of life[3]. Finally, only managers of hospitals may avail themselves of this statutory procedure. Other establishments, such as local authority homes and private nursing and residential homes are unable to manage their residents' finances. This lack of financial management powers is becoming more acute as more and more people with impaired capacity are being moved out of hospitals.

1.22 *Negotiorum gestio* is a useful background doctrine. It provides a legal underpinning for many everyday acts of administration on behalf of incapable adults. However, it suffers from a lack of any document evidencing the appointment or powers of the *gestor*. It is therefore often difficult for *gestors* to persuade third parties to deal with them or accept instructions from them.

1.23 The existing Scottish law is fragmented. With the sole exception of a tutor-at-law all the other methods of dealing with incapacitated adults relate either solely to personal welfare or solely to property and financial affairs. Thus curators have no functions in the personal welfare field while mental health guardians are prohibited by statute from intromitting with the funds of the adults under guardianship[4]. In current practice tutors-dative are restricted to personal welfare matters while attorneys have only financial functions. However, most adults' welfare and finances are inextricably connected and decisions in one area may well have repercussions in the other. Furthermore, for historical reasons various remedies are available only in certain courts. The Court of Session has exclusive jurisdiction to appoint tutors-at-law and tutors-dative while mental health guardians can be appointed only by a sheriff. In order to provide an overall scheme to meet an adult's welfare and financial needs more than one application may have to be made in the same or separate courts.

1.24 Many of the existing methods are inflexible or limited. The law does not allow the remedies to be tailored to the adult's needs. The major exception to this is tutory dative. There is no recognition of the concept of least restrictive action or minimum necessary intervention. A curator takes over the adult's entire estate and financial affairs. A mental health guardian has three limited statutory powers which cannot be added to or subtracted from.

1.25 Much of the law is archaic. Tutors-at-law are appointed under the Curators Act 1585; the law relating to curators rests mainly on the Judicial Factors Act 1849 and even older Acts of Sederunt and practice, and the functions of tutors-dative have to be gleaned from 17th and 18th century cases when such appointments were common. In order to regulate the property and investment powers of curators they have been spatchcocked into the Trusts (Scotland) Acts although they have little in common with trustees. The assets of a trust are made over to and owned by the trustees, whereas the title to an incapable adult's estate remains with the adult, the curator being simply a manager.

1.26 The final general criticism is that Scottish law fails to deal with, or provide adequate remedies in, many common situations. It is not clear whether it is competent to appoint an attorney to make personal welfare decisions on behalf of the granter when he or she becomes incapable. It is not possible to obtain a court order in the financial field limited to a particular area or item of property in order to deal with a particular short-term problem. There is an urgent need for simple schemes not involving the courts for dealing with the finances of those with small or modest estates, such as obtaining authority to use funds in an incapable adult's bank account for the daily needs of that adult. This would be of great benefit to the many carers who are looking after an incapable relative at home. Managers of local authority homes are unable to manage their incapable residents' finances in the same way as managers of hospitals can. The initial and running costs of a curatory are such that it is uneconomic where the estate is modest. The two schemes mentioned previously, together with a system of low cost public management, would go far to address these needs. As far as the authority to give medical treatment to incapable adults is concerned the law in Scotland is uncertain, there is no Scottish authority on advance statements - statements made by patients while capable as to how they wish to be treated when incapable, and the legality of carrying out medical research on those who are incapable of consenting to participate is far from clear.

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1. See *Fraser v Paterson* 1987 SLT 562.
2. S 71.
3. Scottish Health Service Planning Council, *Report of the Working Party on Incapax Patients' Funds*, (1985) p 14.
4. 1984 Act, s 41(3).

Our reforms in outline

1.27 Many of those responding to our discussion paper commented that the existing law was so patchy and inadequate that a radical reform was the only solution. We have endeavoured to produce recommendations and draft legislation dealing comprehensively with the personal welfare and financial affairs of the incapacitated. At the heart of our recommendations lie certain general principles which are set out in our draft legislation and which should influence every exercise of functions under it. The most important of these principles is that any intervention must be for the benefit of the incapable adult concerned and be the least restrictive to achieve that benefit. Another principle emphasises the need to take the past and present wishes and feelings of the adult into account as well as the views of others close to the adult, such as the nearest relative and primary carer as well as any attorney or guardian. Finally, incapable adults should be encouraged to exercise their existing skills and to acquire and develop new skills.

1.28 Incapacitated adults and their carers should be enabled and encouraged to do as much as possible for themselves and to make their own arrangements for possible future incapacity. Into this category comes the appointment of an attorney for management of property and finances and dealing with personal welfare. Another way in which people could influence their medical treatment after they become incapacitated would be by way of advance statements. The status and legal effect of these in Scotland is set out in our draft legislation. Guardianship by relatives or friends rather than professionals is encouraged, particularly for personal welfare matters and where property of modest value is concerned. In all these schemes there would be a certain degree of oversight by public officials and organisations to ensure that incapable adults are not exploited or abused.

1.29 The various gaps we have identified in the existing law are addressed. We recommend the introduction of schemes whereby a carer looking after an incapable adult at home could be authorised to withdraw money from the adult's bank or building society account to meet the adult's living expenses. In institutional settings the managers of hospitals and other approved establishments would be authorised to manage income and certain other financial matters on behalf of their incapable residents. Authority would be granted by a new public official - the Public Guardian - who would also investigate complaints and carry out spot checks and where necessary terminate the carers' or managers' authority. Our draft legislation also contains provisions dealing with the medical treatment of, and medical research on, the incapable in a more coherent and comprehensive way than the somewhat patchy and uncertain common law. Low cost public management of small estates by the Public Guardian is recommended to deal with the problem that the cost of professional management imposes too great a burden.

1.30 In the absence of satisfactory informal or formal arrangements, such as those described in the previous two paragraphs, the court is to have power to make intervention orders or guardianship orders. These form a flexible system by which powers can be conferred which will be tailored to the incapable adults' needs and incapacity. Intervention orders are intended to deal with single issues or single assets - "one-off" situations. Guardianship is designed for those adults where continuous management or assistance is required over a lengthy period. Intervention orders and guardianship orders would form an integrated and coherent system in that both personal welfare and financial issues could be dealt with in the same proceedings and the guardian could have powers conferred in either or both fields as appropriate in the circumstances.

Scope of the report

1.31 Part 2 of the report sets out the general principles which are to apply to all decisions relating to the mentally disabled in the areas covered by this report. It also contains the proposed general jurisdiction of the sheriff courts in relation to incapable adults and the proposed regulatory and supervisory framework of public officials and organisations. Part 3 is concerned with measures that adults can take to ensure that their personal welfare and financial affairs will be looked after should they become incapable at some future date. We look at continuing powers of attorney and recommend that an attorney should be able to deal with personal welfare as well as property and finances. In Part 4 we recommend various schemes that would enable those caring for incapable adults to assist them without having to apply to the courts. The schemes include management of incapable patients' and residents' financial affairs by the hospital, home or other institution in which they are living and allowing, under safeguards, limited access to an incapable adult's bank or similar account for meeting the adult's living and other expenses. Medical matters are the subject of Part 5. We recommend that doctors and other health-care professionals should have a general statutory authority to treat incapable adults. Any decision about treatment would be governed by the general principles set out in Part 2. Certain treatments, however, would require prior authorisation from the courts or an independent second opinion specialist. Advance statements about future medical treatment ("living wills") are also considered and recommendations are made to put them on a firm legal basis. We also recommend a system of strict controls for medical research on the incapable adults. Part 6 relates to measures that require legal proceedings. The courts would, under our recommendations, be empowered to make various orders in the personal welfare and financial fields, including the appointment of a guardian where the incapable adult's circumstances make a long-term appointment necessary. A scheme for financial management of small estates by the Public Guardian (who would also be the Accountant of Court) is put forward to ease the burden on modest estates. Part 7 deals with appeals, transitional

provisions and other miscellaneous matters. Part 8 lists our recommendations. A draft of the legislation required to implement our recommendations forms Appendix A.

1.32 We received a large number of comments on our discussion paper and are grateful to all those who responded. Appendix B to this report lists those organisations and individuals who submitted written comments. Representatives of the Commission participated in many public meetings, seminars and discussion groups organised by some of the bodies involved in the area of mental disability. We found these events extremely useful and derived great benefit from the comments and views expressed at them. We wish to place on record our thanks to the organisations involved and those who attended.

1.33 We have also been greatly assisted in the later stages of this exercise by discussions with the Mental Welfare Commission, the Accountant of Court and his deputy and representatives from the leading Scottish medical bodies. An earlier version of the draft Bill (the final version of which is annexed to this report) was considered in detail by Mr Adrian Ward MBE[1], Mrs Hilary Patrick[2] and Mrs Christine McGregor[3]. We are very grateful to all of them for giving so generously of their time and expertise to assist us with this important project. They are, of course, not responsible for the decisions ultimately taken by us, although their views have always been given very careful consideration.

1.34 In order to shorten commonly occurring references the following abbreviations are used in this report:

(a) "Our discussion paper" for Discussion Paper No. 94 *Mentally Disabled Adults: Legal Arrangements for Managing their Welfare and Finances.*

(b) "The Law Society" for the Law Society of Scotland.

(c) "The Mental Welfare Commission" for the Mental Welfare Commission for Scotland.

(d) "The 1984 Act" for the Mental Health (Scotland) Act 1984.

Two organisations have changed their names since submitting comments on our discussion paper. These are Enable (formerly the Scottish Society for the Mentally Handicapped) and Alzheimer Scotland - Action on Dementia (formerly Scottish Action on Dementia). We use their present names when discussing their comments.

1. A solicitor with wide professional experience of the mentally disabled, an author of several books on the subject and Chairman of the Central Scotland Health Care NHS Trust.
2. Legal adviser to the Scottish Association for Mental Health and author, with Professor Blackie, of a book on the 1984 Act.
3. The Social Work Commissioner with the Mental Welfare Commission and author with her predecessor (Mr Huw Richards) of a book on guardianship in Scotland.

Part 2 General Matters

Introduction

2.1 In later sections of this report we recommend the introduction into Scottish law of guardians of incapable adults with powers in the financial and personal welfare fields, attorneys with a similar range of powers exerciseable after the granter's incapacity and other extra-judicial methods of managing some financial assets of incapable adults in order to use the money for their benefit. In this Part we discuss certain general matters such as what the grounds should be for the appointment of a guardian or other intervention in the financial or personal affairs of an adult, what forum (court, tribunal or other body) should appoint guardians and adjudicate on matters falling within the scope of our recommendations, how the various people exercising functions on behalf of adults are to be supervised and the general principles that should be taken into account in order to decide what intervention (if any) should be made and what form any intervention should take. We conclude with a section on the fiduciary relationship between those exercising functions and the incapable adults.

Adults the report deals with

2.2 Our discussion paper was entitled "Mentally Disabled Adults" and dealt with them and not with mentally disabled children. At the time of its publication adults were those who had attained their eighteenth birthday. Shortly afterwards the Age of Legal Capacity (Scotland) Act 1991 came into force. Now individuals attain full capacity in respect of virtually all matters contained in the discussion paper on their sixteenth birthday, at the latest. Parents also lose corresponding parental rights when their child attains 16. Mentally disabled children under 16 will either be in the care of their parents or others or be looked after under existing child-care legislation. There is a slight overlap in that children's hearings continue to have jurisdiction over individuals up to the age of 18 where a supervision requirement was in force before the child was 16[1], but we do not think that this will give rise to any problems. We therefore recommend that:

1. **The recommendations in this report should apply only in relation to individuals aged 16 and over.**

Clause 67(1)

General grounds for intervention

2.3 On what grounds should the court have power to deal with applications involving an intervention in the personal welfare or financial affairs of a mentally disabled adult? We have found this a difficult issue. We have been unable to derive much help from the legislation in other countries as each country adopts a different approach and their provisions seem open to criticism in one respect or another. Under the present Scottish law a guardian may be appointed under the 1984 Act to a patient if[2]:

"(a) he [the patient] is suffering from mental disorder of a nature or degree which warrants his reception into guardianship; and

(b) it is necessary in the interests of the welfare of the patient that he should be so received".

In our discussion paper[3] we criticised these grounds, especially the welfare test in (b). We suggested that it was too vague[4] and that the word "necessary" imposed too stringent a requirement. We did not see these as suitable grounds for the appointment of our proposed new personal guardians. Instead we proposed[5] that a personal guardian should be appointed or some other personal welfare order made only if the court was satisfied that:

"(a) the person in question lacks wholly or partly the capacity to understand the nature of and to foresee the possible implications of personal welfare decisions or has such capacity but is unable to communicate or act consistently in accordance with such decisions, and

1. Social Work (Scotland) Act 1968, s 30(1).
2. S 36.
3. Para 2.38.
4. See also Richards and McGregor, *Guardianship in Scotland*, HMSO 1992, p 41.
5. Proposal 5, para 2.62.

(b) the appointment of a personal guardian or the making of some other order would result in a substantial benefit to, or necessary protection of, the person."

In addition we considered that the fact that the person has acted or intends to act in a way an ordinary prudent person would not act should not by itself be evidence of lack of capacity.

2.4 The normal ground for appointment of a curator to a person is that the person is of unsound mind and incapable of managing his or her affairs or giving instructions for their management[1]. Curators have in the past been appointed to physically incapacitated persons. "Giving instructions" includes not only the initial act of appointing someone else, such as an attorney, to manage the affairs but also monitoring the appointee's subsequent actings at least to the extent of being able to recall the appointment if the appointee acts improperly[2]. It is very doubtful whether the court would regard a state of facility as a valid ground for appointment. There are old cases in which appointments were made where the person was of weak mind and very apt to be misled[3]. On the other hand there is later, but by no means recent, authority for the view that facility and undue influence are not in themselves sufficient to justify an appointment[4]. Insane delusions also cause problems. If the delusions do not affect the way in which the person manages his or her affairs, then it has been held that the appointment of a curator is not justified[5]. On the other hand if the delusions do affect the management of affairs with the result that the property is used in a way that the person would not have done had he or she been completely sane, a curator may be appointed[6]. In our discussion paper we proposed[7] grounds for the appointment of a financial manager also based on lack of capacity and very similar to those set out in the previous paragraph in relation to personal guardianship.

2.5 The responses received to these proposals were varied. The Scottish Association for Mental Health strongly welcomed the absence of any reasonableness test but also suggested that further discussion was needed to ensure that personal guardianship or other personal welfare orders could be made for all those who could benefit from them. A similar point was made by the Mental Welfare Commission and some other respondents. Guardianship under the 1984 Act is available, not only to adults who lack capacity but also to those who have capacity but are mentally disordered and are being exploited or ill-treated and require guardianship for their protection. A survey of people on guardianship in 1988 was carried out by Huw Richards and Christine McGregor of the Mental Welfare Commission[8]. This study found that "those on guardianship have multiple and cumulative problems and most have problems of family relationships (83%), general vulnerability (80%) and of financial management (83%) ..... 80% of the group were considered vulnerable, gullible or at risk. Half of those studied were unable to care for themselves[9]." Another study of mental health guardianship found that in practice guardians tended to be social workers and commented that as "guardianship is perceived as a protective order and is therefore often used with clients who do not have suitable carers available to become guardians this outcome is inevitable"[10]. If personal guardians could not be appointed for such people then the respondents mentioned above considered that guardianship under the 1984 Act might have to be retained. In view of the otherwise strong response on consultation to having a new unified system of personal guardianship, we think that the grounds for guardianship should be such as to make it available for those in need of protection rather than retaining guardianship under the 1984 Act for this group.

2.6 A somewhat similar criticism to that made by the Mental Welfare Commission and others in relation to personal guardianship was made by the Law Society, Alzheimer Scotland - Action on Dementia, the Scottish Association for Mental Health and Enable in relation to our proposed grounds of appointment for financial managers. They took the view that financial management or some lesser financial intervention order should be available in respect of those who had capacity yet were unable to look after their own affairs or were at risk from exploitation and abuse.

2.7 Our proposed ground of intervention based on "lack of capacity to understand the nature of .... decisions" was criticised. First, the Mental Welfare Commission thought that capacity should not be defined only as intellectual capacity, but should take into account functional ability and potential for autonomy. Secondly, the Law Commission for England and Wales in a consultation paper published after our discussion paper considered that our proposed formula required the adult to understand the nature of the decision-making process itself[11]. In its view the relevant point was the person's ability

1. Walker, *Judicial Factors*, p 22.
2. *Fraser v Paterson* 1987 SLT 562.
3. *Spiers* (1851) 14 D 11; *Dewar v Dewar* (1834) 12 S 315.
4. *Calderwood v Duncan* (1907) 14 SLT 777; *Dowie v Hagart* (1894) 21 R 1052.
5. *Henderson* (1851) 14 D 11.
6. *CB v AB* (1891) 18 R (HL) 40.
7. Proposal 29, para 4.40.
8. *Guardianship in Scotland*, HMSO 1992.
9. P 85.
10. Scottish Office Central Research Unit Paper "*The Hidden Safety Net? Mental Health Guardianship: Achievements and Limitations*", Carole Moore, Anne Connor, Pauline Martin and John Tibbitt (1992), p 84.
11. *Mentally Incapacitated Adults and Decision Making: A New Jurisdiction*, Consultation Paper No 128 (1993), paras 3.20-3.22.

to understand information relevant to the decision rather than "a decision" and to appreciate the reasonable foreseeable consequences of the decision. Thirdly, the Law Society said that lack of capacity was not adequately defined and more detailed criteria were necessary. There is much force in these criticisms.

2.8 Others criticised our inclusion of those who had capacity but acted inconsistently. It was said that many people may choose to act inconsistently, possibly for the very reason that they do understand the implications of rash or unwise decisions. Having made an unwise decision in the past they do not wish to repeat it. Moreover, it was said that many rational people behave inconsistently from time to time. We accept these points and no longer consider that inconsistency should be an express component of our grounds for intervention. Nevertheless, inconsistent behaviour would be a factor to be taken into account in assessing both mental disorder and the ability to carry out the functions in question.

2.9 We have come to the conclusion that it is not desirable to have one single ground that would apply to all the various applications that could be made under our recommendations. The criteria authorising court intervention in relation to continuing powers of attorney, for example, should be different from those where medical treatment is concerned. Guardianship should have different criteria from those for "one off" intervention orders. Guardianship is intended as a long-term appointment which would normally last for years with the possibility of further extension so that the adult should require to have correspondingly long-term needs or inabilities. Furthermore, guardianship has a protective element and should be available to the mentally disabled who are incapable of protecting themselves from serious risk of financial exploitation or physical abuse, rather than be confined to those who are incapacitated in relation to particular decisions.

2.10 Our earlier suggested criteria for intervention in the personal welfare and financial fields set out above contained no express reference to mental disorder. We now consider that a test using mental disorder (as defined in the next paragraph) as a threshold criterion would be preferable. It would help to delimit more clearly the area with which we are here concerned. Mental disorder would be a necessary condition for intervention but clearly should not be a sufficient condition. To intervene in all cases of mental disorder and in all areas of a mentally disordered adult's life would be to fly in the face of our overall principle of least restriction and would be too crude an approach. It would adopt a "label" or "status approach"; fixing a person with a total lack of faculties simply because of a diagnostic finding. Many, if not most, adults will be able to make certain decisions or perform certain tasks notwithstanding their mental disorder. In order to justify intervention we consider that the adult must also be unable, by reason of mental disorder, to make the decision or perform the act in question. The existence of mental disorder and the coupling of that disorder to the lack of ability are in our view necessary. Inability to make a decision or perform an act is something that affects people who are not considered to be mentally disordered, such as the naturally indecisive or those subject to severe conflicting pressures. The more complex the decision or act, the greater the number of people that will be unable to perform it. Relying solely on inability would permit interference in the lives of many people to an extent that we consider would be unjustified.

2.11 We would adopt the definition of mental disorder used in the 1984 Act. Section 1 defines mental disorder to be "mental illness or mental handicap however caused or manifested" but goes on to provide that no person shall be treated as suffering from mental disorder "by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs". This is a well established[1] definition with which doctors and others are familiar. It covers not only the mentally handicapped or those with learning disabilities and the mentally ill, but also dementia sufferers, the brain injured, and patients in a toxic confusional state where an infection has produced toxins which affect the functioning of the brain. Although people who are drunk or under the influence of drugs are not regarded as mentally disordered, those whose mental faculties are impaired due to past drug or alcohol abuse do come within the definition.

2.12 Inability depends on other factors besides the mental disorder. First, in order to make a decision people need to be provided with relevant information, at a level they can understand, about the likely outcomes of the various courses of action. Providing the relevant information in an appropriate form and manner takes more time and effort when the person concerned is physically disabled (blind or deaf) or mentally disabled. Sense Scotland, the National Deaf-Blind and Rubella Association, commented that "There will need to be a commitment to building a structure which can check out as far as possible the extent to which capacity is impaired, and whether that impaired capacity is the result of lack of access to information rather than to lack of understanding". Second, the surrounding circumstances and help available affect a person's ability. Tasks that people might be able to do in the familiar surroundings of their own home may be beyond them in strange surroundings. Having friends around when matters are discussed often enhances the ability of people to make decisions.

2.13 A test based partly on inability to make a decision or perform an act leads to the question of the required standard. In our discussion paper we proposed that as part of our grounds for appointment of a personal guardian[2] or financial

1. It stems at least from the Mental Health (Scotland) Act 1960. Slight amendments were made by the Mental Health (Scotland) Amendment Act 1983 and consolidated into the 1984 Act, but these were not regarded as having changed the categories of people considered in practice to be mentally disordered.
2. Proposal 5(2), para 2.62.

manager[1] the fact that the adult had acted or intended to act in a way an ordinary prudent person would not act should not by itself be taken as lack of capacity. Few respondents directly addressed themselves to this part of the overall proposals, but those that did generally agreed with it. The Scottish Association for Mental Health very strongly endorsed grounds based on inability to make a decision rather than making unreasonable decisions. The Senators of the College of Justice remarked that "acts or an intention to act in the way specified [imprudently] could properly be treated as evidence of lack of capacity and it is enough to say that it should not be conclusive". We consider this point to be equally relevant in relation to grounds of intervention based on mental disorder. Under the 1984 Act mental disorder is not to be taken to be present by reason only of promiscuity and other specified factors[2]. We would add acting imprudently to these.

2.14 In our discussion paper we proposed that personal guardianship[3] and financial management[4] should be considered for those who had the capacity to understand the nature and possible implications of decisions in those areas but were unable to communicate. The paradigm case is the unconscious patient. By inability to communicate we mean total inability to communicate in the circumstances. The inability should have to arise from the adult's physical or other disability and not from circumstances such as absence abroad. Some people, the deaf-blind for example, may be able to communicate only if special interpreters or techniques are used. If these methods of communication are not available when a decision has to be made and intervention cannot reasonably be postponed until they are available then the adult should be regarded, but only for this purpose and on this occasion, as being unable to communicate. We would hope that every effort would be made to provide adequate means of communication to those who need them. In order to avoid any suggestion that those unable to communicate are mentally disordered we would place such people in a separate category.

2.15 Summing up we recommend that:

2. (1) An intervention should be capable of being made under our recommendations if the adult is:

(a) mentally disordered, or

(b) unable to communicate due to physical or other disability
and by reason of such mental disorder or inability to communicate unable to take the decision or carry out the act in question.

(2) Mental disorder should mean mental illness or mental handicap however caused or manifested, but a person should not be regarded as mentally disordered by reason solely of promiscuity or other immoral conduct, sexual deviancy, dependence on alcohol or drugs or acting as no prudent person would act.

Clause 67(2)

2.16 Later in this report in our section on guardianship we recommend slightly different grounds to those recommended above because of the continuing nature of the appointment[5]. However, they too are based on a threshold of mental disorder and inability to perform various functions by reason of such mental disorder.

2.17 In the remainder of this report we use the term incapable adults for those to whom our recommendations apply. In our discussion paper we used the term mentally disabled adults. We do not intend there to be any material difference between the two terms and so, in order to avoid confusion, we also use the term incapable adults when referring to the various proposals in our discussion paper. We would stress that use of the term incapable does not imply that the adult in question is completely incapacitated or cannot manage many aspects of his or her life. As already stated in paragraph 2.9 above mental incapacity has to be evaluated with reference to the task in hand. Thus incapable of making a medical treatment decision means being incapable of making such a decision by reason of mental disorder or inability to communicate.

Which body should authorise interventions?

2.18 In Scotland the vast majority of orders affecting the personal welfare or financial affairs of incapacitated adults are currently made by the courts. Guardianship applications are decided in the sheriff court[6], tutors-dative and tutors-at-law are appointed by the Court of Session, while either court may appoint curators. Some decisions, however, may be made administratively. For example, hospital managers may administer the funds of in-patients who have been certified by the medical officer in charge of treatment as incapable of managing their own property and affairs[7], and persons may be appointed by the Department of Social Security to receive and manage benefits on behalf of incapacitated claimants[8].

1. Proposal 29, para 4.40.
2. S 1(3).
3. Proposal 5(1), para 2.62.
4. Proposal 29, para 4.40.
5. Recommendation 85, para 6.29.
6. 1984 Act, s 40.
7. 1984 Act, s 94.
8. The Social Security (Claims and Payments) Regulations 1987, SI 1987/1968, reg 33.

Many other jurisdictions, such as Alberta and New Zealand, give an equally prominent role to the courts. However, others have set up special tribunals to deal with the issues arising out of mental disability. Victoria, for example, has a Guardianship and Administration Board with a legally qualified president[1]. This board is widely regarded within Australia as a system which works well and has recently been adopted in Western Australia. In England and Wales mental health review tribunals review, on application, cases of patients who have been detained or received into guardianship[2].

2.19 Before the publication of our discussion paper Alzheimer Scotland - Action on Dementia, a voluntary organisation set up to promote the interests of dementia sufferers and their carers, proposed a system of mental health hearings along the line of children's hearings to make decisions on behalf of sufferers[3]. Although the organisation's particular concern was with people with dementia, the proposed hearing system was regarded as suitable for all mentally incapable people. In outline the proposals were as follows:-

(a) A mental health hearing would consist of three people chosen from a list of trained panel members. The members would not necessarily have any legal, medical or social work qualifications. They would be unpaid but would receive allowances for expenses. Panels would be appointed for each region or islands council area.

(b) Each regional or islands council would appoint an official called a mental health reporter, together with appropriate staff.

(c) Hospital staff, social workers, relatives, neighbours and others would be able to contact the reporter if they were concerned about the personal welfare or financial affairs of a mentally incapable adult. The reporter would then come under a duty to investigate and to obtain any necessary reports and assessments.

(d) The reporter could then decide that no action was necessary, dispose of the case informally or refer it to a mental health hearing. He or she would also have power to make interim orders where immediate action was necessary.

(e) A mental health hearing would consist of three members sitting in private together with the reporter, the allegedly mentally incapable adult and his or her representative and relatives. The hearing would have power to appoint an individual to safeguard the interests of an unrepresented incapable adult. Any assessments and reports obtained by the reporter would be available to the hearing. The proceedings would be conducted informally but the hearing could call for witnesses to attend and for documents to be produced.

(f) The hearing would have power to make a wide variety of orders in the personal welfare and financial fields, guided by the principle of minimum intervention. For example, a hearing could order supervision by a social worker, require the incapable adult to reside in a particular home or hospital, attend a day centre, consent to treatment on behalf of the incapable adult, make orders relating to the adult's home, finances and other assets, or appoint a guardian. The hearing's decision would be notified to the Mental Welfare Commission. All orders would be reviewed periodically, or at other times on application by the reporter or the incapable adult.

(g) The reporter or the incapable adult would have a right of appeal to the sheriff in respect of any decision of the hearing.

2.20 In our discussion paper we put forward these three options - court, tribunal, or hearing - outlined their perceived advantages and disadvantages and asked for views as to which would be the most appropriate forum[4]. We were of the view that, whatever forum was adopted, that body should have exclusive jurisdiction over the entire range of matters dealt with in this report and also in relation to applications for detention under the 1984 Act and compulsory removal from home under section 47 of the National Assistance Act 1948 as amended by the National Assistance (Amendment) Act 1951[5].

2.21 The "one door" approach we advocated in our discussion paper was welcomed on consultation. The current need for separate applications (sometimes in different courts) to deal with a mentally incapable adult's personal welfare and financial affairs was deprecated. Tribunals and hearings along the lines proposed were favoured by many respondents, particularly those in the medical and social work field, but the option of using the courts enjoyed majority support. Although, as might be expected, the legal respondents were in favour of courts, support for this option was by no means confined to this category of respondents.

2.22 Those in favour of hearings considered that they would be more user-friendly and approachable than courts. The atmosphere and lay-out of the places where hearings would be likely to be held would put participants more at ease. They also welcomed a non-adversarial approach which would allow incapable adults and their carers, family and others with

1. Guardianship and Administration Board Act 1986, s 5.
2. Mental Health Act 1983, ss 65-79.
3. *Dementia and the Law: The Challenge Ahead* (1988).
4. Proposal 84, para 6.09.
5. Compulsory removal is outwith the scope of this report. We intend to deal with it in a separate report to follow on our Discussion Paper No 96 *Mentally Disordered and Vulnerable Adults: Public Authority Powers* (August 1993).

an interest to play a full part in the proceedings. Another feature regarded as attractive was the lay element. The members of the hearing would be trained, but would not normally have legal, medical or social work qualifications. The Social Work Department of Strathclyde Regional Council commented that the establishment of hearings would strengthen "awareness of the problems faced by mentally disabled people and thus hold the potential to facilitate their integration in their local communities."

2.23 Many objections were raised to the introduction of hearings based on the above model. First, and most importantly, it was questioned whether a hearing consisting of lay members, albeit trained, would be regarded as able to deal with all the issues involved. Cases would often involve substantial sums of money or valuable property, disputes as to facts and difficult questions of law. Disputed facts could, as under the children's hearings, be referred to the sheriff for adjudication[1] and the same could be done with questions of law. But in our view involvement of the sheriff would undermine the attractiveness of the hearing system unless confined to a small minority of cases. Many also felt that it was by no means obvious that a system which worked well for children would work equally well for mentally incapable adults. The members in a children's hearing use their commonsense, experience and training to decide how to dispose of a child's case once the grounds of referral have been accepted or established. A mental health hearing would often be faced with more complex tasks and there would be a much wider range of "disposals". Whilst most people have some experience and understanding of children and their problems the same is not true of mental disability. Recruitment of suitable lay members for hearings was thought to pose problems. There is a danger that those putting themselves forward as potential members would have fixed views and perceptions clouded by their own limited experience. Others considered that going from the existing court system to hearings would be too great a leap in the dark. In their view it would be more sensible to try to make the courts a more attractive forum.

2.24 A study published in 1993 investigated the demand for, and feasibility of, hearings for resolving legal and ethical disputes involving people with dementia[2]. Most of the interviews and responses involved professionals (about 150 in the Renfrew and Glasgow areas) such as social workers, residential care workers, community nurses, and a smaller number of doctors, bank and building society managers and lawyers. Four group discussions were also held with people who cared for dementia sufferers. The study found that there were a substantial number of cases which involved legal or ethical conflicts. Existing arrangements for resolving these cases were generally regarded as unsatisfactory or "technically irregular". Most professionals thought that the proposed Mental Health Hearing system would help resolve such disputes. Carers had mixed feelings; fears being expressed about the intrusion of the State into private family affairs and the competence of lay members of the public to make decisions about people with dementia. It should be noted that the cases considered in the study were mainly about an adult's place of residence and general care and that the professionals involved were not presented with a choice between hearings, tribunals or courts.

2.25 Tribunals were perceived to share with hearings the advantages of user-friendliness, informality and lack of adversarial character. Tribunals would differ from hearings in being staffed by professionals with perhaps some lay people, the members being selected as having skills or experience appropriate to the case in question. Professionals, who would be paid for their attendance, would be easier to recruit and would require less in the way of further training. Supporters of tribunals mentioned the benefit of informed debate among the differently qualified members and the likelihood of a multi-disciplinary approach to the problems faced by the incapable adults. Detractors took a more jaundiced view. They thought that one professional might well dominate the others, especially any lay members, and that proceedings could be taken over by technical discussions between the tribunal members and similarly qualified expert witnesses. Another danger that exists with a tribunal staffed by professionals is the blurring of the distinction between their professional role and their decision-making or judicial role. Furthermore, it might be difficult to find suitable properly qualified workers who are not already employed by, or involved with, organisations such as local authorities, hospitals or health boards with the consequence that the tribunal might not be regarded as being independent.

2.26 As has already been mentioned, the option of using the courts as the forum for dealing with matters affecting the mentally incapable attracted most support. Courts were seen to be impartial, respected and authoritative and experienced in conducting hearings properly and producing reasoned written decisions. The other major factor that weighed with their supporters was that some of the matters would involve property and rights of considerable value, as distinct from considerations of the adult's welfare. This demanded a forum capable of adjudicating such matters properly and this in turn pointed to the courts. Finally, the courts have the benefit of continuity; they are already dealing with many of the matters covered by our recommendations so that one would not need to set up new and untried tribunals or hearings.

2.27 Having considered the responses produced by consultation we are firmly of the view that the courts are the appropriate forum and should have exclusive jurisdiction to deal with matters in this report. We are strongly in favour of the "one door" approach whereby one court should be able to deal with all the aspects of mental disability. People should

1. Social Work (Scotland) Act 1968, s 42.
2. *Mental Health Hearings for Elderly People with Dementia: A Study of Demand and Feasibility* (Scottish Office Home and Health Department, December 1993), C Davison, M Gilhooly, J Kileen and D Hay.

not be required to go to several different courts or tribunals in order to obtain the desired spread of remedies. As well as the delay and expense of multiple applications there is a danger of gaps between the various jurisdictions and conflicting views being taken by the various forums.

2.28 The support on consultation for tribunals or hearings owes much to the perceived disadvantages of the courts. The courts were regarded by many respondents as intimidating, legalistic, adversarial and only willing to look at the issues put in front of them, lacking in understanding of the needs of the mentally incapable, slow, expensive and associated with criminal proceedings. Some of the criticisms are, we think, unfounded in that many hearings under the 1984 Act are presently handled sensitively by sheriffs and do not give rise to any complaints. The Law Society suggested that if the courts were to be the forum then proceedings should be conducted by specially selected "designated sheriffs". These designated sheriffs should receive training about various aspects of mental incapacity and the needs of the mentally incapable and would specialise in such cases and so develop their expertise further. The concept of nominated or designated judges is not a new one. They exist in the Court of Session in relation to judicial review[1] and in England and Wales for cases under the Children Act 1989[2]. We think the Law Society's suggestion is an excellent one that would go a long way to address the concerns expressed by those opposed to the use of the courts.

2.29 The way the courts deal with the mentally incapable could also be improved by requiring all hearings to be held in chambers. The normal public court rooms should not be used as they are unsuitable for small informal hearings. Indeed, we think it should be made competent for the sheriff to conduct a hearing outwith the court if that would be more convenient for those involved[3]. There seems to us no reason why a hearing should not take place in a small private room in the hospital or other place where the adult is living. The sheriff should be directed to encourage discussion and be prepared in appropriate cases to take a pro-active role in the process, by calling for further information, reports or assessments, for example. Some formality is necessary in legal proceedings. In relation to small claims in the sheriff court, hearings are directed to be conducted so far as practicable in an informal manner[4]. We would adopt this standard for hearing applications recommended in this report.

2.30 In our discussion paper we proposed[5] that if the courts were to be considered the appropriate forum then the sheriff courts should have exclusive jurisdiction, apart from appeals. All those responding agreed with the exception of the Faculty of Advocates. The Faculty were of the opinion that the Court of Session should have concurrent jurisdiction so as to be available to decide cases where large sums of money were at stake or the issues were unusually complex. We would adhere to our original proposal with cases being heard only by specially trained "nominated" sheriffs, who would be experienced in dealing with cases involving mental disability. The Court of Session, situated as it is in Edinburgh, is not convenient for litigants in many parts of Scotland nor does it project an approachable, user-friendly, informal atmosphere. Moreover, giving the Court of Session concurrent jurisdiction would, given our proposal for specially-trained, nominated judges, involve training one or more judges who might rarely, if ever, be called upon. As an exception to this general rule we do however recommend later that applications in relation to withholding or withdrawing of medical treatment from incapable patients should be heard by the Court of Session[6].

2.31 We recommend that:

3. (1) Applications and other proceedings under legislation implementing our recommendations should be dealt with in the sheriff courts. These proceedings as well as proceedings under the Mental Health (Scotland) Act 1984 should be heard, so far as possible, by nominated sheriffs who have received special training.

(2) Rules of Court should be made providing that the hearings should take place in chambers, or in another place considered appropriate by the sheriff, rather than in a public court room and should be conducted, so far as practicable, in an informal manner.

Clause 2(5), Schedule 4, paragraph 15(18) and Bill generally

2.32 Many of those responding to our request for views as to the appropriate forum mentioned the need for a reporter, whose functions would be similar to those of a Children's Hearings reporter, even if the chosen forum was the sheriff court. They saw the need for someone to act as a point of contact, investigate the need for action and, if action was needed, to obtain reports, evidence and other matters in preparation for any hearing and to participate in such a hearing. The

1. Rules of Court of Session 1994, rule 58.5.
2. Children (Allocation of Proceedings) Order 1991, SI 1991/1677 and Family Proceedings (Allocation to Judiciary) Directions 1993.
3. This is competent in hearings for detention or guardianship under the 1984 Act, see Act of Sederunt (Mental Health (Scotland) Act 1984) 1986, para 2(2).
4. Small Claim Rules 1988, rule 19.
5. Proposal 85(1), para 6.12.
6. See Recommendation 77, para 5.86.

reporter was also envisaged as being entitled to initiate proceedings. We have given this suggestion careful consideration but have come to the conclusion that the advantages of reporters can be achieved in other ways within the existing structure of the courts. Elsewhere in this report we recommend that the Mental Welfare Commission and local authorities should receive and investigate complaints relating to the welfare of incapable adults and should be entitled to make appropriate applications to the court and that the Public Guardian should have similar functions in relation to financial concerns of adults[1]. Furthermore, the sheriff dealing with a case involving an incapable adult should be empowered by rules of court to appoint a safeguarder if the adult is otherwise unrepresented[2]. The safeguarder's duties would include investigating matters and obtaining appropriate reports and evidence. The sheriff should also have a direct power to order such reports and assessments as seem necessary to a proper disposal of the case[3]. Finally, the administrative functions of a reporter could be performed by sheriff clerks and their staff.

Jurisdiction of courts

2.33 In our discussion paper we proposed[4] that the Scottish courts should have jurisdiction to appoint a personal guardian or make other orders relating to a mentally incapable adult who is either resident or domiciled in Scotland, and to make equivalent financial or property orders on the grounds of the adult's domicile or ownership of property in Scotland. The above criteria were also put forward for the selection of the appropriate sheriff court.

2.34 Most of those commenting on our proposals agreed. The Law Society and Enable made the useful suggestion that the adult's residence in Scotland should also ground financial or property orders since there can be difficulties in establishing the domicile of choice of incapable adults who have moved away from their families. On reconsideration we are not now in favour of using domicile as a ground of jurisdiction. In addition to the difficulties mentioned above, the modern approach, particularly in international conventions, is to base jurisdiction on habitual residence. Situations will arise, however, where action will be urgently necessary for those who are in Scotland but not habitually resident there or in any sheriffdom. We think that the courts should have an emergency jurisdiction based on presence similar to that for children under section 12 of the Family Law Act 1986. We have given further thought to jurisdiction on the ground of ownership of property situated in Scotland. We now consider that ownership of Scottish property should give jurisdiction only in relation to that property. For example, ownership of a flat in Dundee by an incapable adult habitually resident in France should give the sheriff court in Dundee jurisdiction to make orders or to appoint a guardian with powers in relation to that flat, but no powers in relation to medical treatment or personal welfare or wider financial affairs. Two commentators pointed out that the Civil Jurisdiction and Judgments Act 1982 contained provisions that possibly determined jurisdiction in relation to some areas of financial management. We think it would be clearer if jurisdiction for all applications and proceedings under our recommendations were based expressly on the grounds that we now recommend. We recommend that:

4. **A sheriff court should have jurisdiction to deal with any application under our recommendations if:**
   (a) the incapable adult in question is then habitually resident in the sheriffdom, or
   (b) the application relates to property belonging to the adult which is situated in the sheriffdom.

   In addition a sheriff should have jurisdiction to make an order which is immediately necessary for the protection of the adult if the adult is present within the sheriffdom at the date of application.

   Clause 2(2), (3)

2.35 After a guardianship order has been made by the sheriff court of the incapable adult's then habitual residence the adult may become habitually resident outwith Scotland. In most cases it would be more appropriate for the courts of the adult's new residence to deal with further guardianship matters. Situations may arise however where the courts of the new habitual residence have no jurisdiction or where jurisdiction exists but there is no power to make orders relating to existing Scottish guardianship orders. Even if the foreign court has the jurisdiction and the power it may be very inconvenient for the applicant. For example, an adult who was habitually resident in Scotland may go to live in New Zealand. The Public Guardian as a result of investigating a complaint may consider that the existing Scottish guardian should be replaced or the guardianship order recalled. The New Zealand court would probably have no powers to make any such orders and even if it did it would be unreasonable to expect the Public Guardian to apply to that court rather than the original Scottish court. The same problem may occur when adults change their habitual residence within Scotland. Rule 26.1 of the Sheriff Court Ordinary Cause Rules 1993 empowers the sheriff to transfer a case to another sheriff court. Cases on an earlier version of this rule[5] establish that where the court to which it is proposed to transfer the case has no jurisdiction, weighty and compelling reasons for transfer are required[6]. We consider that this test is too stringent for

1. Recommendation 21, para 3.36 and Recommendation 110, para 6.129.
2. Recommendation 6, para 2.36.
3. Para 6.36 and Clause 3(2)(c).
4. Proposal 86, para 6.17.
5. Sheriff Courts (Scotland) Act 1907, First Schedule, Rule 20.
6. *Walden v Campbell* 1940 SLT (Sh Ct) 39: *Chiesa v Greenshield* 1958 SLT (Sh Ct) 58.

applications which relate to existing guardianship orders of the other court and that a test based on reasonableness would be better. The same issues arise in relation to intervention orders but to a lesser extent due to their more limited nature. We recommend that:

5. **The sheriff court which made a guardianship order or an intervention order should have jurisdiction to deal with an application relating to that order if no other court (Scottish or non-Scottish) has jurisdiction to deal with such an application or if it is unreasonable to expect the applicant to make the application to another court with jurisdiction.**

Clause 2(4)

Safeguarders for incapable adults

2.36 Many incapable adults will not be capable of representing themselves in court in connection with applications made by others regarding their welfare or finances. To overcome this lack of capacity we proposed that the court hearing an application should be required to appoint a safeguarder to the adult in question unless satisfied that his or her interests were already adequately safeguarded[1]. While most respondents agreed, some thought that the adult should be entitled to representation by a curator *ad litem*, not merely a safeguarder of their interests. We think that there should be flexibility. Sometimes the adult might need to be represented. At other times an independent look at the papers together with making some further enquiries might be sufficient. A suitable model would appear to be safeguarders appointed to children subject to proceedings relating to the assumption of parental rights by local authorities[2]. Their powers and duties are set out in the Act of Sederunt (Social Work (Scotland) Act 1968) (Safeguarders) 1985[3]. The safeguarder is entitled to see the pleadings and productions, make appropriate enquiries, become a party to the proceedings or lodge a report setting out his or her conclusions as to the interests of the child. A safeguarder who becomes a party to the proceedings has all the powers and duties of a curator *ad litem* to the child, and the safeguarder may appear personally or be represented by an advocate or solicitor. We recommend that:

6. **The sheriff should consider whether to appoint a safeguarder to an incapable adult in respect of whom an application has been made. The safeguarder should have similar powers and duties to one appointed under section 18A of the Social Work (Scotland) Act 1968 (safeguarders to children involved in proceedings relating to the assumption of parental rights by local authorities).**

Clause 3(4), (5)

Title to apply to the courts

2.37 Who should be entitled to make an application to the court under our recommendations in relation to an incapable adult? The list of those entitled to apply under the existing law for the appointment of a curator bonis is very wide and not confined to those with a pecuniary interest. Most petitioners are the adult's relatives but petitions have been brought by the adult's solicitor[4], banker[5], managers of the hospital in which the adult is a resident patient or a person with whom the adult was staying while in Scotland[6]. The adult himself or herself may petition although this is very unusual[7]. The adult certainly has a title to apply for recall of the curatory. The local authority must, and the Mental Welfare Commission may, petition if no one else is doing so and a curator seems necessary[8]. As far as guardianship under the 1984 Act is concerned only a mental health officer or the adult's nearest relative may submit an application to the sheriff for approval[9]. In the eighteenth and nineteenth centuries title to apply for the appointment of the nearest male relative as tutor-at-law to a mentally disabled adult under the brieve and cognition procedure was limited to relatives[10]. This may still be the position under the present petition procedure. It seems that anyone with an interest could apply for a tutor-dative to be appointed[11].

2.38 In our discussion paper we proposed that anyone with an interest should be entitled to apply for the appointment of a personal guardian[12] or financial manager, or for a property order[13]. We considered that interest should be left to be determined by the court, but should not be confined to pecuniary interest. We specifically mentioned the local authority and the Mental Welfare Commission as qualified applicants. All but one of those responding agreed. The Association of

1. Proposal 87(2), para 6.22.
2. Social Work (Scotland) Act 1968, s 18A.
3. SI 1985/780.
4. *Mason* (1852) 14D 761.
5. *Johnstone v Barbé* 1928 SN 86.
6. *Bonar* (1851) 14 D 10.
7. *AB* (1908) 16 SLT 557.
8. 1984 Act, ss 92 and 93.
9. 1984 Act, s 38.
10. Fraser, *Parent and Child*, p 656.
11. Fraser, p 668. A case of friends applying is mentioned on p 669.
12. Proposal 7, para 2.71.
13. Proposal 30, para 4.41.

Directors of Social Work, however, thought that such a wide title could lead to numerous and repeated applications. In their view applications should be made either by the local authority or the nearest relative. We reject such a narrow approach. Some incapable adults need to be protected from their nearest relatives who are exploiting or abusing them. It is not sufficient to rely on local authorities to take protective action. Local authorities are extremely reluctant to apply for a curator to be appointed to adults with modest estates, even though they have a statutory duty to apply, because the estate cannot bear the commission allowed so that the authority would have to act without recovering the full cost of the curatory. Furthermore, we do not accept that casting the net of title to apply wide would lead to numerous and repeated applications. The experience with curators and tutors-dative suggests that once the court has determined an application other applications in respect of the same adult are most unlikely. We prefer the wider title to apply approach taken in relation to curators and tutors-dative than the narrower approach taken by the 1984 Act for mental health guardianship. We also proposed that any person with an interest in the granter's welfare or estate should be entitled to apply to the court for an order relating to a continuing attorney's exercise of his or her functions[1]. Those responding generally approved, but the Sheriffs' Association thought protection was needed against the making of frivolous or maliciously repeated applications. We acknowledge the possibility of such applications, but think that the courts' discretion to award expenses against unsuccessful applicants should be a sufficient deterrent.

2.39 The Law Reform (Parent and Child) (Scotland) Act 1986 entitles "any person claiming interest" to apply to the court for parental rights in respect of a child[2]. In a recent case *D v Grampian Regional Council* 1994 SLT 1038[3] the Inner House considered that "claiming interest" was different from "having interest". The latter suggested that an applicant had to demonstrate his or her interested status before the court could consider the application. Claiming interest seems to us to be the correct approach for applications that could result in benefit to incapable adults. Any relative, friend, professional involved, carer, manager of the establishment in which the adult lives, an organisation involved with incapable adults, and public bodies such as the local authority, Mental Welfare Commission and Public Guardian should be entitled to apply to the courts. The latter three bodies play an important part in our recommended supervisory structure and should have a clear title to apply. We imagine that there will be few applications for the appointment of a guardian to an incapable adult by the adult himself or herself, but applications by an adult for variation or recall of his or her own guardianship could be more numerous. To put the adult's position beyond question we think that an express title to apply should be granted. We recommend later that in connection with certain applications title to apply should be limited. For example, an additional guardian may be appointed to act jointly with the existing guardian. In this situation the only applicant would be the proposed additional guardian.[4] We therefore recommend that:

7. **The Public Guardian, Mental Welfare Commission, local authority and any individual (including the adult himself or herself) or organisation claiming an interest in the welfare or financial affairs of an incapable adult should be entitled to apply to the court under our recommendations, except in relation to matters where a more restricted title is recommended.**

Clause 67(1) and Clauses generally

The supervisory framework

2.40 We recommend in later Parts of this report various ways in which the personal welfare or property and financial affairs of incapable adults can be dealt with by others for the benefit of the adults concerned. Here we look at the overall supervisory structure; the organisations involved and their powers and duties, which are the subject of specific recommendations throughout the report. The courts have a central role in appointing guardians and others, giving directions to the various people with functions under our recommendations and recalling or varying the terms of appointment. However, there is also a need for monitoring and supervision either generally or for specific cases only and also for investigating complaints and taking necessary action. The courts cannot undertake such tasks because they need to remain impartial should matters lead to legal proceedings. Moreover, they do not have the staff to undertake these additional functions, which nevertheless ought to be carried out by some public bodies or officials. Our general approach is to confer additional functions on existing public bodies with expertise in this area. The Accountant of Court already supervises curators bonis, the Mental Welfare Commission has general protective functions in relation to the mentally disordered and specific functions as regards those subject to mental health guardianship under the 1984 Act and the local authority (or their social work staff) act as mental health guardians and monitor non-local authority guardians.

2.41 **The Public Guardian.** Under our recommendations the Accountant of Court's existing role would be considerably expanded. A new post of Public Guardian would be created which would be held by the Accountant of Court. In addition to being guardian when appointed to act as such by the court[5], the Public Guardian would have the following general functions under our recommendations:

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1. Proposals 68-70.
2. S 3(1). The Children (Scotland) Act 1995, s 11(3) uses the phrase "claiming an interest".
3. Reversed in the House of Lords on different grounds 1995 SLT 519.
4. Clause 47(1)(b).
5. Recommendation 94(2), para 6.60.

(a) registering all continuing and welfare attorneys[1], individuals authorised to withdraw from an incapable adult's bank or building society accounts[2], intervention orders[3] and guardianship orders[4]. Any subsequent court orders and events brought to the Public Guardian's attention affecting registered entries would also be noted. The Public Guardian would not supervise appointees in connection with their personal welfare powers, but would pass on details of such appointees to the Mental Welfare Commission and local authority who are more directly concerned.

(b) supervising and monitoring the performance of guardians in relation to their financial powers in much the same way as the Accountant of Court presently supervises curators bonis and other judicial factors[5]. The Public Guardian would have an increased role since we recommend that many functions in connection with the administration of guardianship estates should be exercised by the Public Guardian rather than the courts[6]. Although continuing attorneys would not normally be subject to the same supervisory regime as guardians, the court could, on application, order this where an attorney's actings give rise to concern[7].

(c) investigating complaints relating to the exercise of financial functions by guardians, continuing attorneys, withdrawers, interveners or managers of establishments managing residents' finances. The Public Guardian would also be entitled to look into circumstances which give rise to concern and make spot checks even in the absence of any complaints. As a result of investigations or otherwise the Public Guardian should be entitled to apply to the court for appropriate orders for the protection of incapable adults. In some cases the Public Guardian may be able to take direct action, for example, by suspending or terminating the authority of a withdrawer or giving directions to a guardian.

2.42 The Public Guardian may need to initiate legal proceedings in order to protect an incapable adult's property. For example, as a result of a complaint and investigation the Public Guardian may consider that an unsuitable continuing attorney ought to be superseded and may make an application to the sheriff for the appointment of a guardian. The Public Guardian may also wish to become involved in existing proceedings to argue for the adoption of a particular course of action or to put forward his or her views based on official experience. Where the Public Guardian initiates legal proceedings to protect an incapable adult, the Public Guardian should generally be entitled to expenses if successful. Such expenses should be awardable out of the adult's estate or against any person whose conduct necessitated the application. The court should also have a discretion to award expenses to the Public Guardian when intervening. We recommend that:

8. The court should have a discretionary power to award expenses to the Public Guardian if he or she has initiated or entered proceedings in order to protect an incapable adult's property or to represent the public interest.

Clause 6

2.43 **The Mental Welfare Commission.** The Mental Welfare Commission has general protective functions towards the mentally disordered under the 1984 Act. The functions we recommend in this report are to be seen as additional to those existing statutory functions. Our recommendations would make the Mental Welfare Commission, along with the local authority, the main supervisory and monitoring organisation where the personal welfare of incapable adults was concerned. The Public Guardian would have the main role in financial matters. The Mental Welfare Commission would:

(a) monitor guardians in the exercise of their personal welfare powers in much the same way as it presently monitors guardians appointed under the 1984 Act[8].

(b) investigate complaints relating to the exercise of personal welfare functions by guardians, welfare attorneys[9] and others. The Mental Welfare Commission would also be able to investigate suspicious circumstances, even in the absence of complaints. As a result of such investigations or otherwise the Mental Welfare Commission would be entitled to initiate legal proceedings or take other action in order to protect the welfare of the adults concerned[10].

The Mental Welfare Commission would also have power to recall personal welfare powers previously conferred on a guardian by the court where such powers were no longer appropriate[11].

2.44 **The local authority.** The local authority would have a major role in looking after the personal welfare of incapable

1. Recommendation 21, para 3.36.
2. Recommendation 37, para 4.12.
3. Recommendation 84, para 6.23.
4. Recommendation 91, para 6.40.
5. Recommendations in Part 6 generally.
6. For example, approving a management plan and authorising the making of gifts by the guardian.
7. Recommendations 27 and 28, paras 3.65 and 3.66.
8. Recommendation 106, para 6.118.
9. Recommendation 21(6), para 3.36.
10. Recommendation 111, para 6.129.
11. Recommendation 136, para 6.196.

adults under our recommendations. It would have a duty to apply for an intervention or guardianship order if such an order appeared to be necessary and no other suitable person was applying[1]. The local authority's chief social work officer could be appointed guardian with welfare powers in appropriate cases[2] and the local authority via its mental health officers would be involved in investigating and supplying reports in connection with applications for intervention or guardianship orders[3]. As well as these specific functions the local authority would also have general supervisory functions-

(a) supervising guardians in the exercise of their personal welfare functions in much the same way as it presently supervises non-local authority mental health guardians under the 1984 Act[4]. It would also supervise welfare attorneys and those acting under intervention orders, but only where the court had ordered such supervision[5]. The local authority would be able to give directions to guardians in the exercise of their personal welfare functions, which the guardian would be bound to comply with[6].

(b) investigating complaints relating to guardians, welfare attorneys and others in the exercise of their personal welfare functions. The local authority would also be able to investigate suspicious circumstances even in the absence of complaints. As a result of such investigations or otherwise the local authority would be entitled to initiate legal proceedings in order to protect the welfare of the adults concerned[7].

The local authority, like the Mental Welfare Commission, would also have power to recall the personal welfare powers previously conferred on a guardian by the court where such powers were no longer appropriate[8].

2.45 **Cooperation and provision of information.** Many complaints and investigations will involve matters in the personal welfare field and in the financial field. Close co-operation between the various supervisory bodies (the Public Guardian, Mental Welfare Commission and local authority) and a free exchange of information will be required to carry out "a mixed" investigation properly. For example, a complaint may be made to the Mental Welfare Commission about the actings of a guardian. If initial investigations by the Commission lead to suspicion of financial irregularities it should alert the Public Guardian to these and the two bodies could then come to a mutually acceptable arrangement for further investigations on the financial side. If the irregularities appeared to be minor it might be more sensible for the Commission to include these in its investigation, but serious matters would best be handed over to the Public Guardian. We recommend that:

9. The Public Guardian, the Mental Welfare Commission and the local authority should be under a duty to collaborate and liaise with each other in relation to investigations.

Clause 9(2)

2.46 The Public Guardian, the Mental Welfare Commission and the local authority should also have a role in providing information and advice to guardians, attorneys and others exercising personal welfare or financial functions in relation to incapable adults. One method of doing this would be by means of publications. The Accountant of Court presently produces a very helpful booklet for families where a relation is under curatory[9] and the Mental Welfare Commission issues a series of leaflets about guardianship under the 1984 Act. The Accountant also produces more technical Notes for the Guidance of Judicial Factors[10]. We think there will be a need for more material to help those involved with the changes in the law and practice, by way of publications, guidance notes or otherwise. Information and advice should also be capable of being given in specific cases. For example, a guardian or attorney should be able to contact the Public Guardian, the Mental Welfare Commission or local authority for information and advice according to whether financial or welfare advice was being sought. We recommend that:

10. The Public Guardian should be required to provide advice and information, on request, to those exercising functions under our recommendations relating to incapable adults' property and financial affairs. The Mental Welfare Commission and the local authority should be under a similar obligation in relation to personal welfare functions.

Clauses 4(2)(g), 7(1)(e) and 8(1)(e)

General principles governing interventions

2.47 In our discussion paper when considering the introduction of new style personal guardians we set out the main

1. Recommendation 86(2), para 6.33.
2. Recommendation 94, para 6.60.
3. Recommendation 87, para 6.36.
4. Recommendation 106, para 6.118.
5. Recommendation 29, para 3.67.
6. Recommendation 107, para 6.119.
7. Recommendation 111, para 6.129.
8. Recommendation 136, para 6.196.
9. *Information for Families of Persons Subject to Curatory*, (1989).
10. Parliament House Book, M 301.

principles underlying similar types of guardianship in other jurisdictions[1] and adopted them for our proposed scheme. The principles were:

(a) restricting a guardian's powers in order to make the minimum necessary intervention;

(b) the guardian being under a statutory duty to encourage the incapable adult to do as much as possible for himself or herself;

(c) the guardian being under a statutory duty to consult and give effect to the wishes of the adult and his or her family so far as possible;

(d) mandatory periodic review of the need for a guardian's appointment to continue.

Very similar principles were set out for our proposed new scheme of financial management[2].

2.48 These principles were also contained or alluded to in many of the subsequent proposals dealing with the details of the proposed new schemes of personal guardianship and financial management. In relation to personal guardians we proposed that:

(a) the court considering an application for a personal welfare order or the appointment of a personal guardian should have to be satisfied that it would result in a substantial benefit to, or necessary protection of, the incapable adult (Proposal 5(1)(b));

(b) in considering whom to appoint as guardian the court should take the wishes of the incapable adult into account in so far as it was reasonable and practicable to do so (Proposal 6(a));

(c) the court should be under a duty to choose the least restrictive remedy consistent with safeguarding the rights of the incapable adult and accordingly should not appoint a guardian unless one or more personal orders were insufficient to meet the needs of the adult, and when appointing a guardian should specify the minimum number of powers necessary (Proposal 8(4));

(d) personal guardians should exercise their powers in the adult's best interests. They should consult as far as practicable the adult, family and carers and any financial appointee and have regard to views expressed by the adult while capable (Proposal 11).

Similar proposals were made in relation to the court's powers when considering applications for property orders or the appointment of a financial manager and the powers of financial managers[3].

2.49 In general these proposals and the principles they embodied were agreed by those who responded. Many expressly mentioned in response to a particular proposal which dealt with one of the principles that some or all of the other principles should apply as well. Thus, for example, in connection with our proposal that the court in deciding whether to make a property order or appoint a guardian should be required to make the least restrictive order, the Scottish Association for Mental Health commented that our other principles should also apply. The favourable responses have led us to formulate a set of general principles that should apply throughout the legislation implementing our recommendations.

2.50 Our general principles do not rely on the concept of best interests of the incapable adult. Proposals 11 and 38 suggested that the personal guardian and financial manager respectively should act in the best interests of the adult, these being established after consultation with the adult, family and others interested in the adult's welfare or finances and any personal guardian or financial manager. Although the majority of those responding agreed, others were more critical. The proprietors of a Lothian home for mentally disabled people thought that best interests was too paternalistic, and many others considered that the wishes and feelings of the incapable adult should be given greater weight. The Scottish Association for Mental Health in response to Proposal 11 and the Law Society and Enable in response to Proposal 38 took the view that guidelines were required in order to establish what the best interests of the incapable adults were. The Scottish Association for Mental Health in response to Proposal 38 commented that a best interests test was not always acceptable and a financial manager should override the express wishes of the adult only in exceptional circumstances and where there is no reasonable alternative. Best interests was also rejected in the context of medical treatment. The majority of those responding to Proposal 24 which asked for views as to the criteria the court should adopt in deciding disputes about medical treatment preferred more detailed guidelines instead. We consider that "best interests" by itself is too vague and would require to be supplemented by further factors which have to be taken into account. We also consider that "best interests" does not give due weight to the views of the adult, particularly to wishes and feeling which he or she had expressed while capable of doing so. The concept of best interests was developed in the context of child law where a

1. Para 2.50.
2. Para 4.30.
3. Proposals 29(b), 31(2), 34 and 38 respectively.

child's level of understanding may not be high and will usually have been lower in the past. Incapable adults such as those who are mentally ill, head injured or suffering from dementia at the time when a decision has to be made in connection with them, will have possessed full mental powers before their present incapacity. We think it is wrong to equate such adults with children and for that reason would avoid extending child law concepts to them. Accordingly, the general principles we set out below are framed without express reference to best interests.

2.51 **Benefit to adult.** Our first general principle is based on benefit to the incapable adult. The person intervening should be satisfied that the intervention will benefit the adult and that the benefit cannot reasonably be obtained without the intervention. By intervention we mean any decision by a court, a guardian or any other person on whom functions are conferred under our recommendations which directly affects the welfare or affairs of the incapable adult. The category of "any other person" would include the Public Guardian and managers of establishments who are looking after the finances of their incapacitated patients or residents. In our discussion paper we proposed that the courts should make personal or property orders or appoint a personal guardian or financial manager only if that would result "in a substantial benefit" to the adult[1]. Some commentators thought that the word "substantial" should be omitted, because it raised the question as to what constituted a substantial benefit. We agree. The intervener should have to weigh the intervention against the benefit; the more serious the intervention the greater the benefit that should have to result from it. A requirement of substantial benefit distorts this exercise of discretion and could well result in adults being denied assistance which would produce a modest, but nevertheless worthwhile, benefit to them.

2.52 As well as an intervener being satisfied that the intervention proposed will produce a benefit to the incapable adult he or she should also be satisfied that such benefit cannot be reasonably achieved in another, less intrusive, way. Thus, an adult should not be removed from home (by means of an intervention order or guardianship) if extra help could be made available so as to enable the adult to carry on at home. Again, the appointment of a guardian to manage financial affairs could perhaps be avoided if informal advice and assistance were available or the affairs were reorganised so as to make them easier for the adult to handle. Consideration of other reasonable ways of achieving the benefit does not mean that they have to be tried first and found wanting. That could give rise to unacceptable delay. If a court was involved in considering whether to intervene it should be up to the applicant to satisfy the court that other methods are either impracticable or unlikely to produce the same benefit as the proposed intervention.

2.53 The Law Society and Alzheimer Scotland - Action for Dementia in response to our proposal that a personal guardian should not be appointed if one or more personal orders would suffice and that any guardian should be appointed with the minimum powers necessary[2] were concerned lest the principle of minimum necessary intervention denied guardianship to those who could benefit from it. An incapable adult's welfare and affairs might be being looked after informally by his or her family or others, but the informal controls might be so extensive that they should be placed on a formal footing. Formal guardianship involves independent monitoring of the guardian's actings and also incorporates a series of principles and guidelines which guardians have to have regard to. Informal management lacks these elements. We accept this point but take the view that a court should take it into account in assessing the benefits that will accrue to the incapable adult by reason of the proposed intervention.

2.54 We recommend that:

11. Any intervention in the welfare or financial affairs of an incapable adult under or in pursuance of the proposed new legislation should be required to produce a benefit for that adult. Any person proposing to intervene should have to be satisfied that the intended benefit cannot be reasonably achieved otherwise than by the intervention.

Clause 1(2)

2.55 **Least restrictive intervention.** The second of our general principles is that any intervention must be that which is least restrictive of the adult's freedom having regard to the need to achieve the purpose of that intervention. An alternative formula often used is "minimum necessary intervention". We prefer least restriction in that it focuses on the practical results of an intervention. This was generally approved by those who responded to our various proposals, but concern was expressed as to how it would work in practice. If a property order was granted or a guardian with limited financial powers was appointed and then the mentally disordered adult's capacity took a turn for the worse then a fresh application to the court with its attendant worry and expense might be needed. We think that in these circumstances an additional application to the court would be inevitable, although less might be required in the way of procedure for extending the powers of an existing guardian than for appointing a guardian for the first time. We would not be in favour of some administrative body (such as the Public Guardian or the Mental Welfare Commission) being entitled to increase the powers that have been granted to a guardian by the court. Considerations of civil liberties and the European Convention on Human

1. Proposals 5 and 29, paras 2.62 and 4.40 respectively.
2. Proposal 8(4), para 2.80.

Rights require that any restriction of rights be done by an independent and impartial tribunal established by law after a fair and public hearing[1]. However, where the incapable adult is known to have variable capacity or rapidly deteriorating capacity the court would be entitled to take this into account and appoint a guardian with the powers he or she is likely to need then and in the reasonably foreseeable future. The fact that the principle of least restriction also applies to the guardian in exercising the powers conferred should prevent him or her from exercising powers that were not in fact needed at the time in question.

2.56 The Sheriffs' Association pointed out that a court can proceed only on information presented to it and suggested that the applicant should be under a duty to satisfy the court that the remedy sought was the least restrictive. We are grateful for this observation and have altered the wording of our principle accordingly. In the case of the intervention taking the form of a decision by the guardian or some other person on whom functions have been conferred, the decision-maker would be required to satisfy himself or herself that the proposed course of action was the least restrictive.

2.57 The former Accountant of Court in his general comments on the discussion paper thought that the principles of least restrictive order and encouraging the incapable adult to use existing skills and develop new skills might not be consistent with the adult's need for protection. We would meet this point by making it clear that the purpose of the intervention has to be considered in deciding what the least restrictive remedy is. For example, if a guardian is appointed to manage the incapable adult's bank account because the adult is frittering money away on unnecessary items the principles of least restrictive intervention and use and development of skills point towards the guardian allowing the adult to operate the account under supervision. But the need for protection, which is the purpose of the appointment, requires the guardian to sign (or at least countersign) every cheque.

2.58 We recommend that:

12. Any proposed intervention in the welfare or finances of an incapable adult under or in pursuance of the proposed new legislation should be that which is least restrictive of the adult's freedom having regard to the purpose of the intervention.

Clause 1(3)

2.59 **Encouraging use and development of skills.** Our third general principle is that those with authority in terms of our recommendations over an incapable adult should encourage the adult to use his or her existing skills and develop new skills. It would be all too easy for a guardian appointed to manage the affairs of an adult simply to take over. But someone like a young mentally handicapped person will never develop unless encouraged to deal with his or her own affairs and run his or her own life as far as possible. Even with dementia sufferers the rate of decline may be lessened by encouraging use of their existing faculties. This principle is also founded on respect for the autonomy of the individual. Proposal 39 in our discussion paper embodied the principle by entitling a financial manager to allow the incapable adult to deal with any part of the property under management. The proposal was agreed by all those who commented although some raised queries about protection of third parties dealing with the adult[2]. Two respondents considered that merely entitling the guardian did not go far enough. In their view guardians should be under an explicit statutory duty to encourage incapable adults to exercise their existing skills and develop capacity where there is scope for so doing. We think that expressing the principle as a statutory requirement would enhance its effectiveness. We consider that the requirement should exist not only in relation to financial guardians but to guardians in general, continuing and welfare attorneys and the managers of establishments, all of whom exercise authority over the financial or personal affairs of incapable adults. The requirement cannot be made absolute. It would be unreasonable to require guardians to encourage adults with rapidly deteriorating capacity to acquire new skills, and impracticable for comatose patients and others with virtually no capacity to exercise existing skills. Furthermore, some adults grant continuing powers of attorney in order to be relieved of the burden of managing their affairs. They would not welcome being encouraged to exercise their existing skills, let alone to acquire new skills. We recommend that:

13. Any guardian, continuing or welfare attorney or the managers of an establishment managing an adult's finances under our recommendations should be required to encourage the adult to use existing financial and welfare skills and acquire new skills, but only in so far as it is reasonable and practicable to do so.

Clause 1(5)

2.60 **Consultation and consideration of views.** Our fourth and final general principle is consultation with those who have an interest in the proposed intervention or its effects. The Scottish Association for Mental Health in response to Proposal 38 in our discussion paper[3] (consultation by financial manager when exercising powers) commented that "Whilst

1. Article 6 of the Convention.
2. See para 6.153 for further details of protection of third parties.
3. Para 4.76.

the duty to consult is very important, we would not wish to see the duty so onerous as to be unworkable". We agree with this sentiment and put forward a scheme which we hope will prove workable. We would stress that the principle of consultation applies only to those exercising authority or making decisions under our recommendations. It is not intended that every person dealing with an incapable adult should be required to consult before taking any step. Another important limitation is that the degree of consultation should be appropriate to the scale of the proposed intervention. Consulting incapable adults, their nearest relatives, primary carers and others would be unduly burdensome if it had to be done for every minor matter, such as a guardian allowing an adult to buy small items or go out with some friends.

2.61 We proposed in our discussion paper[1] that a personal guardian before exercising a power conferred should be under a duty to consult, so far as it was practicable to do so, the incapable adult, his or her family and carers and any person appointed to look after the adult's financial affairs and to have regard to the views expressed by the adult when mentally capable. A very similar proposal was made in relation to the exercise of powers by a financial manager[2]. There was strong support for consulting the adult and many considered that the adult's views should always be taken into account although the guardian should also take the disability into account. Enable commented that there may be cases where the adult should not be consulted as that might produce adverse consequences for his or her health. We agree and consider that the duty to consult the adult should not be an absolute one. The intervener should be required to take account of the adult's views so far as they can be ascertained and would be entitled to take into account the difficulties and dangers of trying to ascertain them. For example, the adult may be so disabled as to make consultation pointless. The intervener should still be required to have regard to any known present and past feelings and wishes of the adult because these can often be obtained from others closely associated with the adult or from written material.

2.62 One respondent suggested that the views of an incapable adult which he or she expressed while mentally capable should be followed unless they could be presumed to be no longer applicable. We consider that such views or even instructions should indeed be given great weight but should not be treated as conclusive. As we point out elsewhere in this report in relation to advance refusal of medical treatment[3], the views may be outdated, have been made without adequate information or as a result of pressure or the situation may have changed radically since they were expressed. The same is equally true of instructions in documents conferring a continuing power of attorney. In our view the best approach is to emphasise the importance of the adult's wishes but give the intervener a discretion not to follow them in appropriate cases. We suggested in our discussion paper that a personal guardian should have regard among other things to any wishes expressed by the adult "while mentally capable".[4] We now consider that such a restriction is both unwarranted and unworkable. Even if the adult is or was incapable he or she may express views or react in some way to the proposed intervention and that that should be taken into account. Furthermore, it would be very difficult for an intervener to evaluate the past mental capacity of the adult at a time when the views were expressed.

2.63 The requirement to consult the adult, in so far as it is reasonable and practicable to do so, and to take account of the views expressed should not be confined to a proposed exercise of powers by guardians or determination of applications by courts. We regard this as a principle that should apply throughout this report and to all those having to make a decision under or in pursuance of the proposed new legislation; the Public Guardian, the managers of establishments, doctors in respect of medical treatment as well as guardians and courts. In our discussion paper we proposed[5] that the court should be required to appoint a safeguarder to an adult who was not otherwise adequately represented. Part of the safeguarder's role would be to ascertain the views of the adult and ensure that they were put before the court. Our proposal was supported by all those who commented. The Senators of the College of Justice were of the opinion in connection with the adult's wishes as to a proposed guardian[6] that it would be preferable for the views of the adult to be put before the court via a third party rather than by personal interview. We appreciate this concern but consider that incapable adults should be encouraged to participate in court proceedings affecting them unless they clearly cannot understand the proceedings or are disruptive. To this end we have recommended that the proceedings should be conducted informally in a private room rather than in the normal public court room[7]. Rules of court will require to be made providing for the intimation of all applications to the adult concerned and perhaps any known representative as well.

2.64 We turn now to deal with the role of guardians, continuing attorneys, relatives, carers and others in the decision-making process. Anyone who thinks they have relevant views or information should be entitled to communicate them to the decision-making power or authority and the decision-maker should then take them into account. The more difficult issue is to what extent (if any) the decision-maker should be under a duty to adopt a pro-active role and seek out the views of persons other than the mentally disabled adult concerned? We stress that these others would not simply be

1. Proposal 11, para 2.87.
2. Proposal 38, para 4.76.
3. Para 5.52.
4. Proposal 11, para 2.87.
5. Proposal 87(2), para 6.22.
6. Proposal 6(a), para 2.69.
7. Recommendation 3, para 2.31.

consulted in order that they might pass on any information about the adult and his or her views and wishes, although they would naturally be entitled to do so. We see them as having an independent contribution to the decision-making process. Decisions will usually affect those looking after the adult and his or her close family and it seems to us that their legitimate concerns should be taken into account.

2.65 As far as consultation by other decision-makers is concerned, guardians appointed by the court and continuing attorneys appointed by the adult are in a special category. We think they should always be entitled to be consulted by the decision-maker on matters lying within the scope of their powers since they are to be regarded as legal representatives - standing in the adult's own shoes. We also think that the nearest relative and primary carer of the adult should be entitled to be consulted, but that there should be no obligation on the part of the decision-maker to seek out the views of others who might have an interest in the adult's welfare. This would often be onerous or impracticable, and could place the adult's welfare at risk. However, anyone with an interest who knew of a proposed intervention should be able to make his or her own views known to the intervener, and where they were made known they should be taken into account. In the following paragraphs we discuss further the role of relatives and carers.

2.66 Numerous proposals in our discussion paper mentioned the role of the incapable adult's family, nearest relatives or carers. Proposal 11 suggested that a personal guardian should consult the adult's family and carers. A similar proposal was made in relation to financial managers[1]. These proposals were generally supported but it was pointed out that the interests of adults and their families do not always coincide. For example, the adult might wish to be placed in a well-appointed but expensive home while the family, perhaps with their eye on their eventual succession prospects, might incline to a cheaper alternative. The Scottish Association for Mental Health commented that in some cases the adult would not wish his or her family to be consulted. We deal with this point later[2]. A strong expression of views from the adult against consulting the family might make it unreasonable for them to be consulted.

2.67 The Elms, a registered care home for the mentally handicapped, welcomed our inclusion of carers. It pointed out that welfare decisions may have a devastating effect on primary carers, whilst having minimal effect on physically distant nearest relatives. In its view primary carers should be on a par for consultation purposes with the nearest relative. We agree and have framed our recommendations in terms of equality. Where the adult is living at home the primary carer and the nearest relative may well be the same person.

2.68 "Family" is too imprecise a term for the purposes of consultation. In connection with medical treatment and research we used the concept of nearest relative[3]. Rather than the extended list in the 1984 Act we proposed a shorter list comprising spouse, adult children, parents and siblings. The Law Society, together with some other respondents, thought that the 1984 Act's list of relatives should be used throughout so as to achieve consistency throughout the mental health field. In its view the 1984 Act's list of relatives together with its other provisions for ascertaining the nearest relative or acting nearest relative should continue to be used and be extended to the legislation implementing our recommendations. The National Schizophrenia Fellowship (Scotland) pointed out that many elderly dementia sufferers are cared for by nieces who would be excluded by our proposed abbreviated list but are within the 1984 Act list. We accept the force of these comments and now favour using the list in the 1984 Act.

2.69 We have been made aware of some dissatisfaction with the nearest relative provisions of the 1984 Act. First, some incapable adults have become alienated from their relatives and do not wish them to be consulted. The relatives in turn may not wish to be consulted and would probably have little to offer to the decision-makers were they to be consulted. In these circumstances the adult may well prefer a trusted friend or companion to be consulted. Secondly, the adult may have been cohabiting with a partner or sharing accommodation with a companion on a non-sexual basis. Section 53(6) of the 1984 Act permits such a partner or companion to be regarded as the adult's nearest relative, but only if they had been living together for at least five years. In the case of a married adult there is a further condition that he or she must be permanently separated from his or her spouse. It has been represented to us that a partner or companion of say three years standing is more likely to be aware of the adult's wishes and views than a parent or brother and sister living in some other part of the country. A possible solution to both these problems would be to allow people while capable, to nominate an individual to be consulted in place of their nearest relative. We mention this possibility but do not make a recommendation here for the reasons given in paragraph 2.71 below.

2.70 Should there be a procedure for excluding unsuitable nearest relatives from the consultation process? We put forward such an idea in connection with consultations about an incapable adult's medical treatment[4]. This was generally agreed, although some thought it was unnecessary since doctors simply had to take into account the nearest relative's views and could take into account the unsuitability of nearest relatives in weighing up their views. However, the doctors

1. Proposal 38, para 4.76.
2. See para 2.69 below.
3. Proposals 21 and 26.
4. Proposal 21(3), para 3.21.

or others consulting may be unaware of the unsuitability. Moreover, it is a waste of time and effort to consult those who do not deserve to be consulted. The Law Society supported our proposal as it was aware of many cases where the nearest relative was an abuser or otherwise seriously unsuitable. It expressed the view that some of the existing provisions in section 56 of the 1984 Act, whereby the sheriff may appoint an acting nearest relative in place of the nearest relative were not satisfactory. The sheriff may replace a nearest relative who is incapable of acting by reason of mental disorder and the application may be made by any relative, any person with whom the patient is or was residing or a mental health officer[1]. The nearest relative (and only the nearest relative) may also apply if "he is unwilling or considers it undesirable to continue to act as such [nearest relative]"[2]. There is no mechanism for replacing a relative who is unsuitable but wishes to continue to act or does not consider it undesirable that he or she should continue to act. Moreover, even if a nearest relative does fall into either of these categories, he or she is not usually prepared to incur the trouble and expense of legal proceedings to seek a replacement.

2.71 Although there seems merit in the suggestions in the preceding paragraphs that a nominee could replace a nearest relative and that it should be made easier to replace an unsuitable nearest relative we have decided not to recommend any reforms. It seems to us highly desirable, if not essential, that the same person should be the nearest relative for the purposes of the 1984 Act and for the purposes of our recommendations, given the close similarity of the subject matter. Amendments to the 1984 Act in this area should be preceded by further consultation by the appropriate authorities. Accordingly we have decided to adopt without amendment the nearest relative provisions in the 1984 Act.

2.72 It was suggested to us that the sheriff on appointing a guardian or making some other order should have power to nominate a person other than a nearest relative or primary carer who should be required to be consulted by the guardian or other intervener. For example, a particular social worker or a close friend may have valuable views to offer in connection with all or some specific parts of the adult's welfare or financial affairs. We consider this to be a useful suggestion and have accordingly adopted it.

2.73 Summing up we recommend that:

14. (1) A person proposing to make an intervention in the welfare or financial affairs of an incapable adult under or in pursuance of the proposed new legislation should be required to take account of the present and past wishes of the adult.

(2) An intervener should also be required to consult with the incapable adult's nearest relative, primary carer, any guardian or continuing attorney or welfare attorney with relevant powers, but only in so far as it is reasonable and practicable to do so. The intervener should take account of the views expressed.

(3) An intervener should also be required to take into account the views of any other person appearing to have an interest in the incapable adult's welfare or the proposed intervention, but should not be under a duty to seek out such views.

(4) The sheriff should, on application, have power to direct that a specified person should have to be consulted and their views taken into account in relation to every or any particular intervention (under consideration or in the future) relating to the incapable adult.

(5) An adult's nearest relative should be determined by the provisions of sections 53 to 57 of the Mental Health (Scotland) Act 1984.

Clauses 1(4) and 67(1)

Fiduciary duties in relation to adults

2.74 Certain categories of people who are appointed to look after the affairs of others are regarded as standing in a fiduciary relationship to them or as having fiduciary duties in relation to them.

> "It is a rule of universal application that a person having fiduciary duties to discharge (as, for example, an executor, guardian, judicial factor, agent, promoter or director of a company as well as a trustee in the strict sense) is not allowed to enter into engagements in which he has or can have a personal interest conflicting, or which may possibly conflict, with the interests of those whom he is bound to protect[3]".

A fiduciary who enters into conflicting or potentially conflicting engagements is said to be acting as *auctor in rem suam*[4].

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1. S 56(2), (3)(b).
2. S 56(3)(c).
3. Gloag and Henderson, *Introduction to the Law of Scotland*, 9th edn, pp 770-771.
4. Trayner, *Latin Maxims and Phrases* translates it as "one who acts for his own behoof"; *Aberdeen Railway Co v Blaikie Brothers* (1854) 1 Macq 461.

The engagement is voidable[1] and any profit made has to be held for the beneficiary[2]. Another aspect of the *auctor in rem suam* rule is that a fiduciary cannot make any profit out of the position unless this is authorised by the appointment or the beneficiary. Illustrations of these rules are that a curator bonis appointed to manage the affairs of an incapable adult may not buy the adult's property[3] nor sell his or her own property to the adult or lend to, or borrow from, the adult's estate[4]. The curator is allowed commission which is paid by the Accountant of Court for managing the adult's affairs, but all other commissions and discounts received by the curator in that capacity have to be accounted for to the adult's estate[5].

2.75 Other fiduciary duties are the undivided loyalty rule and the confidentiality rule. The undivided loyalty rule requires fiduciaries not to place themselves in a position where their duty towards one beneficiary conflicts with a duty owed to another[6]. A fiduciary must make available to a beneficiary all the information that is relevant to the beneficiary's affairs. The confidentiality rule requires that a fiduciary must use information obtained in confidence from a beneficiary for the benefit of that beneficiary and must not use it for his or her own advantage or for the benefit of others[7]. These rules are of more importance where a professional curator or judicial factor manages the affairs of several incapable adults.

2.76 Many people who have functions under our recommendations in later Parts of this report will stand in a fiduciary relationship to the incapable adults in question. Guardians and continuing attorneys[8] are clear examples of fiduciaries. Those authorised to use money from an incapable adult's bank accounts for the adult's benefit, managers of establishments who manage their incapable residents' finances and persons appointed to carry out intervention orders would also be regarded as standing in a fiduciary relationship with the adults concerned. Breach of a fiduciary duty gives rise to liability on the part of the fiduciary. It is therefore important that such people are aware of these duties and the consequences of failing to observe them. Professional guardians such as solicitors and accountants ought to be aware of them, but the same may not be true for lay guardians or continuing attorneys. We have suggested that the Public Guardian should produce notes of guidance for guardians and others[9]. These notes should include material relating to fiduciary duties. The various Codes of Practice which we recommend[10] should also deal with this issue.

2.77 Where the fiduciary is a member of the incapable adult's family it may be very difficult or even impossible to avoid breaches of fiduciary duty. Suppose, for example, a woman appoints her husband to be her continuing attorney. Many actions by him such as the apportionment of household expenses between them or deciding whether to invest her estate for maximum income or for income and capital growth involve a conflict or potential conflict between his own interests and those of his incapacitated wife. Again, a daughter who has been appointed guardian to her father faces a conflict of interest between herself as successor to his estate and herself as his guardian in deciding whether or not to place her father in a private nursing home. Actings in breach of a fiduciary duty may be authorised by the appointer of the fiduciary or be consented to by the beneficiary concerned. For example, a trustee is allowed to claim only out-of-pocket expenses, but either the trust deed or the beneficiaries can authorise payment of fees. Neither of these methods would apply in the case of guardianship or most of the other fiduciary relationships under our recommendations.

2.78 Some other method of excusing breaches of fiduciary duty has to be devised. We do not think it possible to set out all the circumstances where a breach of fiduciary duty should be overlooked. The circumstances are too many and too varied. We would also reject the courts being required to grant dispensations for such breaches[11]. Repeated applications would be necessary since in some situations almost every action would be in breach of a fiduciary duty. Moreover, applications to the court would be likely to be numerous and would increase the expense of continuing attorneyship or guardianship, especially where relatives rather than professionals were involved.

2.79 In our view the solution lies in the requirements of reasonableness, good faith and adherence to the general principles. Suppose, for example, a daughter is continuing attorney for her incapable father. It becomes impossible to look after the father at home and he has to go into a residential home. In order to pay for this the father's share of the home which he owns jointly with the daughter has to be realised. The daughter should be able to purchase this share provided she does so openly at a price fixed by an independent professional valuer. Summing up we recommend that:

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1. *Fraser v Hankey and Co* (1847) 9 D 415
2. *Inglis v Inglis* 1983 SLT 437.
3. *Dunn v Chambers* (1897) 25R 247.
4. *Perston v Perston's Trs* (1863) 1M 245 (borrowing from trust); *Wilson v Smith's Trs* 1939 SLT 120 (loan to trust). These cases involved trustees but were decided on the basis of fiduciary duty.
5. *AB's CB* 1927 SC 902.
6. *North and South Trust Co v Berkeley* [1971] 1 WLR 470 at 484-5. There may be a term implied permitting this where an agent (such as an estate agent) acts for several principals *Kelly v Cooper* [1993] AC 205.
7. *Brown's Trs v Hay* (1898) 25R 1112.
8. *Robertson v Dennistoun* (1865) 3M 829; *Maffett v Stewart* (1887) 14R 506.
9. Para 2.46.
10. Such as the code for guardians, Recommendation 106, para 6.118.
11. Under s 32 of the Trusts (Scotland) Act 1921 the court may excuse trustees from personal liability for breach of trust if satisfied that they have acted honestly and reasonably and ought fairly to be excused.

15. (1) **A guardian, continuing or welfare attorney, person authorised to withdraw funds from accounts under Recommendation 37, managers of an establishment authorised to manage residents' affairs under Recommendation 47 and a person carrying out an intervention order who has acted reasonably, in good faith and in accordance with the general principles should not be liable for any breach of fiduciary duty to the incapable adult in question.**

(2) **Codes of Practice and other publications should make guardians and others aware of their fiduciary duties and the need to avoid acting in breach of them.**

Clause 64(1)

Ill-treatment and neglect of incapable adults

2.80 Section 105 of the 1984 Act provides that it is to be a criminal offence for managers or staff in a hospital or for guardians to ill-treat or wilfully neglect their patients. Those convicted are liable to imprisonment for up to six months or to a fine not exceeding the statutory maximum or both (summary conviction) and to imprisonment for up to two years or an unlimited fine or both (conviction on indictment). We consider that this offence should be extended to all those exercising welfare powers under our recommendations; welfare attorneys, persons acting under intervention orders and guardians. We recommend that:

16. **Any person exercising welfare powers under our recommendations who ill-treats or wilfully neglects an incapable adult should be guilty of an offence and liable to imprisonment and/or payment of a fine.**

Clause 65

Part 3 Continuing and Welfare Powers of Attorney

Introduction

3.1 In this Part we look at powers of attorney. The term "power of attorney" is used in two senses. Strictly speaking, it refers to a power of legal representation conferred by one person on another by means of a contract of mandate or agency. However, the term is also frequently used to refer to the document in which the power is granted. In the interests of clarity we use the term in the sense of the power conferred rather than in the sense of the document in which it is conferred. In this sense a power of attorney is a power granted by one individual (the granter) to another (the attorney) to act on his or her behalf in relation to various matters specified. The contract of mandate or agency conferring a power of attorney usually takes the form of a document setting out the powers conferred, but oral contracts are also competent. Contracts of mandate or agency appointing others to manage one's financial affairs and property have been available in Scotland for many centuries and there is a well-developed common law relating to them. Those appointed were known as factors or factors and commissioners, but nowadays the term attorney is more usual and we adopt this for the rest of the report[1]. Attorneys with powers over the granter's personal welfare or health care do not feature to any great extent in current Scottish practice. Their legal status is unclear in Scotland although many other jurisdictions have introduced them recently by legislation[2].

3.2 Powers of attorney are used in various ways that are relevant to this report[3]. Elderly or ill people anticipating likely future incapacity may wish to hand over all or part of their financial affairs to an attorney although at that time they are mentally capable of managing their affairs themselves. Should they become incapable later they wish and expect the attorney to carry on acting. Powers of attorney are also used to a lesser extent as an "insurance policy" by those who are perfectly physically and mentally well but who wish to provide against an unforeseen future loss of capacity. Attorneys appointed by contract are an alternative to the tutors, curators, guardians and others appointed by the court to look after an incapable adult's finances and welfare.

3.3 The main advantage of contractually conferred powers of attorney is that they are relatively cheap and flexible compared with court appointed guardians. The granter can decide whom to appoint as attorney and what powers to confer on him or her. Furthermore, the granting of a power of attorney does not require the acknowledgement by the granter or his or her family of possible future incapacity, its certification by medical practitioners and its publication in legal proceedings. The main disadvantage is that the attorney, unlike a court appointed guardian, is not supervised and monitored by some public official. As long as the granter remains mentally capable he or she can keep an eye on the attorney's actions. Once the granter becomes incapable he or she cannot monitor the attorney's actings or recall the power of attorney. The satisfactory operation of powers of attorney depends to a large extent on the honesty and integrity of the attorneys appointed. Sadly but inevitably a small minority of attorneys take advantage of this lack of supervision and abuse their position. We consider that powers of attorney which have effect after the granter's incapacity should be encouraged as they promote personal autonomy and prevent legal proceedings. However, there must be adequate protection for granters if powers of attorney are to continue to play a useful role in this area.

3.4 In our discussion paper[4] we suggested that it might be possible to regard attorneys as privately appointed guardians. However, we have found that there would have to be too many differences between court appointed guardians and privately appointed guardians/attorneys if the latter were to remain relatively informal and flexible. For example, the supervision, monitoring and auditing of the accounts of court-appointed guardians by the Public Guardian could not be applied to attorneys without destroying the benefits of this way of proceeding. We therefore continue to use the term "attorney" for

1. Samples of documents registered in the Books of Council and Session in 1977 and 1987 showed that nearly all were called power of attorney. A few were termed "power of attorney or factory and commission" or "factory and commission or power of attorney". The last is used in the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990, s 71.
2. California, Durable Power of Attorney Health Care Act 1983; New Zealand, Protection of Personal and Property Rights Act 1988; Ontario, Substitute Decisions Act 1992.
3. Powers of attorney are also used in commercial transactions and by those going abroad wishing to leave someone at home with authority to cope with their affairs during their absence. About half the powers of attorney in 1977 were estimated to have been granted for this reason, the other half were by "infirm" granters. D Nichols, *Legal Arrangements for Managing the Finances of Mentally Disabled Adults in Scotland*, 1992, Journal of Social Welfare and Family Law, 193.
4. Para 8.3.

the appointees who would be subject to our new recommended regime, although we call them "continuing attorneys" to emphasise that their authority in relation to financial matters continues after the incapacity of the granter. Use of the term attorney or continuing attorney brings in much useful Scottish common law, such as the fiduciary relationship between granter and attorney, the events which terminate the attorney's authority and the effect of termination on the attorney and any third party dealing with the attorney. Adoption of a term other than attorney or continuing attorney would involve setting out all these common law rules in new statutory provisions.

3.5 In our discussion paper we dealt with powers of attorney for property and financial affairs separately from powers of attorney relating to personal welfare. While it is, and has for many centuries been, accepted that people can delegate management of their financial affairs it was, we thought, questionable whether and if so to what extent delegation of personal welfare decisions should be permitted. Delegation of personal welfare decisions raises ethical issues which are absent from the financial management area. Our proposal[1] that legislation should be introduced permitting attorneys to take welfare and health care decisions on behalf of granters after the granters' incapacity was widely welcomed, although some respondents questioned the need for welfare attorneys as well as court-appointed guardians with welfare powers. We consider the two posts to be complementary in the same way as financial attorneys and guardians with financial powers are. Later on in this Part[2] we recommend that a power of attorney in relation to personal welfare matters should not become effective until the granter becomes incapable of making the personal welfare decision in question. Such a power is not a continuing power for it never had effect prior to the granter's incapacity. We therefore use the term "welfare power of attorney" for it, with the person appointed being termed a "welfare attorney". The term "continuing power of attorney" is confined to a power of attorney relating to the granter's financial affairs, since such a power may be operable before incapacity and continues to be effective after incapacity if completed in accordance with our recommended requirements. The appointee we call a "continuing attorney". Apart from this nearly all our recommendations as to the form of the contracts of mandate or agency conferring continuing or welfare powers of attorney and the functions of the continuing or welfare attorney appointed are identical. It would be possible for a granter to appoint a continuing attorney who is a different person from the welfare attorney and to do so by separate contracts in different documents. We imagine, however, that in most cases a single document will be employed and the same person will be appointed as welfare and continuing attorney.

Effectiveness after incapacity to be express or implied?

3.6 A power of attorney granted on or after 1 January 1991 does not lapse by operation of law on the subsequent mental incapacity of the granter. Section 71(1) of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990, which came into force on that date, provides:-

> "Any rule of law by which a factory and commission or power of attorney ceases to have effect in the event of the mental incapacity of the granter shall not apply to a factory and commission or power of attorney granted on or after the date on which this section comes into force".

Granters who do not wish their powers of attorney to continue must insert an express clause "opting-out" of the statutory rule. The above statutory provision was intended as an interim measure pending our consideration of the issue[3]. In our discussion paper we proposed[4] that granters who wished their attorneys to continue to have authority after incapacity should be required to insert an express clause to that effect in the document conferring the power. They should have to "opt-in" rather than "opt-out". To put it another way the general rule should be that powers of attorney do not continue after the granter's incapacity, but it should be competent for granters by express provision to grant continuing authority after incapacity on their attorneys. An opting-in system enables appropriate safeguards to be incorporated for those contracts expressly providing for continuing powers of attorney without extending them to powers of attorney in general. It also ensures that granters have to consider carefully the desirability of granting a continuing power and prevents them inadvertently conferring a continuing power through ignorance or forgetfulness of the need to opt-out. Many powers of attorney are granted for commercial reasons or for a limited purpose and it is doubtful whether such granters intend the attorneys appointed to operate after their incapacity.

3.7 Most of the many respondents who commented on the opting-in proposal were in favour of a new statutory regime for powers of attorney with increased protection for granters and thought that that purpose would be better achieved by an "opting-in" system. Two of those consulted preferred the existing system because of its simplicity. Some of those supporting the new regime urged us to adopt a flexible scheme which did not contain too many restrictions and conditions. We consider that the balance between simplicity and protection of granters falls on the side of the latter and that the present system of automatically conferring continuing authority on attorneys without much in the way of protective

1. Proposal 76, para 5.101.
2. Recommendation 23, para 3.42.
3. HL Debs, Vol 522 Col 1651 (25 Oct 1990).
4. Proposal 58(2), para 5.12.

measures is unsatisfactory. We have, however, endeavoured to build in protection without undue rigidity, bureaucracy and expense.

3.8 Should the clause which has the effect of imparting a continuing effect to a power of attorney be prescribed? The advantages of a prescribed style are that third parties can readily see that the document confers a continuing power and that granters and their advisers are more likely to use continuing powers of attorney if there is a prescribed style whose effect is laid down by statute and hence is certain. The disadvantage is that any deviation from the prescribed style would deny effect to the granter's intention, unless there was a further provision allowing minor deviations. In our discussion paper we proposed[1] that a style should be prescribed but that it should not be mandatory to use it. Any words showing that the granter clearly intended the document to confer continuing authority should suffice. There was little comment from those consulted on this aspect of continuing powers of attorney. One commentator with wide experience of enduring powers of attorney in England and Wales said that while prescribed forms were easier for third parties they created difficulties for granters in situations that were out of the ordinary. On reconsideration we think the form of words is best left unprescribed. The only requirement should be that the document clearly shows that the granter intended the attorney to have continuing power.

3.9 In our discussion paper we proposed that granters of welfare powers of attorney should also have to "opt-in"[2]. Our later recommendation that a welfare power of attorney only becomes effective on the granter's incapacity[3] requires this to be reconsidered. Strictly speaking, a contract of mandate or agency conferring a welfare power of attorney need not contain an express clause conferring power on the welfare attorney to act after the granter's incapacity since that is the only period during which the welfare powers could be exercised. Nevertheless, we consider that it would be better to have the same "opt-in" rule for both continuing attorneys and welfare attorneys. An express clause would make it obvious to granters what they were doing in granting a welfare power of attorney.

3.10 We therefore recommend that:

17. (1) A person having a power of attorney granted after the commencement date of legislation implementing our recommendations should have power to act after the granter's incapacity only if the contract of mandate or agency conferring the power of attorney clearly shows that that was the granter's intention.

(2) There should be no style prescribed for conferring a power of attorney which is to have effect after the granter's incapacity.

(3) Section 71 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990 should be repealed with respect to powers of attorney granted on or after the commencement date of legislation implementing our recommendations.

Clauses 11(1),(3)(b) and 12(1), (3)(b) and Schedule 5

Execution of continuing or welfare powers of attorney

3.11 At present a power of attorney may be conferred orally or in writing and in the latter case may be simply signed by the granter. As a matter of practice a document conferring a power of attorney is almost invariably subscribed by the granter and witnessed in accordance with the statutory requirements for attestation[4]. It is then presumed to be authentic and formally valid until the contrary is established in court proceedings. In our discussion paper we proposed[5] that a document conferring a continuing power of attorney should have to be in writing and signed by the granter at the end in order to be valid. Oral grants of powers would therefore be ineffective. This was agreed by all those who responded. Section 2(1) of the Requirements of Writing (Scotland) Act 1995 now provides that the granter's subscription is sufficient for formal validity. In practice documents providing for continuing or welfare powers of attorney will continue to be attested for evidential purposes. Not only would the Public Guardian wish some presumption of formal validity before registering the document[6] but also the strong presumption of authenticity would be very useful in a document which is going to be relied on for an indefinite future period at a time when evidence from the granter would be unavailable.

3.12 We also proposed that there should be a statutory prohibition on the attorney acting as a witness to the granter's signature of a document conferring a continuing power of attorney[7]. Although there was unanimous agreement on consultation we now consider that there is no need for a statutory provision. Attestation is a matter of evidence, not validity

1. Proposal 58(2), para 5.12.
2. Proposal 77(1), para 5.103.
3. Recommendation 23, para 3.42.
4. The Requirements of Writing (Scotland) Act 1995, s 3 provides for a single witness in documents executed after commencement (1 August 1995). Before then two witnesses were required.
5. Proposal 59(1), para 5.21, extended to welfare powers in Proposal 77(2), para 5.103.
6. See Clause 14(2) of the draft Bill.
7. Proposal 60, para 5.22.

and current practice is to obtain completely independent witnesses wherever possible in order to minimise the risk of future challenge and we consider that this is unlikely to change in the future. We therefore recommend that:

18. A contract of mandate or agency conferring a continuing or welfare power of attorney should be required to be in a written document and subscribed by the granter in order to be formally valid.

Clauses 11(3)(a) and 12(3)(a)

Signature by attorney?

3.13 At present attorneys do not sign the document conferring the power of attorney to signify their consent to appointment. In our discussion paper we proposed[1] that it should not become a requirement for formal validity that a document conferring a continuing power of attorney was signed by the attorney. Most of those who responded agreed with our proposal, but some took the view that an attorney should sign to indicate acceptance. We think, however, that the stage at which a formal indication of acceptance should be required is when the document is presented to the Public Guardian for registration. It is at that stage, when the power is about to be used, that attorneys are in a position to know whether or not they can accept the appointment. It does not seem reasonable to require those named as attorney to bind themselves to act at some indeterminate time in the future, when circumstances might be very different. If the attorney's subscription is not binding, it is merely confusing to require it for formal validity. Why should an unnecessary signature, signifying at most that the signatory has read the document, be necessary for formal validity? Another disadvantage of requiring the attorney's signature for formal validity is that this would open up a difference between continuing or welfare powers of attorney and other powers of attorney. This we are reluctant to do unless it is necessary. It would create further problems such as whether the attorney's subscription would have to be attested for evidential purposes and, if so, whether the statutory provisions on attestation of the signatures of granters of documents applied to a person who was signing not as a granter but in some vague and unspecified capacity. For all these reasons we do not recommend that subscription by the attorney should be necessary for the formal validity of a continuing or welfare power of attorney.

Ensuring granters understand document when signing

3.14 Continuing powers of attorney by their very nature continue to have effect after their granters have lost capacity. Welfare powers of attorney become effective then. Granters should be fully aware of what they are doing in signing a document conferring a continuing power of attorney or a welfare power of attorney. They are handing over the future management of their affairs or personal welfare to individuals they will be unable to supervise and if necessary dismiss. There may well be no-one sufficiently interested to monitor the attorney's actings and take steps to terminate the appointment if the attorney acts improperly. We consider that proper measures of protection should be introduced at the earliest possible stage - when the document conferring the power of attorney is signed. The formalities of execution should be such as to ensure that granters are fully aware of the consequences of creating a continuing or welfare power and that they are not subject to any pressure to do so. We note that the Alberta Law Reform Institute has come to a similar conclusion[2]. A research report into the workings of enduring powers of attorney in England and Wales suggested that certification of capacity at the time of execution might be a more effective safeguard for granters than the current notification and registration procedures contained in the Enduring Powers of Attorney Act 1985[3]. In our discussion paper we asked whether over and above signature by the granter there should be other requirements for formal validity in order to ensure that granters were aware of the long term consequences of granting a continuing financial power[4]. We suggested three such requirements:

(a) a signed statement by the granter that he or she had read a prescribed form of explanatory notes.

(b) a certificate by a solicitor that the effects of the document conferring a continuing power had been explained and the granter appeared to understand the explanation, or

(c) a certificate by a doctor or other appropriate person that the granter had capacity to understand the consequences of signing the document conferring a continuing power of attorney.

We also proposed that the requirements for valid execution of a welfare power of attorney should be the same as those for a financial power with continuing effect[5].

3.15 There was little support amongst those responding for granters having to certify that they had read prescribed form explanatory notes. This was regarded as an ineffective safeguard; people who signed documents without fully understanding their effects would in all likelihood not read and take in the explanatory notes either. They would simply sign the document conferring the power of attorney and any accompanying certificate. Nevertheless we think many

1. Proposal 61, para 5.24.
2. *Enduring Powers of Attorney*, Report No 59, p 3.
3. S Cretney and others, *Enduring Powers of Attorney: A Report to the Lord Chancellor* (1991), para 2.40.
4. Proposal 59(2), para 5.21.
5. Proposal 77(2), para 5.103.

granters would find brief explanatory notes helpful and we suggest that the appropriate authorities should consider issuing them.

3.16 Certification by a solicitor that the granter had had the effect of a continuing power of attorney explained and appeared to understand it was generally welcomed by those consulted[1]. This would not give rise to extra expense in most cases since most powers of attorney are prepared with the involvement of lawyers. The Scottish Association for Mental Health suggested that other independent people of standing in the community should also be able to certify, as otherwise granters using printed form powers would be put to the expense of employing a solicitor just to have their understanding certified. We would adopt this helpful suggestion because it would encourage the use of continuing and welfare powers of attorney if forms were provided by voluntary organisations and the granter's understanding could be certified by a minister of religion, doctor or other member of a prescribed class. "Appearing to understand" the explanation of the effect of a power of attorney is perhaps somewhat vague. We are now in favour of a slightly stricter test - that the solicitor or other certifying individual should be satisfied that the granter understood the nature and effect of the document conferring the power. The certifier would be expected, as a matter of course, to question the granter and make such other enquiries as seemed necessary in order to be in a position to give the certificate.

3.17 Many granters of continuing or welfare powers will be failing in their mental and physical faculties and suggestible to pressure from others. We consider that the solicitor or other certifying individual should also have to state that he or she had no reason to believe that the document conferring the power was being signed as a result of anything (such as undue influence) which would vitiate the granting of the power.

3.18 Respondents were not in favour of a medical certificate of capacity being mandatory in all cases, partly on grounds of expense and partly because those with undoubted full capacity would find a compulsory medical assessment insulting. However, many saw a role for such a certificate where the solicitor was unable to certify the granter's understanding. Others doubted whether a medical practitioner was the appropriate person to certify an individual's capacity to understand the meaning of a legal document; capacity is as much a legal concept as a medical one[2]. We consider that a certificate of capacity should not be a mandatory requirement, but if there were doubts as to the granter's capacity an assessment of the granter's capacity by a medical or other specialist should be sought. A report indicating that the granter had capacity would enable the solicitor or other certifier to certify the granter's understanding. We received a suggestion that the sheriff should have power to declare that an intending granter of a continuing or welfare power of attorney had capacity to grant it so that the validity of the document could be established. After careful consideration we have decided not to recommend this. First, there is a presumption of capacity at common law which those challenging the power of attorney later would have to rebut[3]. This presumption would be greatly strengthened if the granter had been assessed as capable at or around the time of signing by a medical or other specialist. Second, to prevent a later challenge the declarator would have to be conclusive. We do not think that a declarator should be given this effect since all those likely to be affected by the validity or otherwise of the document could not be identified in advance and called as contradictors. A declarator which merely created a presumption would add nothing to the existing law.

3.19 Summing up we recommend that:

19. In order to be formally valid a document conferring a continuing or welfare power of attorney should:

(a) contain a certificate by a solicitor (or a member of some other class of persons to be prescribed by the Secretary of State) that, after interviewing the granter and obtaining any necessary reports, he or she is satisfied that the granter understood the nature and effect of the document, and

(b) contain a certificate by a solicitor or other certifying person that he or she has no reason to believe that the document was being signed as a result of anything which would vitiate the granting of the power.

Clauses 11(3)(c) and 12(3)(c)

Who may be appointed a continuing or welfare attorney?

3.20 Under the present law an attorney must be over 16[4], mentally capable and not bankrupt at the time of appointment in order for the appointment to be valid. An initially valid appointment falls on the attorney's later bankruptcy or mental incapacity[5]. In our discussion paper we proposed that these personal attributes should continue to be required for both

1. This is done in New South Wales; Conveyancing Act 1919, s 163F(2) added by the Conveyancing (Powers of Attorney) Amendment Act 1983. Barristers and clerks of petty sessions may also certify the granter's understanding.
2. The British Medical Association and the Law Society of England and Wales are currently producing a booklet about assessment of capacity in relation to legal matters.
3. *Lindsay v Watson* (1843) 5D 1194.
4. Age of Legal Capacity (Scotland) Act 1991.
5. Halliday, *Conveyancing Law and Practice*, Vol I, para 13-11.

financial[1] and welfare[2] continuing attorneys. There was almost unanimous acceptance of our proposals for financial attorneys, but many questioned the exclusion of bankrupts from acting as welfare attorneys. Close relatives who had been appointed attorney and who would be in the best position to decide personal welfare matters might become bankrupt and so have to be replaced by court-appointed guardians. It was said that in times of recession bankruptcy did not necessarily imply dishonesty or a lack of probity. While we would prefer to minimise distinctions between continuing attorneys and welfare attorneys we consider that a distinction is justified in relation to bankruptcy. Those whose financial affairs are taken out of their own hands should not be permitted to manage the financial affairs of others, but purely personal welfare powers should be exercisable by a bankrupt welfare attorney unless the power of attorney provides otherwise. This may give rise to problems where the same individual is appointed continuing attorney and welfare attorney, but careful drafting of the document of appointment with possible future bankruptcy in mind should mitigate such problems.

3.21 The bankruptcy of the granter of a power of attorney automatically terminates the authority of the attorney[3]. On sequestration the trustee is vested in the estate of the bankrupt[4] and clearly must supersede the attorney in relation to matters affecting the estate. We consider that a welfare attorney's authority should not be terminated automatically since there would be no direct conflict between the welfare attorney and the trustee.

3.22 In current practice an attorney is almost invariably an individual although there is no prohibition against a corporate appointment. We asked in our discussion paper whether it should be competent to appoint a corporation as continuing financial[5] attorney, but proposed confining continuing welfare attorneys to individuals[6]. This approach was approved by the majority of those who responded although some considered that corporate attorneys should not be allowed even in the financial field. We consider that granters should be free to appoint a corporate attorney to exercise financial powers should they wish to do so, although we do not anticipate this being done to any great extent. Enable have set up a trustee scheme whereby a company limited by guarantee can act as trustee for trusts created for mentally handicapped individuals. It or other organisations may wish to set up similar schemes for continuing attorneys. As far as welfare powers are concerned we consider that it should be competent to grant them only to one or more individuals.

3.23 The Law Society in its response said that the provider of services or facilities to the granter or the employee of such a provider should not be permitted to be a continuing attorney, while Alzheimer Scotland- Action on Dementia considered that the proprietors of private residential and nursing homes should also be excluded in respect of their residents. We recognise the possibility of abuse and concentration of power in such appointments. This, however, could also occur with individuals looking after the affairs of their incapacitated relatives at home and would be more difficult to detect because such carers are not subject to the local authority registration and inspection that residential homes are subject to. Moreover, somebody in a residential home may be the most appropriate person to be appointed as an attorney by a resident who has been in the home for many years and who is without close family. We recommend below[7] that all continuing and welfare powers of attorney should be registered with the Public Guardian so that it would be possible for the local authority charged with carrying out inspections of residential homes and the Public Guardian to monitor situations which might give rise to concern.

3.24 Joint attorneys and substitute attorneys are frequently met with in current practice. Our proposal to permit such appointments with financial[8] and welfare[9] attorneys was agreed by all those who commented. Joint attorneys have many advantages. It is helpful for an attorney to have someone to discuss problems with and share the responsibility. The functions could be divided up informally between the appointees according to their wishes and abilities. For example, a son looking after his elderly mother could look after her day-to-day finances while her investments could be managed by someone with more experience and aptitude for such business. Joint attorneys also cater for the situation where one attorney is temporarily unable to act. The main disadvantage is that the joint attorneys may disagree so leading to stalemate, but this only happens when all the joint attorneys have to agree to any act. It is more usual for the appointment of more than one attorney to be made joint and several, in which case any one can act without the others[10]. Irreconcilable differences between joint attorneys might have to be resolved by the court (or the granter if still capable). This adjudication would be part of the court's recommended general power to give directions to continuing or welfare attorneys[11].

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1. Proposal 63(1), para 5.33.
2. Proposal 77(3), para 5.103.
3. *McKenzie v Campbell* (1894) 21R 904.
4. Bankruptcy (Scotland) Act 1985, s 31.
5. Proposal 63(2), para 5.33.
6. Proposal 77(3), para 5.103.
7. Recommendation 21, para 3.36.
8. Proposal 63(1), para 5.33.
9. Proposal 77(4), para 5.103.
10. Halliday, *Conveyancing Law and Practice*, Vol 1, para 13.08.
11. Recommendation 30, para 3.68.

3.25 A substitute attorney allows for succession to the post should the original attorney die or wish to resign. Without a substitute a continuing or welfare power of attorney would come to an end so that an application would have to be made to the court for the appointment of a guardian. The granter might wish to specify events other than death or resignation of the original attorney that would trigger the substitute taking over and this should be permitted. The Public Guardian as registration authority should require to be notified that the substitute had taken over.

3.26 As most of the above points are already covered by the existing law on powers of attorney it is necessary for us to make only the following recommendations:

20. (1) A welfare attorney should be permitted to exercise welfare powers notwithstanding his or her bankruptcy or the bankruptcy of the granter.

(2) Welfare powers under a welfare power of attorney should be exercisable only by individuals.

Clause 12(4), (6)

Registration of continuing or welfare powers

3.27 At present there is no requirement for documents conferring powers of attorney to be registered or made public in any way. As a matter of prudent professional practice, in order to guard against loss of the document, solicitors invariably register documents conferring powers of attorney in the Books of Council and Session (a national public register of documents situated in Edinburgh) or similar public registers kept at sheriff courts. Registration may take place immediately after completion of the document or it may be delayed until the attorney needs to exercise the powers.

3.28 In our discussion paper we put forward three options for a possible registration system[1]. The first, and most elaborate, was registration with some public authority that supervised and monitored the registered attorneys and required annual accounts for auditing. The second was modelled on that used in England and Wales under the Enduring Powers of Attorney Act 1985. The attorney would be under a duty to register the document with some public authority when the granter is, or is becoming, mentally incapable. Before applying for registration the attorney would have to give notice of the intended application to the granter and the granter's nearest relatives who would be entitled to object. The registration authority or the court would adjudicate on any objections. The third option was to make publication by registration in the Books of Council and Session mandatory by rendering ineffective a document conferring a power of attorney that was not registered within a specified period from the date of signature. Our provisional conclusion was that none of the options should be adopted and that the existing practice of voluntary registration should continue.

3.29 Many of those consulted agreed with our provisional conclusion that there should be no requirement of registration. Many others, however, favoured the introduction of a simple registration system so that possible abuse could be detected and notified to the appropriate authority. For example, one individual being registered as an attorney for a number of granters (apart from solicitors or accountants for their clients) might give rise to suspicion. We now think there would be merit in having a simple registration system. An open public register would bring continuing or welfare powers of attorney into the public domain and this, coupled with the requirement to present documents to public officials, would act to some extent as a deterrent to unscrupulous attorneys. We would stress that registration of a document conferring a continuing or welfare power would not imply any mental incapacity on the part of the granter or affect the granter's capacity to enter into transactions. The question of the granter's capacity would be one of fact both before and after registration. We would reject the first option of the registration authority also being a supervising and monitoring authority since that would be too complex and duplicate our recommended system of guardianship. The second option, a registration authority and procedure along the lines of that in England and Wales under the Enduring Powers of Attorney Act 1985 also seems to us to be too complex. Registration should be an administrative act rather than a procedure which gives an opportunity to air family feuds by way of relatives' objections. The Law Commission of England and Wales have come to a similar conclusion in their *Report on Mental Incapacity*[2]. The third option, compulsory registration in the Books of Council and Session would achieve only publication but most powers of attorney are registered there already. Those respondents who were in favour of a simple registration system undoubtedly wished to see something more than mandatory publication.

3.30 Continuing and welfare attorneys would lose their advantages, and would indeed become redundant, if such attorneys were to be subject to the same statutory regime as guardians. In order to be effective a registration system should have to be:

(a) compulsory;

(b) in a single national register open to public inspection;

(c) not more expensive than registration in the Books of Council and Session; and

1. Paras 5.44-5.49.
2. Law Com No 231 (March 1995), paras 7.37 and 7.38.

(d) kept by some public authority which would be under a duty to investigate complaints or circumstances giving rise to concern and to pass on information to other investigating bodies on request.

3.31 We envisage that the overwhelming majority of attorneys will be appointed with financial powers, either solely or in addition to welfare powers, so that the registration authority should be an organisation familiar with the management of finances and property. The Accountant of Court's office is the most obviously appropriate registration authority because of its existing functions in supervising and monitoring curators bonis and other judicial factors. Furthermore, the office would have staff familiar with carrying out investigations and capable of carrying out spot-checks. We do not think that those responsible for the Books of Council and Session should be given investigative functions into the conduct of attorneys. Their task is to maintain an accurate register of documents presented to them. Investigating the legal efficacy of continuing or welfare powers of attorney and the conduct of attorneys would be a radical and substantial new function. Elsewhere in this report we recommend that the Accountant of Court should be the Public Guardian and as such should maintain a register of guardians appointed by the court to incapable adults[1] and a register of people entitled to withdraw funds from incapable adults' bank accounts[2]. The Public Guardian would also have investigative functions in relation to these registered appointees. There seems to us to be considerable merit in having all these registration and investigatory functions undertaken by the same body. It is not worth creating a separate registration authority for welfare attorneys who are appointed solely with welfare powers. The Public Guardian should register them but any investigation should be carried out by the Mental Welfare Commission or the local authority. We envisage that registration of continuing or welfare powers of attorney would be a simple administrative process. The Public Guardian would be expected to check the documents to see that they complied with the requirements for formal validity we recommended earlier[3]. In practice, attestation would be the normal way of establishing the authenticity of the granter's subscription[4]. Acceptance for registration would not preclude a later challenge to the document's validity. We also think that the Public Guardian should not be required to register a document unless satisfied that the attorney accepts the appointment. There would be no point in registering documents which were never likely to be used.

3.32 The Books of Council and Session and the sheriff court registers are public registers. Documents registered there may be inspected by any member of the public during normal office hours on payment of the appropriate fee. We think it would be a retrograde step to make the Public Guardian's register of continuing and welfare attorneys a closed one. Many organisations and individuals involved with incapable adults or their attorneys have a legitimate interest in details of the attorneys and their powers. Registration in a public register may not be sufficient in itself to alert people to the continuing or welfare power of attorney. It should be open to the granter in the document conferring the power to add a clause requiring the Public Guardian to send a copy of the registered document to no more than two specified individuals or office holders. The Public Guardian should automatically send a copy of the registered document to the granter.

3.33 Registration would have to be compulsory if it were to achieve the results desired by those consultees in favour of registration. The only sensible sanction for non-registration is that the continuing or welfare power of attorney should be ineffective unless the document conferring it is registered. Any document conferring a continuing power of attorney that was expressed to be effective after incapacity would therefore have to be registered in a register kept by the Public Guardian before the attorney could competently use the powers conferred, even while the granter remained mentally capable. Welfare powers of attorney, however, would not become effective merely by virtue of registration because welfare powers are exerciseable only if the granter is incapable. Financial powers of attorney that are granted because the granter is going abroad or for some other commercial purpose would, we imagine, not normally contain an express continuation clause. Our recommendations as to registration and the other recommendations in this Part would not apply to such powers of attorney.

3.34 An attorney under an ordinary power of attorney granted after the commencement of the new legislation recommended here might be able to continue to act after the granter's incapacity since there is no clear rule in Scottish law that the power of attorney lapses then. Repeal of section 71(1) of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990[5] would leave the law doubtful. Documents conferring powers of attorney without an express continuation clause might therefore be used to circumvent our recommended registration provisions. In order to avoid this there should be a new statutory provision rendering ineffective during the granter's incapacity a power of attorney which does not contain an express continuation clause.

3.35 One of the purposes of the register is to enable those with an interest in the incapable granter to find out current details of the continuing or welfare attorney. Any significant changes should therefore be required to be notified to the Public Guardian so that the register can be amended. Such changes should include a permanent change of address of either the granter or the attorney, the death of the granter and the resignation or removal by the sheriff of the attorney.

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1. Recommendation 91, para 6.40.
2. Recommendation 37, para 4.12.
3. Recommendations 18 and 19, paras 3.12 and 3.19.
4. See para 3.11 above. An alternative would be a certificate or decree under section 4 of the Requirements of Writing (Scotland) Act 1995.
5. See para 3.6.

3.36 We recommend that:

21. (1) The Public Guardian should set up and maintain a register of documents conferring continuing or welfare powers of attorney.

(2) The Public Guardian should not be required to register a document conferring continuing or welfare powers of attorney unless the document appears to comply with the requirements of Recommendations 18 and 19 (signature by granter and certification of granter's understanding and absence of vitiating factors) and he or she is satisfied that the attorney accepts the appointment.

(3) The register should be open to inspection by any member of the public. On registration the Public Guardian should give a copy of the document to the attorney or other ingiver with a certificate of registration and also send a copy to the granter and, if the document requests this to be done, to up to two other specified individuals.

(4) A continuing or welfare attorney should have no authority by virtue of the power of attorney until the document conferring such a power is registered with the Public Guardian.

(5) Once the document conferring the power has been registered the Public Guardian should be notified of any permanent change of address of the granter or continuing or welfare attorney or the death of the granter.

(6) The Public Guardian should be required to investigate complaints made about the actings of continuing attorneys and alert the competent authorities in order to prevent further abuse. The Mental Welfare Commission and the local authority should have similar functions in relation to welfare attorneys.

(7) A power of attorney conferred after the commencement of the new legislation otherwise than in accordance with our recommendations should lapse on the granter's incapacity.

Clauses 4(2)(c), 4(2)(d), 7(1)(c), 8(1)(c), 13, 14(1), (2), (5), and 16

Springing powers of attorney

3.37 Normal contracts of mandate or agency conferring powers of attorney confer immediate authority on the attorney. Under our recommendations registration of the document conferring a continuing power would be required before continuing attorneys could exercise their powers. Nevertheless, the document could be registered immediately after its signature by the granter. Many granters do not wish to confer immediate authority on their attorneys. At the date of signing they are perfectly capable of managing their affairs and are merely making prudent provision should incapacity occur later. Such people may be deterred from granting a power of attorney by its immediate effect.

3.38 In our discussion paper we asked[1] whether there should be new statutory provisions for springing powers - powers of attorney that would spring into effect only on the occurrence of an event specified in the document conferring a power of attorney. The most common springing event is likely to be the granter's incapacity, but others could be imagined such as moving from home into permanent residential care. Most respondents were in favour of new statutory provisions, but some questioned the need for them. We understand that some solicitors are preparing springing powers for their clients at the moment and the Scottish Association for Mental Health was of the view that practice should be allowed to develop, rather than rules being laid down in legislation.

3.39 Taking account of the views expressed we have decided to deal with the matter slightly differently using our recommended registration system. We consider that the Public Guardian should be required to register any document conferring a continuing or welfare power of attorney unless the document contains a clause prohibiting registration until the occurrence of a specified event. Where such a clause exists the person presenting the document for registration would have to satisfy the Public Guardian that the event had occurred. This approach allows granters to confer springing powers on their continuing or welfare attorneys without regulating such powers in detail by statute. Welfare powers of attorney are in a sense always springing powers since the powers conferred may not be exercised until the granter becomes incapable. But the welfare power should be registrable at any time after granting unless the granter stipulates otherwise.

3.40 We recommend that:

22. Where the terms of a document conferring a continuing or welfare power of attorney prohibit registration until the occurrence of a specified event, the Public Guardian should not register it unless satisfied that the event has occurred.

Clause 14(3)

1. Proposal 73, para 5.86.

When should welfare powers be exercisable?

3.41 In our discussion paper we proposed[1] that a personal welfare attorney should not have authority to make a decision in respect of a personal welfare matter while the granter was capable of making that decision. This proposal was strongly supported on consultation. Immediate authority while the granter remains capable may be desirable in the financial field but does not seem sensible in the personal welfare field. For example, a doctor requesting consent to medical treatment would naturally ask the patient if capable rather than a welfare attorney, even if the latter had registered the document conferring the welfare power. The welfare attorney should therefore have authority to make a personal welfare decision if the granter is unable to make that decision by reason of mental disorder or an inability to communicate. The welfare attorney should also have authority to take a personal welfare decision if he or she reasonably believes the granter to be incapable, but the third party involved could take a different view of the granter's capacity, refuse to recognise the attorney's authority and deal directly with the granter. Irreconcilable differences of opinion between welfare attorneys and third parties as to capacity might have to be resolved by the courts. In its response Sense in Scotland considered that an attorney should always take account of the express wishes of the granter. We agree and deal with this by means of the general principles that we recommend should govern all decision-makers. One of these principles[2] requires a decision-maker to take account of the past and present wishes and feelings of the incapable adult. Past instructions or wishes might be contained in the document conferring the welfare power of attorney. The greater the granter's capacity the more weight the attorney should give to the granter's present wishes and feelings.

3.42 We recommend that:

23. A welfare attorney should not be entitled to exercise a welfare power contained in the document conferring the power of attorney unless the granter is incapable of making a decision regarding the welfare matter in question, or the attorney reasonably believes the granter to be incapable.

Clause 12(4)

Powers of continuing and welfare attorneys

3.43 The authority of a continuing or welfare attorney is delimited by the powers conferred by the granter in the document of appointment. There are also restrictions imposed by the common law both as to what an attorney cannot competently do (such as make a will for the granter) and the manner in which the attorney exercises the powers[3]. In our discussion paper we looked at limitations in the financial and welfare fields. In the financial field we proposed[4] following the existing common law relating to attorneys so that a continuing attorney should in general not be entitled to remuneration or to make gifts or use the granter's estate for the benefit of others unless the granter was under an obligation to them (such as an obligation of aliment). We considered that the granter should, however, be able to expressly authorise the continuing attorney to receive remuneration or to do any of the other acts. There was no dissent on consultation, but one body did suggest that a continuing attorney should be entitled to make gifts even in the absence of any power to do so in the document of appointment, provided that the entitlement was appropriately restricted. We do not favour this even though enduring attorneys in England and Wales have statutory power to make reasonable birthday, seasonal and charitable gifts[5]. If the granter wishes the attorney to be able to make gifts, such as birthday and Christmas gifts to grandchildren or donations to charities, then this should be expressly provided in the continuing power of attorney. "Reasonable" and "seasonal" are vague terms that a less than scrupulous attorney could exploit. We prefer a simple straightforward rule that prohibits gifts unless the granter expressly provides for them. If the continuing attorney wished to make gifts and had no power to do so he or she could resign and apply to the court for appointment as guardian. Under our recommendations a guardian has power to make such gifts as are approved by the Public Guardian[6]. The attorney's authority to benefit others should as under the existing law be limited to alimenting those whom the granter is obliged to aliment. This would allow a wife looking after her incapable husband to keep the household going.

3.44 Entitlement to remuneration should have to be conferred expressly or by clear implication. Professional attorneys, such as solicitors or accountants, expect to be paid but relatives and close friends generally do not. This should be something that should be decided by the granter, but we would adopt the existing position in relation to powers of attorney that remuneration is not due unless authorised by the granter[7].

3.45 Another matter we raised was whether a continuing attorney should be entitled to see the granter's will. Doing so would help the attorney manage the estate in a way that would avoid difficulties on the granter's death. In our discussion

1. Proposal 82, para 5.124.
2. See Part 2, paras 2.61 to 2.63.
3. Attorneys also have fiduciary duties to their granters, see paras 2.74 to 2.79.
4. Proposal 64, para 5.39.
5. Enduring Powers of Attorney Act 1985, s 3.
6. Recommendation 104, para 6.110.
7. *Orbiston* v *Hamilton* (1736) Mor 4063.

paper we proposed[1] that the power to see the will should be one that had to be expressly conferred. This was agreed. In connection with guardianship we consider that a guardian should not be empowered to make a will on behalf of an incapable adult[2]. The common law already prohibits such action on the part of an attorney. The existing law as to the extent to which a granter can delegate to an attorney his or her functions as a trustee, executor or other fiduciary is unclear. Discretionary functions cannot be delegated[3], but administrative acts like voting at a company meeting and perhaps signing documents can be performed by an attorney[4]. In our discussion paper we proposed[5] that it should not be competent for a trustee or other fiduciary to appoint an attorney to act in his or her place on incapacity. All those who responded agreed with our proposal. The purpose of continuing powers of attorney is to enable the attorney to manage the granter's affairs not the affairs of others which have been entrusted to the granter on the basis of his or her personal qualities. We also suggested that, in order to avoid legal proceedings to remove an incapable trustee[6], a continuing attorney for the trustee could be given power to resign the trusteeship on behalf of the trustee. Although our suggestion met with no dissent on consultation we now think it is an unnecessary refinement. If it were to be introduced there would have to be an exception where the granter was the sole trustee, since a sole trustee cannot generally resign without the leave of the court[7]. The number of cases where it would be useful would be small and the extra statutory provisions required would complicate the law relating to continuing powers of attorney.

3.46 Again, we do not need to make any recommendations for reform in this area as the existing law on powers of attorney will apply to continuing attorneys.

3.47 In connection with welfare attorneys we asked in our discussion paper[8] whether the attorney should have power to consent to the granter's admission to hospital for treatment of mental disorder, and if so whether such a power could be implied from a general power to take personal welfare and medical treatment decisions or whether it should have to be expressly conferred. There was a wide variety of opinions expressed on consultation, ranging from outright prohibition of such a power to acceptance that such a power would be useful and could be implied from a general power to take welfare decisions. A welfare attorney would normally be involved only if an incapable granter was refusing to go to hospital, for unprotesting granters could simply be taken there and treated. Where some measure of compulsion is needed we consider that the detention provisions of the 1984 Act should be used rather than obtaining the consent of a welfare attorney with appropriate powers. The Mental Welfare Commission foresaw difficulties in the status of patients if welfare attorneys could commit them to hospital against their will. Would the patient be detained in terms of the 1984 Act or not? It suggested as one possible solution that the welfare attorney could have the same powers as the nearest relative has under the 1984 Act in connection with detention. Thus if the welfare attorney had appropriate powers under the power of attorney he or she could apply for admission, require a mental health officer to consider the case for admission or consent to an emergency admission. We would adopt this suggestion, but would stress that any action by the attorney would not by itself result in detention. Further action by doctors, mental health officers or the courts would also be required. The welfare attorney could also have the same powers as the nearest relative in connection with discharge from detention. In Part 5 of this report we recommend that certain treatments for incapable patients (such as sterilisation or ECT) should require prior authorisation by the sheriff or a favourable second opinion from an independent specialist and that restraint should be used only in an emergency[9]. It should not be possible for a welfare attorney to circumvent these protective measures by consenting to such treatment or restraint. The views of the attorney would of course be taken into account by the doctors and he or she would be entitled to make representations to the sheriff or second opinion specialist.

3.48 We recommend that:

24. (1) A welfare attorney should not be entitled to place the granter in a hospital for treatment of mental disorder against the granter's will. However, the welfare attorney should, if the power of attorney confers such powers, have the same rights in relation to detention as the granter's nearest relative has under the Mental Health (Scotland) Act 1984.

(2) A welfare attorney should not be entitled to authorise any of the prescribed treatments in Recommendations 59 to 64 or consent to the adult being restrained.

Clause 12(5) and Schedule 4, paragraph 15

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1. Proposal 64(2), para 5.39.
2. Para 6.105.
3. *Freen v Beveridge* (1832) 10S 727.
4. *Wolfe v Richardson* 1927 SLT 490.
5. Proposal 65, para 5.42.
6. Trusts (Scotland) Act 1921, s 23.
7. 1921 Act, s 3(1). The incapable granter would not, and the attorney should not, be able to appoint a new trustee.
8. Proposal 79, para 5.120.
9. Paras 5.21 to 5.32.

A duty to act?

3.49 We now turn to consider whether a continuing or welfare attorney should be under a statutory duty to use the powers conferred by the document of appointment and be liable for loss caused by failure to use them. At present the position depends on the terms of the power of attorney, but the usual styles confer various powers on the attorney without imposing any express obligation to use them, and indeed often give the attorney a discretion whether to act[1]. It is difficult to imply an obligation to act in such circumstances, or the existence of a delictual remedy for failure to act, except where professionals such as solicitors or accountants are employed to look after the granter's affairs on a remunerated basis.

3.50 In our discussion paper we proposed that continuing financial attorneys should be under a statutory duty to carry out the functions set out in the document of appointment[2] and asked for views as to whether a similar duty should be imposed on welfare attorneys[3]. These proposals were agreed by almost all those who commented on them, subject to the proviso that the duty should arise only after the attorney had accepted the appointment. The main argument in favour of imposing a duty to act is that it would be in line with the granter's expectations. Continuing powers of attorney are created so that there will be someone to manage the granter's affairs when the granter is incapable or wishes to hand over financial matters to an attorney, or in the case of welfare powers to make decisions in the welfare field when the granter is incapable of doing so. The granter's intentions would be frustrated if the attorney simply did nothing. In connection with welfare attorneys the Senators of the College of Justice thought, however, that such a duty would be difficult to enforce and the possibility of being sued in respect of some failure to act might be a deterrent against agreeing to act as welfare attorney.

3.51 On reconsideration we have come to the conclusion that a statutory duty should not be imposed on either continuing or welfare attorneys. A statutory duty would pose particular difficulties in the welfare field where an attorney may be reluctant or unable to come to a decision. For example, if the power of attorney included power to consent to surgery should the attorney be forced, on pain of liability to damages, to come to a decision about the proposed operation? Another argument against imposing a duty to act is that relatives and friends might be unwilling to be appointed continuing attorneys in such circumstances. Moreover, any duty to act would be qualified once the granter was incapable by our recommended general principles of least restrictive action and having regard to the present wishes and feelings of the granter. We would point out that as far as paid professional attorneys are concerned the absence of a statutory duty to act would not make much difference since there would be an implied obligation on them to carry out the functions to the normal professional standard. We discuss the duties arising out of the fiduciary relationship between granter and attorney in Part 2[4].

3.52 We think that granters are best protected against inaction by choosing people who can be relied on to take appropriate action rather than the imposition of any statutory duty. Although we reject the imposition of an express statutory duty to act on continuing or welfare attorneys, such attorneys should consider exercising the powers conferred in appropriate circumstances. Making attorneys aware of this is something that should be included in the Code of Practice[5], a copy of which might be issued by the Public Guardian to continuing or welfare attorneys on registration.

Should there be official supervision of continuing or welfare attorneys?

3.53 In dealing with financial continuing attorneys in our discussion paper we rejected a scheme whereby some public authority should register continuing attorneys and monitor the performance of their functions[6]. As we pointed out regular monitoring would require a considerable number of new officials to be appointed since there could be somewhere in the region of 10,000 continuing attorneys active at any one time. Duplication of the monitoring system presently used for curators bonis and recommended by us for guardians appointed by the court would deprive continuing powers of attorney of much of their utility and make them much more expensive than they are at present. These points were accepted by those consulted and we received no evidence of widespread abuse by attorneys which would justify setting up a monitoring authority for all attorneys. Many respondents did, however, wish to see a simple registration system and we have already recommended[7] that the Public Guardian should register all documents conferring continuing or welfare powers of attorney and investigate complaints against registered attorneys.

3.54 In our discussion paper we asked whether welfare attorneys should be supervised by the Mental Welfare Commission in much the same way as mental health guardians appointed under the 1984 Act are as at present[8]. This includes periodical

1. Halliday, *Conveyancing Law and Practice*, Vol 1, para 13.12; Journal of the Law Society of Scotland 1981, W209.
2. Proposal 71(1), para 5.74.
3. Proposal 81(1), para 5.122.
4. Paras 2.74 to 2.79.
5. Recommendation 25, para 3.56.
6. Proposal 66(a), para 5.50.
7. Recommendation 21, para 3.36.
8. Proposal 83, para 5.126.

visits to those under guardianship as well as dealing with any problems and complaints as and when they arise[1]. Responses on this issue were divided. Some considered that welfare attorneys should be so supervised and monitored but questioned whether the Mental Welfare Commission would be able to offer the same supervisory service as it presently does for mental health guardianship without an enormous increase in resources. At present there are 81 active cases of guardianship[2]. If even a modest proportion of all future attorneys were to be granted welfare powers the case load could increase by a factor of ten. Others thought that the Mental Welfare Commission's existing protective role in relation to the welfare (and property) of the mentally disordered should suffice, so that the Commission would be under a duty to investigate complaints. We prefer this latter approach. There should be a difference in the degree of supervision between continuing or welfare attorneys and guardians that have been appointed by the court. Attorneys have been freely appointed by granters when capable and have been chosen on the basis of their knowledge of the granter and their reliability and honesty; guardians are appointed by a court to incapable adults on the basis of need. Moreover, attorneys are privately appointed so that there should not be extensive intervention by public agencies. One body suggested that local authorities, via their social work departments, should have the same functions (periodical visits and supervision of non-local authority guardians) in relation to welfare attorneys as they do for mental health guardians[3]. We disagree for the same reasons as we have put forward for not conferring such functions on the Mental Welfare Commission.

3.55 Although the Public Guardian, the Mental Welfare Commission and local authorities would not supervise or monitor the performance of every continuing or welfare attorney they would in terms of our earlier recommendations be under a duty to investigate where there was a complaint or cause for concern[4]. Furthermore, the court could, on the application of any interested person subject a continuing or welfare attorney to supervision and monitoring by one of the appropriate bodies. As a result of such investigations or otherwise any one of these bodies is to be entitled to apply to the court for various orders in relation to continuing or welfare attorneys[5]. A Code of Practice would help in making continuing and welfare attorneys aware of their duties and responsibilities. This in turn should cut down the number of complaints and investigations. Registration of the document conferring the power of attorney provides an opportunity to hand every attorney a copy of the Code.

3.56 We recommend that:

25. (1) Continuing and welfare attorneys should not be monitored or supervised either by the Public Guardian, Mental Welfare Commission or local authority except where a court order is made to this effect under Recommendation 26. This should be without prejudice to the existing and recommended investigative and protective functions of the Public Guardian, Mental Welfare Commission and local authority.

(2) The Secretary of State should prepare and publish a Code of Practice containing guidance to continuing and welfare attorneys as to the exercise of their functions.

Clause 10(1)(b)

Court orders relating to continuing or welfare attorneys

3.57 In our discussion paper we put forward various powers which could be conferred on the courts in order to improve the protection of granters[6]. We saw increased court powers as a less intrusive alternative to the continuous supervision and monitoring of attorneys by some public authority, and the possibility of court intervention would tend to make attorneys more careful. Before discussing the powers in detail we consider the general grounds for making an application to the court.

3.58 In our discussion paper we proposed that an application for production of accounts by an attorney[7] or for removal of a continuing attorney[8] should not be competent as long as the granter remained mentally capable. We considered that intervention while the granter remained capable would be an unwarranted intrusion into the granter's affairs. The granter and the attorney may have agreed to dispense with accounts or the granter may have agreed with, or acquiesced in, the attorney's actions. Moreover, a capable granter could defeat any court order by granting a fresh power of attorney or reappointing the attorney. On the other hand basing competence on the granter's capacity means that an applicant must first satisfy the court that the granter is incapable and this could cause practical difficulties.

3.59 Although there was general agreement with our proposals, some respondents pointed out that the effect would be that vulnerable or facile granters with limited capacity would be denied protection unless they took the necessary action

1. 1984 Act, s 3.
2. Mental Welfare Commission, *Annual Report, 1993/94*, p 14.
3. The Mental Health (Specified Treatments, Guardianship Duties etc) (Scotland) Regulations 1984, SI 1984/1494.
4. Recommendation 21(6), para 3.36.
5. Recommendation 26, para 3.60.
6. Paras 5.51 to 5.63.
7. Proposal 68(1), para 5.57.
8. Proposal 69(1), para 5.63.

themselves. We appreciate the concerns of these respondents but intervening in every case of vulnerability would go too far. Vulnerable is a vague concept as is facile. In Part 6 we recommend that a guardianship order may be granted if the court is satisfied that the adult is incapable of making decisions or is incapable of acting to promote or safeguard his or her interests[1]. We think the same test should apply to court orders for continuing and welfare attorneys, except that the incapacity should have to exist in relation to the matters covered by the power of attorney. In addition the court should have to be satisfied that the making of an order is necessary to safeguard or promote the interests of the granter in the matters to which the power of attorney relates. This additional requirement prevents the court from revoking the power of attorney and replacing the attorney with a guardian simply because the granter has become incapable. As far as welfare attorneys are concerned it is most unlikely that any application would need to be made to the court in advance of the granter's incapacity. This is because of our previous recommendation that a welfare power should not be exerciseable by a welfare attorney until he or she considers that the granter is no longer capable of making the welfare decision in question[2].

3.60 We recommend that:

26. In order to better protect granters of continuing or welfare powers of attorney, the court should have power, on application by any person claiming an interest in the granter's welfare or finances, to make various orders relating to the attorney. The power should be exercisable only if the court is satisfied that the granter is incapable of giving directions to the attorney or of safeguarding his or her own interests in relation to the matters covered by the power of attorney and that the making of the order is necessary to safeguard the granter.

Clause 15(1), (2)

3.61 **Accounting.** In our discussion paper we proposed that the court should be empowered to order a continuing attorney to produce accounts and receipts for all or any part of the period since the date of execution of the continuing power of attorney[3]. The accounts produced were to be audited by the Public Guardian. We pointed out the difficulties that had arisen in Ontario where a similar power is limited to accounts for the period after incapacity. Because of the difficulty in deciding when incapacity occurs the power is rarely used.

3.62 Those responding to this proposal were generally in favour. The Accountant of Court, however, commented that attorneys would have to be under a statutory duty to keep accounts during their period of acting as attorney so that they would be available for production if the court so ordered. We see the force of this comment but think it would be unduly onerous to impose a duty to keep accounts on every continuing attorney. Many attorneys will be relatives or friends who could not prepare formal accounts and would have to pay for this to be done. Attorneys should simply keep a record of their transactions. These records could then be used to prepare the accounts if the court ordered production of accounts. Of course, if accounts had been prepared, as might be the case where a solicitor or accountant was acting as continuing attorney on a paid basis, then such accounts could be produced to the court.

3.63 Under our recommended registration scheme a continuing attorney has no authority to act as such until the document of appointment is registered with the Public Guardian[4]. The earliest date from which the court should be able to order accounts or records to be produced should be the date of registration rather than the date of execution of the continuing power of attorney as we had originally proposed.

3.64 One respondent questioned the desirability of disclosing the accounts and the Public Guardian's audit report to the applicant and others. We consider this is best left to the discretion of the court. The accounts and audit report should always be lodged with the court which thereafter would decide whether to disclose them and if so to whom they should be disclosed. Any further action would also be a matter for the court on receipt of an application made to it.

3.65 We recommend that:

27. The court should have power under Recommendation 26 to order a continuing attorney to produce accounts of his or her transactions with the granter's estate. Accounts should be ordered in respect of all or any of the period from the date of registration of the document conferring the continuing power to the date of the order. The accounts should be audited by the Public Guardian and the accounts and audit report thereafter lodged in court.

Clause 15(2)(b)

3.66 **Supervision by Public Guardian.** Some of those responding to our proposal that the court should have power to order a continuing attorney to produce accounts for auditing suggested that future supervision of the attorney might be

1. Recommendation 85, para 6.29.
2. Recommendation 23, para 3.42.
3. Proposal 68(2), para 5.57.
4. Recommendation 21(4), para 3.36.

appropriate. We are attracted to this suggestion. It could be a useful halfway house between letting the attorney carry on unchecked and revoking the appointment with the substitution of a fully supervised court-appointed guardian. For example, the court might order that the granter's dwellinghouse and other valuable assets should be disposed of only with the Public Guardian's consent. We recommend that:

28. The court should have power under Recommendation 26 to order that a continuing attorney should in future be subject to such supervision by the Public Guardian as it thinks fit.

Clause 15(2)(a)

3.67 **Reporting to court and supervision by local authority.** Some equivalent of a financial audit is needed in relation to a welfare attorney's powers. We consider that the court should be empowered to order the attorney to produce a report on how the welfare powers have been exercised. The report should be made to the court in the first place. Thereafter it may decide to ask the local authority Social Work Department to consider the report, investigate as necessary and report back to the court. As a result of these proceedings the court should, we consider, have power to order the attorney to be supervised in the exercise of his or her welfare functions. We recommend that:

29. (1) The court should have power under Recommendation 26 to order a welfare attorney to produce a report as to how any welfare powers have been exercised in all or any of the period between registration of the document conferring the welfare power and the date of the order.

(2) As a result of the report or otherwise the court should have power to order the welfare attorney to be subject in future to such supervision by the local authority in respect of any welfare powers as it thinks fit.

Clause 15(2)(c), (d)

3.68 **Directions to attorney.** Some jurisdictions have conferred on their courts the power to give directions to the attorney as to the exercise of his or her functions, and we proposed that a similar power be introduced to Scotland[1]. All those responding agreed. A directory power would be useful for an attorney faced with a difficult decision since a ruling could be obtained from the court after all those interested had been given an opportunity to make representations and be heard. Others with an interest in the granter's welfare and estate could also apply, either to prevent an attorney carrying out some proposed transaction or to have the attorney directed to do something. We recommend that:

30. The court should have power under Recommendation 26 to give directions to a continuing or welfare attorney as to the exercise of his or her functions.

Clause 3(3)

3.69 **Removal of continuing or welfare attorney and revocation of power.** As long as the granter retains capacity he or she may remove the attorney and appoint another or revoke the continuing or welfare power of attorney already granted. Once the granter becomes incapable removal or revocation by the granter is no longer possible. At present the court has no express power to remove an attorney or revoke a power of attorney. The court can, however, appoint a curator who supersedes the attorney in the management of the granter's financial affairs[2]. Appointment of a guardian under our recommendations in Part 6 would have the same effect but only in so far as the guardian's financial or welfare powers coincided with those of the attorney.

3.70 We proposed in our discussion paper that the court should have an express power of removal[3]. This would be useful where the continuing or welfare attorney ought to be removed but the granter's estate and welfare could be managed without the appointment of a guardian. Removal of the acting attorney might also be sought in order to allow the substitute attorney specified in the power of attorney to take over, or to remove one of two joint attorneys. All those consulted agreed, but it was pointed out that the court should have power to remove the substitute attorney as well since the terms of the power of attorney might be inappropriate rather than the way in which a particular attorney has exercised the functions. We agree and consider that this is best achieved by giving the court an express power to revoke the power of attorney (wholly or partially) as well as to remove the attorney. For removal of an attorney we proposed a simple general formula that removal was in the best interests of the granter rather than detailed guidelines. While this was agreed we now consider that the general principles recommended in Part 2 above should guide the court in the exercise of its powers of revocation and removal. The Public Guardian as registration authority should be informed of any revocation or removal so that the register of attorneys could be amended.

3.71 The overlap between guardians and continuing or welfare attorneys needs to be considered. In most cases we imagine that the appointment of a guardian will be sought in order to supersede the attorney completely. The effect of the appointment of a guardian should be to terminate the authority of the attorney in relation to matters within the scope

1. Proposal 70(2)(a), para 5.68.
2. See, for example, *Fraser v Paterson* 1987 SLT 562.
3. Proposal 69, para 5.63.

of the guardian's powers[1]. But it ought to be possible to appoint a guardian with powers that do not impinge on those of the attorney. For example, another person could seek appointment as guardian with welfare powers and thereafter collaborate with the financial continuing attorney in promoting the overall welfare of the granter or the continuing attorney himself or herself could seek appointment as welfare guardian. There might even be situations where a guardian is appointed with financial powers in an area where the continuing attorney has no authority. Where the attorney is to remain functioning along with a guardian directions might need to be given by the court as to how each appointee is to exercise their functions.

3.72 We recommend that:

31. The court should have power under Recommendation 26 to revoke a continuing or welfare attorney's appointment (including one or more joint attorneys or a substitute attorney) and to revoke in whole or in part the continuing or welfare power of attorney. The revocation should be notified to the Public Guardian.
Clause 15(2)(e), (3)

3.73 **Variation of continuing or welfare power of attorney.** Should the court have power to vary the power of attorney? The attorney may find that he or she lacks a power to deal with something that was not anticipated by the granter. We did not favour conferring a power of variation on the courts in our discussion paper[2] and most of those consulted agreed. The Senators of the College of Justice commented that variation would be worthwhile to deal with cases where carrying out the granter's instructions had become impossible, unduly burdensome or expensive. But the general principles that we have recommended should govern all decision-makers, including continuing or welfare attorneys, would not require the exercise of powers after the granter's incapacity in these circumstances. Two bodies considered that variation should be available to deal with drafting errors. New statutory provisions however seem unnecessary to deal with errors which stem from the failure of the document to express accurately the intentions of the granter. Such errors can be rectified by the court under section 8 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1985.

3.74 Some flexibility is necessary: granters should not be left without anyone able to help or protect them because their powers of attorney turn out to be inadequate in the circumstances. However, we remain of the view that this aim should not be achieved by court variation of the power of attorney. Variation involves interfering with the expressed wishes of the granter and the court in re-writing the document could only guess at what the granter would have decided in the circumstances. We consider that an appropriate remedy would be available under our other recommendations. Where the granter's instructions were such that to carry them out would be unduly burdensome or expensive the attorney would be justified in not following them under our recommended general principles. In extreme cases the attorney might have to resign and seek appointment as a guardian with more appropriate powers. Where extra powers over and above those conferred by the granter seemed to be needed the attorney could apply to the court for an intervention order or a limited guardianship order conferring such powers. This would not be a variation of the contract of mandate or agency conferring the continuing or welfare power of attorney because the attorney would continue to exercise the existing power of attorney according to the contract and would exercise the other powers conferred by the court in terms of the intervention order or guardianship order. Accordingly we recommend that:

32. The court should not have power to vary the terms of a contract of mandate or agency conferring a continuing or welfare power of attorney.

Resignation of continuing or welfare attorneys

3.75 An attorney acting under an ordinary power of attorney may resign at any time. Resignation by a continuing or welfare attorney at a time when the granter is incapable would leave the granter without anybody to take financial or welfare decisions. In our discussion paper we asked whether a sole or remaining continuing attorney should be required to notify his or her intention to resign to the granter if capable and, where the granter was not capable, to the granter's nearest relative and the local authority[3]. This proposal was put forward in order to avoid any undesirable hiatus in the granter's affairs since steps could be taken after notification to ensure that a guardian was appointed before the attorney's resignation became effective.

3.76 All those responding agreed that continuing attorneys should be required to notify their intention to resign, although it makes continuing powers of attorney a little more complex. Several suggestions were made which we consider useful. First, that if continuing powers of attorney were to be registered then notice of intention to resign should be given to the registration authority. In our scheme the register is to be kept by the Public Guardian. Our recommended resignation procedure should apply only to continuing or welfare powers of attorney conferred in documents which have been registered with the Public Guardian, since before registration the powers cannot be exercised. Secondly, that there should

1. Recommendation 34(2), para 3.79.
2. Proposal 70(1), para 5.68.
3. Proposal 72, para 5.79.

be a period before the resignation took effect in order to allow time for alternative arrangements to be made. 28 days seems to us to be an appropriate period. This period would not be necessary where there were other joint attorneys willing to continue to act or a substitute attorney willing to take over. Thirdly, notification to the local authority and the granter's nearest relative was queried. It was pointed out that the granter may not have wished the nearest relative to be involved and may have deliberately appointed someone else as attorney. We would substitute the granter's primary carer, the individual or organisation primarily responsible for looking after the granter. Notification to the local authority was proposed since that body had under our proposals a duty to apply for appointment as a financial manager if no one else applied. We recognise the force of the criticism that powers of attorney are meant to be private documents and that there should be minimum involvement by public authorities. Notification to one public official, the Public Guardian, should suffice unless a welfare attorney was being supervised by the local authority in accordance with a court order. A duty to notify only capable granters could cause problems for attorneys, especially where capacity fluctuates. We now think that the granter should always be notified of the attorney's intention to resign. In the rare case where a guardian has been appointed to act alongside the attorney, the attorney should also notify the guardian. The above resignation procedure should also apply to welfare attorneys.

3.77 We recommend that:

33. (1) In order to prevent a lapse in arrangements made for the safeguarding of the granter's welfare and financial affairs a continuing or welfare attorney acting under a registered power of attorney should have to give notice of his or her intention to resign to the granter, the Public Guardian, the granter's primary carer, and, if the local authority was supervising the attorney or a guardian had been appointed, also to the local authority or guardian.

(2) The resignation should become effective 28 days after notification to the Public Guardian. But where the attorney's resignation would still leave at least one continuing or welfare attorney (joint or substitute) in post the resignation should be effective as soon as the Public Guardian is satisfied that the remaining joint attorney(s) will continue to act or the substitute attorney is willing to act.

Clause 17

Termination of continuing or welfare powers of attorney

3.78 Termination of continuing powers of attorney on the occurrence of certain events and the protection of good faith attorneys and third parties who engage in transactions in ignorance of the termination were considered in our discussion paper. We came to the provisional conclusion that the common law rules were adequate and no reform was needed[1]. No contrary comments were made by those consulted. However, we consider that it would be helpful for the new legislation to contain an express provision making it clear that the common law rule that the appointment of a curator terminates the authority of an attorney[2] applies to the appointment of a guardian in so far as their powers coincide.

3.79 A new statutory provision also seems necessary to deal with the situation where the granter appoints his or her spouse to be continuing or welfare attorney and the couple subsequently separate or divorce or their purported marriage is annulled. We imagine that most granters would not wish their spouses to continue to act, and accordingly consider that the appointment should fall automatically. Granters who wish their spouses to continue to act after a decree of separation divorce or nullity may insert a provision to that effect in the contract of mandate or agency conferring the continuing or welfare power of attorney. We recommend that:

34. (1) The appointment by the granter of his or her spouse as continuing or welfare attorney should be revoked automatically by a decree of separation, divorce or nullity relating to the granter and his or her spouse, unless the granter provides otherwise in the contract of mandate or agency conferring the continuing or welfare power of attorney.

(2) Where a guardian is appointed with certain powers the authority of a continuing or welfare attorney in relation to matters within the scope of those powers should automatically terminate.

Clause 18(1), (2)

Disposal by attorney of special legacies

3.80 A special legacy is adeemed if the item bequeathed is not part of the deceased's estate at death because it had been disposed of earlier. The intended beneficiary receives nothing in lieu[3]. This could cause problems with continuing attorneys. Suppose, for example, a granter leaves by will her shares in British Gas to her son and her shares in British Petroleum to her daughter. The continuing attorney sells the British Gas shares to raise cash or invest elsewhere. As a result the

1. Paras 5.87 to 5.90.
2. *Fraser v Paterson* 1987 SLT 562.
3. Gloag and Henderson, *An Introduction to the Law of Scotland* (9th edn), para 43.16.
4. Proposal 70(3), para 5.68.

special legacy is adeemed and the son receives nothing. In our discussion paper we considered whether the court should have power to award the disappointed beneficiary something in lieu. In order to avoid litigation we proposed[4] that the present rule for disposals by curators should be adopted ie disposal of a specially bequeathed item does not result in ademption unless disposal was necessary[1].

3.81 While most of those responding agreed with our proposal, the Law Society was not in favour. The problem was in its opinion best solved by granters giving instructions in the document containing the power of attorney as to what the attorney should do with items that were the subject of special legacies and by the attorney being aware of the granter's will. There is also the practical difficulty of deciding years later whether it had been necessary for the attorney to dispose of a particular item. On reconsideration we have concluded that this report is not the appropriate place to deal with the problem of ademption of legacies. The problem is one of succession law since people other than attorneys and guardians may dispose of items specifically bequeathed.

Private international law aspects

3.82 Our discussion paper dealt with the authority in Scotland of non-Scottish powers of attorney. As far as formal validity is concerned a document conferring a power of attorney will be regarded as valid in Scotland if it is executed in accordance with the law of the country in which it was executed or, it is thought, in accordance with the rules of the proper law[2]. The more difficult issue is the authority in Scotland of an attorney appointed by an enduring, durable or continuing power of attorney granted in another jurisdiction whose internal law would confer authority on the attorney during the granter's incapacity. With the increasing mobility of people and possession of property in more than one country this and similar issues are becoming increasingly important. In order to clarify the matter we proposed[3] that the authority of such an attorney to act after the granter's incapacity should be governed by the proper law of the power of attorney. The proper law is the law which the granter either expressly or impliedly indicates to be the applicable law in the document conferring the power of attorney or the one which has the closest or most real connection with the power of attorney. All those who responded agreed. The Contracts (Applicable Law) Act 1990 does not apply to the question whether an agent is able to bind a principal to a third party[4]. As we recommend in the next paragraph non-Scottish attorneys should be subject to the same restrictions relating to personal welfare powers and the same protective jurisdiction as Scottish continuing or welfare attorneys. We recommend that:

35. Subject to Recommendation 36 the effect during the granter's incapacity in Scotland of a mandate or agency conferring a continuing or welfare power of attorney (however expressed) should be determined according to the proper law of the mandate or agency.

Clause 19

3.83 To what extent should non-Scottish attorneys be equated with Scottish attorneys for the purposes of our previous recommendations? In Part 6 we deal with a similar question in relation to guardianship[5]. Our general approach there is that the registration, supervision and regulatory provisions should apply only to Scottish guardians, but that the investigation of complaints, the taking of protective action and making protective orders and obtaining and considering the views of guardians in relation to proposed courses of action should apply to non-Scottish guardians as well. We would adopt the same approach in relation to continuing and welfare attorneys. The special execution requirements we recommend for Scottish continuing and welfare powers of attorney clearly should not be applied to non-Scottish documents conferring similar powers; such documents should be treated as formally valid if executed according to the applicable foreign requirements. We therefore recommend that:

36. The following recommendations in Part 3 relating to Scottish continuing or welfare attorneys should apply to their equivalents appointed under the law of any other country:

(a) Recommendation 23 (welfare powers exerciseable only during granter's incapacity),

(b) Recommendation 24 (welfare attorney not to place granter in hospital for treatment of mental disorder against granter's will),

(c) Recommendations 26-31 (various court orders relating to continuing or welfare attorneys), and

(d) Recommendation 34(2) (appointment of guardian terminates attorney's authority in so far as powers coincide).

Clauses 12(7), 15(5) and 18(3)

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1. *McFarlane's Trs v McFarlane* 1910 SC 325.
2. Anton, *Private International Law*, (2nd edn) p 305.
3. Proposal 74, para 5.93.
4. Sch 1, Article 1(2)(f).
5. Paras 6.218 to 6.225.

Part 4 Other Types of Extra-Judicial Management

Introduction

4.1 Our investigations have revealed that there is an unmet need for simple inexpensive ways of managing the property or financial affairs of incapable adults with modest means. The expense of appointing a curator bonis often rules out this solution and it is unlikely that our recommended guardianship will be substantially cheaper. Continuing attorneys would be a solution but only a small proportion of incapable adults currently take steps before incapacity to appoint an attorney to act should they become incapable later. Even if this proportion increases substantially there would still be a very large number of incapable adults without attorneys.

4.2 The affairs of incapable adults may be managed informally using the concept of *negotiorum gestio*. This, according to Bell is "the management of the affairs of one who is absent, spontaneously undertaken without his knowledge, and on the presumption that he would, if aware of the circumstances, have given a mandate for such interference"[1]. Absence includes absence of mind through mental incapacity[2]. *Negotiorum gestio* is not limited to urgent or immediate acts of administration and management by a *gestor* may continue for many years[3]. *Negotiorum gestio* enables a husband, wife, parent, child or other relative or close friend to look after the affairs of an incapable adult without the expense of having a curator appointed. The main disadvantage is the lack of any document evidencing the powers of the *gestor*. Because of this and the doubts about the limits of a *gestor's* powers it is often difficult for *gestors* to persuade third parties to deal with them or accept instructions from them. Nevertheless, we think *negotiorum gestio* has a useful role to play in the management of the affairs of the incapable and we do not make any express recommendations for curtailing it. However, some of our recommendations, by providing new statutory procedures for some matters that currently fall within the scope of *negotiorum gestio*, will to that extent make reliance on it unnecessary.

4.3 In this Part we put forward three schemes for dealing with the financial affairs of incapable adults in terms of which authority may be obtained otherwise than from the courts. The first would allow an individual caring for an incapable adult at home to obtain authority from the Public Guardian to withdraw money from the adult's bank or building society account to meet household and other necessary expenditure for the adult. The second would authorise hospitals and other residential establishments approved by the Public Guardian to set up properly run and accountable systems for managing the finances of their incapable residents up to a specified monetary limit. Both schemes build upon existing statutory and extra-statutory methods but extend them to other organisations and add an element of accounting to, and scrutiny by, a public official - the Public Guardian. The third scheme would entitle one account holder of a joint account to carry on operating the account when the other became incapacitated.

WITHDRAWALS FROM BANK ACCOUNTS

The scheme in outline

4.4 In our discussion paper we pointed out that some of the financial problems of incapable adults, especially the dementing elderly, could be solved if access could be given to their bank or building society account otherwise than by the appointment of a curator[4]. Income such as a pension, dividends and social security benefits payable to the adult can readily be paid into his or her account, but there is often difficulty in obtaining money from the account to pay for food, clothing and household expenses for an incapable adult being cared for at home. Informal arrangements can sometimes be made with the bank whereby the carer is permitted to withdraw money, but even where such an arrangement is made it is often only a temporary facility pending the appointment of a curator. Some building societies have in their rules a more formal, but nevertheless non-statutory, procedure for allowing access by a carer to an incapable adult's account.

4.5 In our discussion paper we proposed an administrative system whereby a named individual could obtain authority to withdraw money from an adult's bank account[5]. The individual was required to present -

1. *Principles*, para 540.
2. *Fernie v Robertson* (1871) 9M 437.
3. *Maule v Graham* (1757) Mor 3529; *Fernie v Robertson*; *Dunbar v Wilson and Dunlop's Tr* (1887) 15 R 210.
4. Para 4.173.
5. Proposal 57, para 4.178.

(a) a medical certificate that the adult was mentally disabled to a substantial extent,

(b) a certificate from a solicitor or social worker that the named individual was looking after the adult, and

(c) an undertaking from the individual to use any money withdrawn for the benefit of the adult.

On presentation of the certificates and undertaking the bank was to be entitled, but not bound, to allow the individual to withdraw. The bank might terminate the arrangement at any time on becoming aware of circumstances making it inappropriate for the arrangement to continue. Termination could also have been ordered by the court on application by any interested person.

4.6 Our proposal was welcomed in principle by nearly all those who replied. Respondents considered there was a need for a fairly simple method of withdrawing money from an incapable adult's bank account. One dissenting organisation commented that it was sadly the case that people sometimes exploited their incapacitated relatives and that the proposals would make it easier for them to do so. Many other respondents also voiced concern about abuse and put forward helpful suggestions for improvements to minimise abuse. We accept that any scheme not involving close supervision by a public official could lead to increased abuse. It is a question of balancing this against the undoubted benefits to be gained from making access by the vast majority of honest and reliable carers easier and cheaper.

4.7 The Scottish Association for Mental Health suggested that the arrangements should have to be reported to the Accountant of Court or the Mental Welfare Commission who would maintain a register and could identify potential abuse if an individual was found to have obtained access to several adults' accounts. We agree with this suggestion and have taken it further. We have also had the benefit of further consultation with the Accountant and Deputy Accountant of Court, the Committee of Scottish Clearing Bankers and the Building Societies Association. We are grateful to them for their comments and suggestions which have greatly assisted us in preparing a new scheme. We now consider that the Public Guardian (whose functions would be carried out by the Accountant of Court) should not only keep a register but should also act as the authorising body. In our view any scheme for managing the financial affairs of an incapable adult which is imposed without that adult's advance consent ought to be controlled and monitored to some extent by a public official. The outline of the scheme we now put forward is as follows. Individuals wishing to obtain authority to withdraw should have to apply to the Public Guardian for such authority. The application should be accompanied by a medical certificate that the adult is incapable of operating the account. The application would be countersigned by a member of a prescribed class of persons that to the best of the countersigner's knowledge and belief the applicant was a fit and proper person to be given authority to withdraw. The Public Guardian would then notify the adult and his or her nearest relative and primary carer and give them an opportunity to object. If there were no objections or the Public Guardian was satisfied that any objection was groundless the Public Guardian should grant authority. Details of the authorisation would then be recorded in a public register kept by the Public Guardian. The Public Guardian's certificate of authority would then be handed to the applicant, for presentation to the bank concerned.

4.8 The scheme outlined in the previous paragraph also meets concerns expressed by the Committee of Scottish Clearing Bankers about our proposed certificates. It queried how a bank manager could ensure that the certificates had indeed been given by the account-holder's general practitioner, solicitor or social worker and whether the bank would be liable for failing to carry out adequate checks on the certificates and any further information provided by the individual applying for authority to withdraw. The Building Societies Association informed us that many of its members operating in Scotland would also prefer not to have to decide the suitability of applicants and the appropriateness of allowing withdrawals themselves lest they leave themselves open to claims. Under our new scheme the bank or building society would be entitled to rely on a document from the Public Guardian showing that authority to withdraw had been granted. We do not regard this scheme as duplicating guardianship or intervention orders which we recommend later[1]. Guardians are appointed to safeguard and promote all or part of an incapable adult's welfare and finances over an extended period. Because of the range of their powers, and the effect of their appointment on the adult's own legal capacity, they are to be appointed by the court after checks to ensure that guardianship is needed and the proposed guardian is suitable. Where the question at issue is a limited power to withdraw from a bank account, which has no effect on the adult's own legal capacity, a simpler administrative procedure is justified. Intervention orders are designed for "one-off" situations where a decision has to be made or a consent granted. They are not intended to continue for a considerable period of time, unlike authority to withdraw from accounts.

4.9 Registration in a public register held by the Public Guardian of individuals having authority to withdraw would also have other benefits. The fact that the authorisation is in the public domain would serve as some check on abuse. Bodies such as the Mental Welfare Commission with statutory duties to protect the property of the mentally disordered and others with an interest in the welfare of incapable adults (either generally or in relation to particular individuals) would have ready access to information about those authorised to withdraw and could take the appropriate action if abuse

1. See Part 6.

was suspected. The Public Guardian's office would also act as a place to which complaints could be made or possible abuse reported. If there seemed to be any substance in a complaint the Public Guardian should be entitled to suspend or terminate the authority to withdraw, in either case immediately notifying the withdrawer and the bank concerned.

4.10 What degree of incapacity should have to exist before authority to withdraw should be granted? We consider the incapacity should be such as to render the adult incapable of operating the account. Those incapable of operating the account should include adults who can physically sign cheques or perform other tasks in connection with the account, but do so without any understanding, and also adults who are unable to communicate in any way due to their physical condition. A definition tied to the particular area in which authority is sought is necessary otherwise there would be too great an interference in the financial affairs of those who, while having some degree of incapacity, could still manage their banking arrangements. A functional test is also easier for applicants and those certifying incapacity to work with.

4.11 The scheme we are putting forward should be limited to Scotland in some way. This should be done using two criteria. First, the incapable adult account holder should have to be habitually resident in Scotland. Second, the account should have to be held at a branch situated in Scotland, but the bank need not be a Scottish bank.

4.12 We recommend that:

37. (1) The Public Guardian, on application, should be empowered to authorise the applicant to withdraw money, or arrange for payments to be made, from a specified bank account held at a branch situated in Scotland of an adult who is incapable of operating the account and habitually resident in Scotland.

(2) The Public Guardian should keep a public register of individuals authorised to withdraw.

Clauses 4(2)(c)(iii) and 20(1), (2)(a), (3)

When scheme applies

4.13 The recommended scheme is intended to enable named individuals to obtain authority to withdraw money from an incapable adult's bank account without having to go to court for an intervention order or the appointment of a guardian. The scheme should not be capable of being used where other persons have already been appointed with powers over the account[1]. For example, if the adult has appointed a continuing attorney with powers over his or her bank account or the court has appointed a guardian with similar powers or made an intervention order, then the Public Guardian should not grant authority to withdraw to the applicant. The Public Guardian would be aware of the existence of a continuing attorney or guardian or an intervention order since these would have been registered with the Public Guardian. Non-Scottish attorneys or guardians would not be so registered, but the bank ought to be aware of their existence if their powers extended to such accounts. If so, they should decline to allow withdrawals. Our recommendations would allow them to do this since the scheme merely entitles, but does not oblige, the bank to allow withdrawals. Those who operate the scheme in good faith and without knowledge of a prior appointment should be protected. We recommend that:

38. (1) The withdrawal scheme recommended in Recommendation 37 should not apply if the incapable adult's bank account was subject to an existing intervention order or powers granted to a guardian or continuing attorney or similar appointee under the law of any other country.

(2) No liability should be incurred by any person who acts in good faith and in ignorance of any grant or appointment.

Clause 26

Procedure in obtaining authority to withdraw

4.14 Our proposed certificates, one from the adult's general practitioner certifying incapacity and the other from a solicitor or social worker who knew the incapable adult and the individual caring for him or her were criticised by many of those who responded. The British Medical Association (Scottish Branch) thought that certifying incapacity for this purpose was not an appropriate use of a doctor's time and Enable doubted whether a general practitioner necessarily had sufficiently detailed knowledge of the patient's degree of disorder and the extent to which it affected his or her ability to manage finances. It was also pointed out that certification by a solicitor or social worker who knew the adult and his or her circumstances would not be possible for many people who had neither a solicitor nor a social worker. Other respondents thought that the certification scheme was too complex and suggested a countersigning procedure by persons of standing in the community similar to that used for authenticating passport photographs. We are most grateful for this helpful suggestion and have adopted it. We now recommend that an applicant for authority to withdraw should provide information about himself or herself, the incapable adult and the bank account by filling in a prescribed application form. The form would contain an undertaking by the applicant to use money withdrawn only for the purposes sanctioned by the scheme[2]. The applicant would also be required to provide a medical certificate that the adult was incapable of operating the account.

1. See para 4.24 for the effect of the subsequent appointment of a guardian or the making of an intervention order.
2. See paras 4.16 and 4.17.

The form should include a statement by a person of standing in the community, (such as a doctor, social worker or police officer, being a member of a class prescribed by regulations made by the Secretary of State) that, to the best of his or her knowledge and belief, the information given in the form by the applicant was true and that the individual applicant was a fit and proper person to be granted authority to withdraw. The form should contain a prominent warning that making false statements was a serious offence. We consider that those wishing to obtain authority to withdraw should be able to find a countersigner without undue difficulty. Accordingly we recommend that:

39. (1) An applicant for authority to withdraw should have to apply on a prescribed form. The form should require details of the applicant, the incapable adult and the bank account to be provided. It should also contain a declaration by a member of a prescribed class of persons that to the best of his or her knowledge and belief the applicant was a fit and proper person to be granted authority to withdraw.

(2) The application should be accompanied by a certificate from a medical practitioner or other person qualified to assess incapacity that the adult was incapable of operating his or her bank account.

Clause 21(1)

4.15 On receipt of the application the Public Guardian should intimate it to the incapable adult, and his or her nearest relative and primary carer if they exist and their whereabouts are known. The applicant would have to give the names and addresses of these individuals in the application form. We envisage that in most cases no objections would be made so that the Public Guardian would grant authority. The Public Guardian should be empowered to grant the application even if objections were made. In this case the Public Guardian should give the applicant and any objector an opportunity to lodge further material and if the objection is still persisted in an opportunity to make oral representations. Where an objection raised complex issues or testimony from others seemed necessary to deal with the objection then the Public Guardian should be empowered to remit the application to the sheriff for a determination. Any objector should also be entitled to ask the Public Guardian to remit to the sheriff. An appeal would lie to the sheriff against the Public Guardian's decision on the application and also against a refusal to remit[1].

40. The Public Guardian should give the incapable adult and his or her nearest relative and primary carer an opportunity to object to the application. The Public Guardian should have power to grant the application after considering any objections and any further representations by the applicant and any objector, or to remit the matter to the sheriff.

Clause 22(3)-(6)

Limits on amounts withdrawable

4.16 In our discussion paper we considered whether to propose limits on the amount that could be withdrawn under the scheme in order to cut down abuse[2]. We pointed out that cash limits would be difficult to operate since household needs and expenditure vary so much from one person to another. Many of those responding were in favour of some limitation of the right to withdraw. It was pointed out that a deposit account could contain many thousands of pounds representing the adult's entire savings. We have accordingly reconsidered the question of financial limits. The idea behind the scheme is to enable money in an incapable adult's bank account to be made available to meet living expenses. Many regular household expenses can be paid for by standing order or direct debit. Gas and electricity bills, council tax, rent, mortgage or accommodation charges and household insurance are familiar examples. There should be a statutory list of items which the withdrawer's normal authority should cover. Withdrawals of cash should be kept to a modest level to minimise the risk of abuse, but some cash purchases will always be necessary for items such as food. We consider that at present a weekly cash limit of £50 should be adequate, but this figure should be reviewed periodically and altered as necessary by the Secretary of State.

4.17 The statutory list of items payable by standing order or direct debit together with the weekly cash should suffice for many households. Others may require goods and services outwith the list or which cannot be paid for by standing order or direct debit. We do not think the withdrawer should be given a cash card or chequing facilities since there is no effective control over the use of these. We consider that the Public Guardian should be given a discretion, to be exercised where appropriate, to extend the withdrawer's normal authority. This could be done by specifying extra goods or services or payment by the bank (on request by the withdrawer) directly to specified suppliers. We see authorisation of these extras by the Public Guardian as having a number of advantages. First, it gives the adult and the nearest relative and primary carer an opportunity to object. Secondly, it introduces an element of public control and, thirdly, it removes from the bank staff the burden of having to decide whether or not to accede to requests by the withdrawer for extra-statutory payments.

4.18 The authority granted by the Public Guardian should apply only to a specified account held in the sole name of the adult at a specified branch of the bank[3]. We would not be in favour of withdrawals being made simultaneously from

1. See Recommendation 146, para 7.3.
2. Para 4.175.
3. See para 4.28 for joint accounts.

several different branches or banks because that would render the recommended financial limits meaningless. To cater for those people who keep modest sums in several branches or banks we think that it should be competent to reapply to the Public Guardian for authority to withdraw from a different organisation if funds in the initially authorised one had been exhausted. Extra caution would no doubt be exercised by the Public Guardian in dealing with serial applications. We recommend that:

41. (1) The Public Guardian's authorisation should entitle (but not oblige) the bank to allow the applicant to:

(a) withdraw £50 per week (or such other sum as may be prescribed by the Secretary of State) in cash, and

(b) authorise the bank to pay by direct debit or standing order for fuel, accommodation, clothing, sustenance and related goods and services;

in order to meet the living expenses of the incapable account holder. The authorisation should not entitle the withdrawer to overdraw the account.

(2) The Public Guardian should be empowered, if satisfied that an extension of authority is needed, to authorise:

(a) payment otherwise than by direct debit, standing order or cash to specified suppliers of goods and services, or

(b) payment for specified goods and services outwith those listed in paragraph (1)(b) above.

Clause 22(1), (2), (7)

Further safeguards for incapable adults

4.19 The scheme which we are recommending is designed to make an incapable adult's money in his or her own bank account available to meet the daily needs of that adult. The withdrawer should therefore be under a statutory duty to apply any money withdrawn only for the benefit of the adult, and be liable to repay any money spent on other matters. It would be difficult to apply this rule strictly where the withdrawer was living in the same household as the incapable adult, especially if the adult owed the withdrawer an obligation for aliment. Suppose, for example, a wife was looking after her demented husband. Is she supposed to pay her own share of the bills? We consider that the Public Guardian should have a discretionary power to authorise in appropriate cases the withdrawer to use money from the adult's account on household expenses. It follows from the fact that money must generally be spent only for the benefit of the adult that no gifts may be made out of the money withdrawn either to charities that the adult used to support or birthday or other seasonal gifts to members of the adult's family. The scheme is intended to be a simple one. If such gifts are desired then an application should be made for the appointment of a guardian who would, under our recommendations, have power to make such gifts with the consent of the Public Guardian[1]. Simple repayment of money misspent by the withdrawer would not be sufficient recompense to the account holder. We would therefore recommend repayment with interest at a rate substantially higher than the withdrawer could have obtained from misappropriating the money for his or her own benefit. A suitable enhanced interest rate would in our opinion be 5% above the rate from time to time applicable to a sheriff court decree in the absence of any rate specified in the decree[2]. This rate is readily ascertainable and does not change so frequently that interest calculations become laborious. At present the enhanced rate would be 13%.

4.20 We have considered whether the withdrawer should be under a statutory duty to keep accounts or records of what the money withdrawn has been spent on. Having to keep accounts or records for possible later examination would help to prevent abuse, but a duty to keep accounts would we think be too onerous, as many of the withdrawers would be unable to prepare accounts without professional assistance. Even a statutory duty to keep records is in our opinion too heavy a duty to impose on ordinary family carers. Many of the transactions will be on a cash basis, buying food and other household items. Withdrawers might wish to keep records for their own protection should their actings be challenged. A Code of Practice containing guidance to withdrawers as to how to operate the scheme would help develop good practice. The Secretary of State should prepare and issue such a code. If it appears after the scheme has been operating that withdrawers should be required to keep records of expenditure then this should be introduced. To avoid new primary legislation the Secretary of State should have power to introduce such a requirement by way of regulations. The Public Guardian could also have a role in policing the scheme by investigating complaints about withdrawers and carrying out "spot checks" even in the absence of complaints. The Public Guardian should be empowered to require a withdrawer to produce such records and vouchers as exist. Failure to comply could lead to termination of the withdrawer's authority to withdraw[3]. We recommend that:

42. (1) The withdrawer should use money withdrawn under the scheme only for the benefit of the incapable

1. Recommendation 104, para 6.110.
2. Sheriff Court (Scotland) Extracts Act 1892, s 9.
3. See Recommendation 44(2), para 4.25.

account holder except in so far as otherwise authorised by the Public Guardian. If money is used otherwise the withdrawer should be obliged to repay it with interest at 5% above the rate from time to time applicable to a sheriff court decree in the absence of any rate specified in the decree.

(2) The Public Guardian should be entitled to receive and investigate complaints and carry out checks on individual withdrawers even in the absence of complaints.

(3) The Secretary of State should issue a Code of Practice containing guidance to withdrawers and banks as to how they should exercise their functions.

(4) The Secretary of State should have power to make regulations requiring withdrawers to keep records of their expenditure under the scheme and to produce them to the Public Guardian on demand.

Clauses 4(2)(d)(ii), 10(1)(d), (e), 22(4)-(6), and 23

Liability of the bank

4.21 We now turn to consider the liability of the bank in respect of payments made to, or on the instructions of, authorised withdrawers. Payment of cash within the weekly limit should give rise to no liability. The bank cannot know whether or not the money had been spent for the benefit of the incapable adult and any detailed questioning of, or accounting from, the withdrawer would render the scheme unduly complex and impose an inappropriate burden on the bank. On the other hand liability should, we think, arise where the bank allows cash withdrawals over the weekly statutory limit. The bank should be aware of the limit and any amount already withdrawn that week. It would also be impracticable for a bank to have to satisfy itself that every third party to whom payments were made by standing order, direct debit or otherwise had indeed supplied goods and services within the scope of the withdrawer's authority in order to avoid liability for misuse of the sums so paid[1]. Banks should be entitled to rely on the probity of withdrawers who have been authorised by the Public Guardian. But if the bank staff were suspicious they could decline to make the payment. The scheme only entitles them to make payments, it does not oblige them to do so. We recommend that:

43. (1) The bank should be liable for allowing cash withdrawals over the weekly limit but on restoring the money to the incapable adult's account it should be entitled to claim against the withdrawer.

(2) The bank should not be liable for making payments for goods and services that were outwith the ambit of the withdrawer's authority.

Clause 22(3)(a)

Termination of authority to withdraw

4.22 In our discussion paper we asked whether the scheme should be reviewed periodically[2]. Those whose responded to this question were in favour of some limit to the duration of authority to withdraw and some mentioned a period of two years. Some asked what sort of review we had envisaged and who should be charged with carrying it out. On looking at this issue again we have come to the view that the authority to withdraw granted by the Public Guardian should last for two years unless terminated earlier. The Law Society thought that thereafter the person seeking further authority to withdraw should have to apply to the court. We think that to limit the life of the scheme to a maximum of two years would deprive it of much of its usefulness. Many elderly people with dementia live for longer than two years after becoming incapable of operating their bank accounts. We think that it should be competent for the withdrawer to present a fresh application for authority to withdraw to the Public Guardian which, if granted, would authorise withdrawal for a further two years. The Public Guardian might decide to see the withdrawer's records from the previous period before granting the application in respect of a new period.

4.23 Another protection against abuse is that the Public Guardian should be entitled to suspend or terminate the authority already granted at any time. The Public Guardian might become aware of facts giving rise to concern either through complaints, spot-checks of records of expenditure or otherwise. As urgent action may be necessary the Public Guardian should not be required to inform the withdrawer of an intention to suspend or terminate or to give the withdrawer any right to make representations beforehand. The Public Guardian's decision would, however, be appealable to the sheriff[3].

4.24 The authority to withdraw should also come to an end if a guardian is appointed to the incapable adult with powers over matters that include the adult's bank account. A guardian might for example be necessary because of the need for wider financial management than the scheme permits or a guardian might be appointed specifically to supersede an unsatisfactory withdrawer. As the Public Guardian is, under our recommendations, the registration authority both for guardians appointed by the Scottish courts and for withdrawers he or she would be in a position to notify the bank and the withdrawer that the latter's authority had terminated on appointment of a guardian. The same action should be taken when the court makes an intervention order in relation to the bank account which is incompatible with the withdrawer's

1. See para 4.24 for withdrawals after termination of the withdrawer's authority.
2. Proposal 57(4), para 4.178.
3. Recommendation 146, para 7.3.

authority. A suspension or termination should be notified by the Public Guardian to the withdrawer and the branch of the bank concerned. Pending receipt of the notification neither the withdrawer nor the bank should be liable for continuing to operate the scheme provided they acted in good faith and in ignorance of the suspension or termination. The bank should be liable for any withdrawals made by the branch after it received notification, but on making good the amount withdrawn should be entitled to recover from the withdrawer.

4.25 We recommend that:

44. (1) A withdrawer's authority should cease two years after the date of its grant, but the withdrawer should be able thereafter to make a fresh application to the Public Guardian.

(2) The Public Guardian should be empowered at his or her sole discretion to suspend or terminate the authority. The authority should automatically terminate on the appointment of a guardian or continuing attorney or the making of an intervention order in relation to the account.

(3) Notification of suspension or termination should be given by the Public Guardian to the withdrawer and the branch of the bank at which the account is held. The withdrawer and bank should not be liable for withdrawals made in good faith and in ignorance of the suspension or termination.

Clauses 22(3)(b) and 24(1)-(3), (5)

Extension to other organisations

4.26 So far we have dealt with withdrawals from bank accounts of incapable adults, but the scheme outlined above might be suitable for other sources of money that could be accessed for the adults' benefit. In our discussion paper we asked for views on extending the scheme[1]. Many respondents mentioned building society accounts. As we have noted in paragraph 4.4, many building societies have somewhat similar schemes already under their rules. Furthermore, many people have building society accounts which they use in much the same way as a bank account; having pensions, dividends and other income paid in and making withdrawals to meet current expenditure. We favour extension to building society accounts.

4.27 Other extensions mentioned by those consulted included payments due under life or accident insurance policies, small legacies and compensation payments. These lump sum payments would require a different scheme from that proposed for bank accounts. It would not be appropriate, for example, to require an insurance company to make payments of cash weekly or pay third party suppliers. We consider it would be better to see how our recommended scheme for bank and building society accounts works before deciding whether to extend it to other sources of money. The Secretary of State should however have power to extend the scheme by regulations to other organisations with which adults had accounts. We therefore recommend that:

45. The scheme set out in Recommendations 37 to 44 should be applicable to building society accounts in the same way as it applies to bank accounts. The Secretary of State should have power by regulations to extend the scheme to other organisations similar to banks or building societies.

Clause 20(2)(b), (c)

JOINT ACCOUNTS

4.28 A useful extra-judicial method for managing the affairs of an adult who is becoming incapable is for a close relative or carer and the adult to open an "either or survivor" joint account. A joint account enables either account holder to operate the account without a signature being required from the other. As the adult becomes more incapacitated so the other holder can take over operating the account to a greater extent, until the stage is reached where the adult is wholly unable to operate the account and the other holder becomes the sole user. Many married couples already have a joint bank or building society account which could be used in the same way if one of them becomes incapable. We understand, however, that many banks take the view that if one holder of a joint account becomes incapacitated then that has the effect of bringing to an end the holders' instructions to the bank. Thus, once the bank becomes aware of the adult's incapacity it may freeze the account preventing further withdrawals, so that a curator bonis usually has to be appointed.

4.29 The law as to the termination of joint mandates and similar arrangements on the incapacity of one party is somewhat uncertain where that party has no obligations to perform[2]. Whatever the law may be, the practice of freezing joint accounts has unfortunate consequences for many incapable adults and their carers. Although we did not raise this issue in our discussion paper it has since been represented to us that enabling a joint account holder to continue to operate the bank or building society account notwithstanding the incapacity of the other holder would be a useful reform. We agree, although

1. Proposal 57(4), para 4.178.
2. McBryde, *Contract*, 8-45.

it has to be recognised that the facility will occasionally be abused. While the adult remains capable he or she can monitor withdrawals by the other account holder, but this would cease on incapacity. Any person who considers that the joint account holder is operating the account to the detriment of an incapable adult would, under our recommendations made in Part 6 of this report, be entitled to apply to the court for an intervention order in relation to the account or a guardian to be appointed to the adult, or to raise the matter with the Public Guardian[1].

4.30 We would stress that our recommendation is not intended to apply to joint accounts where all the joint account holders have to sign every cheque or withdrawal document. Furthermore, it should be competent for joint account holders in an "either or survivor" joint account to opt out of our scheme by agreeing with the bank or building society that the incapacity of one of them should terminate the authority of the other account holder to operate the account. The scheme should apply only to accounts held at a branch situated in Scotland of a bank or building society. The bank or building society, however, need not be Scottish.

4.31 Where a curator bonis is appointed to an individual who has a joint account with others the account is frozen until the curator establishes the rights of all the account holders. After this the others are allowed to withdraw their shares (if any). It has been pointed out to us that this process, which inevitably takes some time, can have an extremely serious effect on the other joint account holders. Married couples often have joint accounts which they rely on for meeting household expenses. A wife to whose husband the curator is appointed may be left without access to money for weeks or even months until the joint account is unfrozen. The problem is not confined to married couples because others living together may have joint accounts too. We have considered whether the sheriff in appointing a guardian to one joint account holder should have a discretionary power to allow the other holder to continue to operate the account, but we have decided against it. We think it would make the job of the guardian (and the Public Guardian supervising the guardian) very difficult if others had uncontrolled access to joint accounts. Guidance notes prepared by the Public Guardian should alert guardians to the problems faced by joint account holders and suggest that they be resolved as a matter of urgency immediately after appointment.

4.32 We recommend that:

46. (1) If two or more individuals are holders of a joint bank or building society account at a branch situated in Scotland whose terms allow any one individual to operate it and one individual becomes incapable of operating the account, then the other account holder or holders should continue to have authority to operate the account.

(2) The continued authority to operate should not apply if the account holders have agreed, or the court has ordered, otherwise, or a guardian or continuing attorney has been appointed or an intervention order made in relation to the account.

Clauses 25 and 26

MANAGEMENT BY ESTABLISHMENTS OF RESIDENTS' FINANCES

The existing system and criticisms of it

4.33 Section 94 of the 1984 Act empowers the managers of a hospital to receive and hold money and valuables belonging to a patient if the doctor in charge of the patient certifies that he or she is incapable, by reason of mental disorder, of managing and administering his or her own financial affairs. A hospital may spend the money for the patient's benefit and dispose of the valuables but must have regard to their sentimental value[2]. Once the funds of a particular patient exceed £5,000[3] the hospital requires the consent of the Mental Welfare Commission in order to continue to manage them. Whether consent is given depends on the type of assets in the patient's estate and their capital value[4], consideration of a possible curatory and the extent of the involvement of family members in current management. The hospital is not entitled to manage the funds of a patient who already has a curator. Similarly the hospital managers cease to be entitled to manage as soon as a curator is appointed, although curators sometimes delegate some expenditure decisions to the hospital[5].

4.34 The management of patients' affairs under section 94 was investigated by a Working Party (Chairman Mr W S Crosby) set up by the Scottish Health Service Planning Council. Its report, the *Report of the Working Party on Incapax Patients' Funds* ("the Crosby Report"), was published in 1985. The report stated that in 1985 most of the funds held on behalf of patients were fairly small. One-quarter of the balances were less than £50 and three-quarters were less than £500[6]. The amounts may be larger now as the Crosby Report recommended that reduction or termination of allowances

1. Para 2.41(c).
2. 1984 Act, s 94(3).
3. This figure is set by the Secretary of State and increased from time to time, s 94(2). It was raised to the present amount in January 1993.
4. Mental Welfare Commission, *Annual Report 1992/3* p 14. Further guidance is given as to whether a curator should be appointed on p 15.
5. 1984 Act, s 94(6).
6. Appendix II, Table 4.

should be sought only in very exceptional circumstances[1]. One hospital financial manager in responding to our discussion paper remarked that the management of incapable patients' finances was a growing problem as they could be in receipt of considerable sums of money.

4.35 In our discussion paper we set out several criticisms of the current management scheme under section 94[2]. First, a hospital can take over the management of a patient's funds if the medical officer in charge of the treatment certifies that the patient is incapable, by reason of mental disorder, of managing and administering his property and affairs[3]. This administrative procedure compares unfavourably with that for appointing a curator where two medical certificates are required, the "incapable" person is given an opportunity to challenge averments of incapacity and the appointment is made by a court after consideration of the evidence. Many in-patients could manage their affairs if more help and advice was available to them, yet the current procedure pays no attention to this possibility. Moreover, the present procedure is possibly in breach of the European Convention of Human Rights. Article 6(1) stipulates that determinations of civil rights (which include the right to manage one's own property and financial affairs) should be decided by an independent and impartial tribunal established by law after a fair and public hearing.

4.36 Secondly, the hospital managers' statutory duty is to hold and receive the money and personal possessions. They have a discretion to spend money held for a patient on his or her behalf. The Crosby Report noted and deprecated the negative attitude that incapable patients have no need for money because they cannot appreciate the benefits[4]. This may lead to hospitals seeking termination of state benefits or not claiming them on behalf of patients, allowing money to accumulate, or spending only small amounts on items such as sweets or cigarettes. The Crosby Report recommended that all income should be claimed and a more active policy should be adopted towards spending it to enhance the quality of life of in-patients[5].

4.37 Thirdly, it is not clear whether the hospital managers' duty to receive money extends to withdrawing money from a patient's bank or building society account which the patient had before admission in order to spend it on the patient's welfare. Practice varies but all too often small balances have to lie untouched if the advice received is that a curator would have to be appointed.

4.38 Fourthly, there is a danger that patients' funds are used to buy items that the National Health Service should provide free of charge. The Crosby Report[6] and the Mental Welfare Commission[7] have drawn attention to misuses of patients' funds in this way.

4.39 Fifthly, management of patients' funds by hospital central management may lead to a remote and impersonal service. Unlike curatory there is no single individual responsible for the funds of particular patients. The family of an in-patient who helped him or her to manage money before admission to hospital are superseded by the hospital administration and may feel excluded.

4.40 In the light of the various criticisms we proposed that hospital managers should be entitled to manage funds only up to a prescribed limit for each individual patient, above which either the Public Manager (whom we now term the Public Guardian) or a financial manager (now a guardian) supervised by the Public Manager should be appointed to manage them[8]. We also proposed that the doctor in deciding whether to certify a patient as incapable of managing his or her affairs and so entitling the hospital to manage them should consider the help that was available to the patient or could reasonably be made available to the patient in this respect[9], and that the hospital managers should be entitled to access funds held by the patient in an existing bank or building society account[10].

4.41 Those responding to the proposals in our discussion paper were generally in favour of continuing with the present system whereby hospital managers may manage the affairs of patients certified as incapable of managing them. There was no pressure for wholesale replacement of hospital management by curators bonis. However, many stated that the present system was in urgent need of reform and there was a general view that more guidelines and external monitoring were needed. It is against this background of qualified approval of the present system that we put forward recommendations for its reform.

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1. Recommendation 8, p 37.
2. Paras 4.156-4.161.
3. 1984 Act, s 94(1).
4. P 14.
5. Recommendation 1.
6. Recommendation 6.
7. *Annual Report 1988*, pp 11-13.
8. Proposal 53(1), (3), para 4.167.
9. Proposal 53(4), para 4.167.
10. Proposal 53(2), para 4.167.

Which establishments?

4.42 In terms of section 94 of the 1984 Act certified patients in a hospital can have their affairs managed if they are liable to be detained there under the 1984 Act or are receiving treatment for mental disorder as a patient there. "Hospital" means an NHS hospital, an NHS Trust hospital, the State hospital, and any private hospital registered under Part IV of the 1984 Act. This leaves out many categories of establishments with incapable patients or residents, such as private hospitals not registered under the 1984 Act, residential establishments run by the local authority under the Social Work (Scotland) Act 1968, private residential homes registered with and inspected by the local authority under that Act and nursing homes registered under the Nursing Homes Registration (Scotland) Act 1938. This gives rise to difficulty where residents of such establishments have finances which require more management than a DSS appointeeship yet where the sums involved are not large enough to make it worthwhile appointing a curator. These difficulties are becoming more acute with the increasing number of people in private nursing and residential homes. In our discussion paper we proposed extending the management scheme under section 94 to the above establishments presently excluded from its scope[1].

4.43 Our proposal received by and large a favourable response. Two respondents were opposed to allowing the managers of private hospitals and homes to manage residents' finances because of the potential conflict of interest due to the charging of fees and the system being too open to abuse. In their view current problems, such as absorbing residents' DSS personal allowances into the fees, would be intensified and other similar problems created. The other respondents were in favour of such an extension but only if there was strict external monitoring and control of the system. Enable saw no reason why hospitals should be specially favoured and observed that there were examples of good and bad practice in the public sector as well as in the private sector. The Scottish Association for Mental Health considered that there was no reason in principle to limit management of residents' finances to public hospitals. The controls suggested by respondents included approval of the establishment by the Accountant of Court, the drawing up of a Code of Practice that would require to be followed, spot-checks of individual residents' accounts, indemnity by the managers against loss caused by mismanagement and proper separation of residents' funds from those of the establishment.

4.44 The Law Society and some other respondents suggested that the management scheme should be available to hospitals, nursing homes and other residential establishments provided they had been approved on an individual basis by the Accountant of Court as Public Manager (now Public Guardian). Approval should be granted provided the arrangements made by the establishment in respect of patients' funds and their use were satisfactory. We consider this to be a very worthwhile suggestion and have adopted it with some modifications. A distinction can be drawn between NHS hospitals (including NHS trust hospitals and the State hospital) and other establishments since no fees are charged for the former and hence any conflict of financial interest between the managers and the patients is less than in private establishments. Moreover, NHS hospitals have been operating section 94 for many years. We do not suggest that NHS hospitals should be exempt from all external monitoring and observance of Codes of Practice but we do think that they should be automatically approved to run the new management scheme we recommend[2]. Other establishments should have to apply to the Public Guardian for approval. In order to lessen the administrative burden we would permit a local authority or other person that had more than one establishment to apply for approval in respect of all of them in a single application. Other classes of residential establishment may emerge in the future. We consider that the Secretary of State should be empowered to extend our recommended management scheme to them. All establishments should have to be situated in Scotland to be within the scheme.

4.45 Summing up the previous paragraphs we recommend that:

47. (1) The management of patients' finances by the managers of hospitals under section 94 of the Mental Health (Scotland) Act 1984 should be replaced by a new scheme as set out in Recommendations 48 to 57.

(2) The new scheme should apply to NHS hospitals in Scotland (including NHS trust hospitals and the State hospital), unless the sheriff terminates their authority to manage.

(3) The new scheme should also apply to residential establishments in Scotland run by, or registered with, the local authority under the Social Work (Scotland) Act 1968, private hospitals and nursing homes in Scotland registered under the Nursing Homes Registration (Scotland) Act 1938; but only if the Public Guardian so permits after an application for approval made by the managers of the establishment. The managers of one or more establishments seeking approval for them should be entitled to submit a single application in respect of all of them.

(4) The Secretary of State should have power to make regulations amending the list of establishments in paragraphs (2) and (3) above.

Clauses 4(2)(f), 27(1)-(4) and 28(1) and Schedule 5

1. Proposal 56, para 4.172.
2. This approval may be withdrawn later by the sheriff, see para 4.71.

4.46 In their comments the Law Society stated that an adequate and satisfactory service of managing residents' finances should be an essential part of the total provision made by hospitals and other institutions caring for incapable people. If an institution was neither able nor willing to provide such a service then it should be provided by the Public Guardian and the institution charged for it. We do not agree with these views. Hospitals, nursing homes and other residential establishments are primarily concerned with the treatment and personal welfare of their patients or residents. Managing finances is a facility which an establishment may wish to provide but which should not be imposed on it. Residents in establishments which do not offer a financial management scheme could have their affairs looked after in other ways, for example DSS appointeeships, authority to withdraw from bank accounts or guardianship by a relative on an unpaid basis. Guardianship by a solicitor or the Public Guardian on a paid basis would also be available.

Which residents?

4.47 At present section 94 of the 1984 Act covers patients who are liable to be detained under that Act in a hospital or who are receiving treatment for mental disorder as a patient in a hospital. Those liable to be detained include patients on leave of absence under section 27 of the 1984 Act. Patients resident in private establishments where contractual arrangements exist with an NHS trust hospital or health board in respect of their medical treatment are also regarded as coming within section 94 so that the managers of those establishments can manage the patients' finances in the same way as the managers of hospitals can[1]. The management scheme should also cover in-patients in long stay wards who are not detained and are not being treated for mental disorder, although of course to qualify they would have to be certified as incapable of managing their finances. The kind of patients we have in mind are those suffering from dementia or severe head injuries. For nursing homes and other residential establishments we consider that the scheme should apply to people whose main residence is the establishment. We recommend that:

48. The management scheme should be available for managing the financial affairs of:

(a) persons who are liable to be detained in a hospital under the provisions of the Mental Health (Scotland) Act 1984 or who are receiving treatment for mental disorder as resident patients in a hospital, and

(b) persons who are resident patients in an NHS hospital, an NHS Trust hospital or the State Hospital,

(c) persons who have as their main residence an establishment approved by the Public Guardian under Recommendation 47.

Clause 27(5)

In the remainder of this Part we use the term "residents" for individuals to whom the new scheme applies.

Certification of residents as incapable

4.48 A hospital can at present hold money and valuables on behalf of a patient if the medical officer in charge of his or her treatment certifies that the patient is incapable, by reason of mental disorder, of managing and administering his or her property and affairs[2]. As we pointed out in our discussion paper[3] this administrative procedure compares unfavourably with that for appointing a curator to a person, where two medical certificates are required, the person has an opportunity to challenge averments of incapacity and the appointment is made by a court after consideration of the evidence. The certification procedure under section 94 of the 1984 Act may well be in breach of the European Convention on Human Rights. Article 6(1) of the Convention provides that:

> "In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law".

Furthermore, there is no appeal against certification under section 94 whereas the appointment of a curator can be challenged by means of an appeal to a higher court. The Law Society, Alzheimer Scotland - Action on Dementia, the Scottish Association for Mental Health and Enable all regarded the present certification procedure as unacceptable.

4.49 Introducing more complex certifying procedures and invoking a court would lose all the simplicity and ease of operation of the present administrative scheme. Moreover, there seems to be little point in having a procedure to authorise managers of establishments to manage their residents' finances that mirrors that for the appointment of a curator or our recommended replacement, a guardian. The law would be unnecessarily complicated by having two management schemes with very similar procedures and effects. Accordingly, we do not favour introducing a judicial element at the initial stage, although for reasons set out later[4] we think that the decision to certify incapacity should be challengeable by way of an application to the sheriff.

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1. Mental Welfare Commission, *Annual Report 1992/93*, p 15.
2. S 94(1), 1984 Act.
3. Para 4.156.
4. Para 4.52 below.

4.50 We have also decided against introducing a requirement for two certificates of incapacity. A certificate from a single doctor should be sufficient provided he or she is suitably qualified to assess the resident's capacity to manage finances and has no financial interest in the establishment. Those incapable of managing their finances should include residents who are unable to communicate in any way due to their physical condition. Where the establishment has no attached medical staff with the required qualifications then a resident should have to be certified by an outside doctor. But we do not consider that outside doctors should always have to be used. If a hospital or other establishment does have suitably qualified persons on its staff with no financial interest then certification by such persons should be allowed. When considering whether to certify a resident the doctor should have to take into account the help that is available, or that could reasonably be made available, to the resident in managing his or her financial affairs. Where the family had been helping the resident at home before the move to the establishment they should be encouraged to continue to help and not be excluded by the establishment managers using our scheme. This can happen at present with hospitals[1]. Some initial reorganisation and simplification of a resident's finances might enable him or her to manage them in future. Consideration should also be given as to whether the resident has sufficient capacity to grant a continuing power of attorney[2].

4.51 The Mental Welfare Commission in their 1993/94 Annual Report[3] have urged that more use should be made of section 94 of the 1984 Act in relation to patients whose incapacity to manage their affairs is only temporary. Cases arise of functional psychoses, most notably hypomanic illness, where patients spend money recklessly or dispose of their property in a manner which later causes them considerable regret and hardship. We intend our scheme to apply both to temporary and permanent incapacity to manage. In the case of recovery of capacity it would be a simple matter for a doctor to certify this. The effect of such a certificate should be to terminate the managers' authority to manage that resident's affairs.

4.52 The lack of a right to appeal against certification was adversely commented on in our discussion paper and also by the Law Society, Alzheimer Scotland - Action on Dementia, the Scottish Association for Mental Health and Enable in their responses. In our opinion the right to apply to an "independent and impartial tribunal established by law" would make the administrative certification procedure by a single doctor more acceptable. The application should be for a determination of the current capacity of the resident rather than an appeal against the granting of the original certificate. The application should be heard by the sheriff because under our other recommendations nearly all applications would be heard in the sheriff courts. It would involve obtaining fresh reports from independent specialists and other evidence as appropriate. The sheriff should also have to consider the help that is, or could reasonably be made, available to the resident.

4.53 We recommend that:

49. (1) The managers of an approved establishment should have authority to manage the financial affairs specified in Recommendation 53 of a resident who has been certified as incapable of managing them by a doctor suitably qualified to assess capacity who does not possess a financial interest in the establishment.

(2) Where a certificate has been issued under paragraph (1) above an application may be made to the sheriff, by any person claiming an interest in the resident's welfare or finances, for a determination of the resident's mental capacity to manage his or her financial affairs.

(3) The managers should cease to have authority when the resident is certified as capable of managing them by a suitably qualified doctor or declared to be so capable by the sheriff.

(4) In deciding whether a resident is incapable of managing his or her own affairs account should be taken of assistance that is available or that could reasonably be made available.

Clauses 29 and 35

4.54 The management scheme we recommend for managers of establishments clearly should not apply where a guardian (or equivalent from another legal system) had previously been appointed with powers over the resident's financial affairs or an intervention order had been granted in relation to any of them. Judicial appointees should take precedence over administrative ones. A similar policy exists at present under section 94(6) of the 1984 Act in relation to hospital managers when a curator is appointed. We also consider that a continuing attorney who has been registered with the Public Guardian should be allowed to continue to act in the financial field rather than be superseded by the managers of the establishment. The management scheme is designed for those adults whose affairs are not being managed already by other means and should apply only in so far as no other person with authority to manage financial affairs is in existence. Thus, for example, if the resident has a DSS appointee to deal with his or her social security benefits the managers of the establishment should not have authority in that area. A similar restriction should apply if an individual had already obtained authority

1. Adrian Ward, *The Power to Act* (published by Enable 1990), p 112.
2. See Part 3 above.
3. P 29.

to withdraw funds from the resident's bank or building society account. The managers of the establishment could, however, take steps to have the continuing attorneyship, DSS appointeeship or authority to withdraw revoked if they considered that this would be of benefit to the resident. We recommend that:

50. The authority of the managers of an establishment should be subject to any existing intervention order or to the existing authority of a previously appointed guardian or continuing attorney (or their equivalents under other legal systems), a DSS appointee or an individual authorised to withdraw from the resident's bank or building society account.

Clause 36

4.55 Where a guardian is appointed after the managers of an establishment have become authorised to manage a resident's financial affairs, then we consider that the guardian should supersede the managers. However, the guardian would be entitled to delegate appropriate financial matters to the managers. For example, a guardian may permit hospital managers to continue to receive and spend the resident's DSS personal allowance or the guardian could periodically hand over money to be spent by the managers on the resident's welfare. The hospital managers would, however, be acting as delegates or agents of the guardian and would have to account for money received and spent. A similar solution should be adopted if a continuing attorney appointed before certification of incapacity is registered with the Public Guardian afterwards. Accordingly we recommend that:

51. The authority of the managers of an establishment should be subordinated to the authority of a guardian or continuing attorney (or their equivalents under other legal systems) appointed or registered after the managers have commenced to act, but the guardian or continuing attorney may appoint the managers to act as his or her agent.

Clause 31

4.56 We do not make any recommendations for dealing with the potential clash of authority between the managers of an establishment and subsequently appointed DSS appointees or withdrawers from bank or building society accounts. This is because we consider such a situation to be most unlikely to occur. The managers would be in contact with the Department of Social Security in relation to benefits so that the Department would be aware of their authority and should not appoint someone else. If the managers were managing a resident's financial affairs it is unlikely that any individual would need to apply for authority to withdraw and if it were granted we consider the bank or building society should decline to give effect to it if aware of the managers' authority.

4.57 At present incapable patients in hospital can have their financial affairs managed by the managers of that hospital. On discharge, however, the managers' authority ceases. There is a lack of any system for looking after the finances of discharged patients unless they are rich enough to merit the appointment of a curator. Our recommendations relating to withdrawals from bank accounts would go some way towards meeting the problem as would public management of small estates by the Public Guardian. But we think there would still be a substantial number of incapable residents without close relatives whose affairs would benefit from continued management after discharge. It was suggested to us that hospital managers should continue to have authority to manage the affairs of discharged patients at least until other satisfactory methods have been found. We endorse this useful suggestion and would extend it to other approved establishments. The continuing authority of managers after discharge should be a facility and not something they should be under a statutory duty to provide. We do not think it would be acceptable to impose such a duty especially on private nursing and residential homes. The likelihood of being bound to continue managing the affairs of former residents might deter many homes from entering into financial management at all. We therefore recommend that:

52. The managers of an establishment should be entitled, but not bound, to continue managing the financial affairs of a former resident if no other adequate arrangements appear to have been made.

Clause 32(6)

What matters may be managed?

4.58 Hospital managers acting under section 94 are authorised to "receive and hold money and valuables" of a patient and may "expend that money or dispose of those valuables for the benefit of that person". The extent of this authority is unclear particularly in relation to items outwith the hospital such as the patient's own bank account. We do not consider that managers of an establishment should be given the same wide powers as a curator has or that a guardian with full financial powers would have under our recommendations. Management by establishments is intended to operate without extensive supervision by the Public Guardian and so should be confined to fairly straightforward matters. If acquiring accommodation for a resident or disposing of it or making investments in shares is needed, then a guardian ought to be appointed or an intervention order made.

4.59 The managers of an establishment should be entitled to hold, on behalf of the resident, items brought into the establishment by the resident. Likely items include personal possessions, a television set or other furniture. The managers should, we think, also be able to claim, receive and manage on behalf of the resident any pensions and benefits whether

from the Department of Social Security, the resident's former employment or otherwise. The Crosby Report deprecated the negative attitude adopted by some hospitals that certified patients were unable to appreciate money spent on them and therefore had no need of any money. It recommended that all income should be claimed and a more active policy adopted towards spending it to enhance the patients' quality of life[1]. The Code of Practice which we recommend later would address this problem. There are many sources of money falling due to the resident while certified other than pensions and benefits that we think should also be available to the managers. These include therapeutic earnings from participation in industrial therapies[2], compensation and insurance claim payments, proceeds of a life policy and legacies. The managers should be entitled to claim and receive these on the resident's behalf. The managers should also be entitled to withdraw money from an existing bank or building society account in the sole name of the resident in order to use it for the benefit of the patient[3]. We recommend below[4] an aggregate monetary limit on management by managers of establishments which would prevent managers acquiring large lump sums from these sources.

4.60 Once the money or items are in the possession of the managers they should be empowered to hold, spend or dispose of them for the benefit of the resident. Decisions in relation to substantial assets and the general course of management to be adopted would be governed by the general principles set out in Part 2 and by the Code of Practice which we recommend later[5]. Subject to these considerations the managers should follow a general policy of spending the money received for the resident's benefit and to enhance his or her quality of life rather than saving it. However, there will be situations where saving would be appropriate, for example, when the resident is to be discharged in the near future or where some costly item is wanted. The managers should be permitted to spend capital as well as income but further guidance on expenditure is best left to the Code of Practice.

4.61 We recommend that:

53. The managers of an establishment should be entitled to:

(a) claim and receive any pension or benefit due to the resident while certified and any sums falling due to the resident while certified and to hold them along with any other money brought by the resident into the establishment.

(b) spend any money so held by them on behalf of the resident in order to enhance his or her quality of life in accordance with the provisions of the Code of Practice recommended in Recommendation 56.

(c) hold or dispose of items which the resident brought into the establishment or which have been acquired by or on behalf of the resident subsequently.

(d) withdraw money from an existing bank or building society account in the name of the resident.

Clauses 30 and 32(3)

Safeguards for residents

4.62 At present hospital managers are entitled to hold money and valuables up to an aggregate value of £5,000 for each patient by virtue of their general authority under section 94[6]. They may hold in excess of this value with the consent of the Mental Welfare Commission. The current guidelines used by the Mental Welfare Commission[7] are that for sums between £5,000 and £10,000 there should have to be a good reason for replacing hospital management by curatory and for estates over £20,000 there should have to be a good reason for not appointing a curator. For estates between £10,000 and £20,000 there is no presumption either for or against curatory.

4.63 In our discussion paper we suggested[8] that managers of hospitals should be permitted to manage funds only up to a specified limit over which management would have to be undertaken by a financial manager (now a guardian) or the Public Manager (now the Public Guardian). Views were invited as to what the specified limit should be. There was a wide variety of views expressed on consultation. A few respondents favoured a figure of about £3,000[9], but most favoured the now current limit of £5,000. Others mentioned a substantially higher figure of £10,000. Most of those responding wished the existing system to continue whereby permission could be given to manage sums over the specified limit rather than, as we proposed, making the limit an absolute ceiling. On reconsideration we now favour flexibility and think that the Public Guardian should be entitled to approve management of funds in excess of the specified limit. In approving management in excess of the limit the Public Guardian should have power to impose conditions such as submission of

1. Recommendation 1.
2. Crosby Report, p 18.
3. See para 4.37.
4. Recommendation 54, para 4.64.
5. Recommendation 56, para 4.70.
6. Direction issued by Secretary of State under s 94(2) of the 1984 Act dated 7 January 1993.
7. *Annual Report 1992/93*, pp 14 to 16, see also para 4.33 above.
8. Proposal 53(1), para 4.167.
9. The limit at the date of publication of our discussion paper.

reports or even accounts from time to time. Approval of management over the specified limit is presently entrusted to the Mental Welfare Commission[1]. We recommend that this function should be carried out in future by the Public Guardian instead, as it is more in line with that official's current duties and responsibilities in relation to curators and our recommendations that guardians, continuing attorneys and others with financial powers should be supervised by the Public Guardian. We would stress that our recommendation does not imply any criticism of the way the Mental Welfare Commission has carried out this function in the past. The specified limit should, we think, remain at its current level of £5,000 for hospitals, but other lower limits may be appropriate for other classes of establishment. Hospitals have been managing substantial funds for many years, but this would be a new venture for local authority establishments and private nursing and residential homes. The Secretary of State should be empowered to prescribe different limits for different classes of establishments as well as changing the monetary limits from time to time to take account of changes in the value of money.

4.64 We recommend that:

54. (1) The managers of an establishment should be entitled to manage money and items up to £5,000 in total value, or such other sum as may be prescribed, for each individual certified resident.

(2) The power to permit the management of money and items in excess of the above limit should be transferred from the Mental Welfare Commission to the Public Guardian. The Public Guardian should be empowered to grant approval subject to conditions.

(3) The Secretary of State should be empowered to make regulations prescribing a limit or limits other than £5,000 for establishments other than NHS hospitals and altering the £5,000 limit and other limits from time to time.

Clause 32(1), (2) and (7)

Oversight by the Public Guardian

4.65 We have recommended in the previous section that the Public Guardian should be charged with approving management of residents' funds over a specified limit. In our discussion paper[2] we proposed that the Public Manager (now the Public Guardian) should be entitled to require the managers of the establishment to produce accounts of their transactions with specified individual residents' money and personal possessions. This "spot-check" system was approved by all those responding. One body commented that such accounts should always be produced, but we consider that this would be too expensive and unnecessary. Most managers will have already carried out an internal audit of residents' accounts and there is no point in the Public Guardian duplicating that work. Of course, if serious deficiencies are revealed by a spot check then the accounts of all residents in that establishment could be called for. Another body commented that management services might be provided by a private contractor. Our recommendations are framed so that the managers of establishments remain liable for the performance of their statutory management functions whether they perform them personally or by agents. In addition we consider that the Public Guardian should also have a general supervisory role in relation to approved establishments and be the authority to whom complaints could be made. The Public Guardian would be under a duty to investigate any complaints or other circumstances giving rise to concern, but we do not thereby intend to exclude the Mental Welfare Commission from exercising their general protective statutory functions in relation to the mentally disordered. Accordingly we recommend that:

55. The Public Guardian should be under a duty to receive and investigate complaints about the management of certified residents' funds by managers of approved establishments and be entitled to question the managers regarding their transactions with funds of specified residents, and require them to produce accounts and records even in the absence of complaints.

Clauses 4(2)(d)(iii) and 33

Duties of establishments under scheme

4.66 The Crosby Report made many recommendations in relation to a proper system of accounting for patients' funds and preventing such funds being used to purchase items that hospitals should provide free of charge. The Mental Welfare Commission in their subsequent Annual Reports[3] have drawn attention to continuing deficiencies in these areas. We consider that the basic responsibilities of managers of establishments should be set down in statute and be fleshed out by a Code of Practice prepared by the Secretary of State.

4.67 Residents' funds clearly should have to be kept separate from the funds of the establishment. The managers should be entitled to open individual accounts for all their residents, but they should also have the option of a block account for all the residents. Block accounts are currently run by some hospital managers for patients' funds. They offer the advantage

1. 1984 Act, s 94.
2. Proposal 55, para 4.169.
3. 1987, p 13 and 1988, pp 11-13.

of reduced administration costs and better terms from the bank. For example, higher rates of interest can be obtained on say £100,000 in a block account than on several hundred accounts with the same aggregate value. If block accounts are to be used then the establishment's records must be such as to enable the balance (including interest) due to each participating resident to be identified at all times. Money belonging to a particular patient above a prescribed limit (which we suggest should be £50) should have to be placed in an interest-bearing account (block or individual).

4.68 There should in our opinion also be a statutory duty on the managers of an establishment to spend a resident's money only on items which benefit that particular resident and which are not provided as part of the service provided free under the NHS or included in normal fees charged by the establishment. We think this duty is of prime importance in relation to private nursing and residential homes where the proprietors could gain a direct pecuniary advantage by failing to comply with it. Many of those responding to our proposal to extend the present system of hospital management to other establishments expressed concern over possible misuse of funds, particularly in using them to meet any shortfall in fees. Other instances of which we have become aware include buying extra furniture for the resident's room from his or her funds which stays there when the resident moves. Some of the misuse occurring at present may well result from uncertainty as to what is allowable. The Code of Practice should therefore give clear guidance on this issue.

4.69 The managers should not be liable for any loss to a resident's funds if they act reasonably, in good faith and in accordance with the recommended general principles in Part 2. A similar restriction of liability has been recommended for breach of fiduciary duty[1]. The Public Guardian should be empowered, as a condition of granting approval, to require the managers of an establishment to provide a satisfactory indemnity by way of insurance or otherwise against such losses. NHS hospitals should normally be exempt from such a requirement as health boards and NHS trusts should have access to funds to meet any such claims that might be made against them.

4.70 Summing up the previous paragraphs we recommend that:

56. (1) The managers of an approved establishment should be under a statutory duty to:

(a) keep certified residents' funds separate from those of the establishment.

(b) if the funds are not in separate bank or building society accounts for each individual resident, maintain records enabling the balance due to each resident at any time to be ascertained.

(c) place sums over £50 (or such other amount as may be prescribed by the Secretary of State) in an interest-bearing account.

(d) spend a resident's money only on goods and services that are of benefit to that resident, not including items which should be provided by the establishment as part of the normal service to residents.

(e) adhere to a Code of Practice drawn up and published by the Secretary of State.

(2) The managers should be liable for any loss to a resident's funds arising from a breach of the duty of care or any misuse of funds, only if they fail to act reasonably, in good faith and in accordance with the general principles set out in Recommendations 11 to 14, and should be under a duty to make proper provision for indemnification for losses for which they are liable.

Clauses 10(1)(f), 32(4) and 64

Withdrawal of approval of establishments

4.71 The duties laid on managers of approved establishments in managing the funds of certified residents, either directly by statute or under the Code of Practice, require to be backed up by sanctions. One sanction, liability to make good losses arising from a breach of duty, has already been mentioned. We consider that in appropriate cases the approval of the establishment should be withdrawn by the sheriff or continued only on conditions. Withdrawal of approval would prevent further management by an establishment that was demonstrably unfit to manage its residents' funds, while the threat of withdrawal of approval or attaching conditions to continued approval should be sufficient to secure future compliance in other cases.

4.72 Withdrawal of approval should, we think, be a judicial act involving the sheriff courts. We do not consider that the Public Guardian can properly decide whether contested allegations of mismanagement are substantiated since this would involve hearing evidence. That official's role should be to investigate and make the application to the court. Moreover, withdrawal of approval would have serious consequences for the standing of an establishment and it is right that the issue should be decided by an independent public tribunal. The process should start by an application to the sheriff by the Public Guardian who would have been involved in the initial investigations. The sheriff, on being satisfied that the managers of the establishment have failed to comply with any statutory requirement (including adherence to the Code of

1. Recommendation 15, para 2.79.

Practice) or are otherwise unsuitable, should be empowered either to withdraw approval or attach conditions to the continued approval. Unsuitability could, for example, arise where the proprietor of a residential home had been convicted of a crime involving dishonesty but unconnected with the running of the home. Another reason for withdrawing approval should be that the establishment no longer falls within the terms of the scheme, such as a nursing home losing its registration under the Nursing Homes Registration (Scotland) Act 1938. Any conditions imposed should be capable of being subsequently varied or removed. The sheriff should also have power to make interim orders since action might be urgently needed to protect residents' funds.

4.73 If the sheriff withdraws approval from an establishment to manage the funds of the certified residents the managers will lose their authority to manage those funds. In order to provide short term management until some more permanent arrangements are made, the Public Guardian should be appointed interim guardian with the same powers as the managers enjoyed.

4.74 We recommend that:

57. (1) The sheriff should have power, on application by the Public Guardian, to withdraw approval from an establishment or to impose conditions on its continued approval. The sheriff should have to be satisfied that the managers had failed to carry out any statutory requirements relating to the management of certified residents' funds or that the managers or the establishment were otherwise no longer suitable.

(2) Any conditions imposed should be capable of being subsequently removed, varied or added to.

(3) On withdrawing approval the sheriff should have power to appoint the Public Guardian as interim guardian of the funds of the certified residents of that establishment with the same powers that the managers had.

(4) The sheriff should have power to make any appropriate interim order (including the suspension of approval) pending the determination of the application by the Public Guardian.

Clauses 3(2)(d) and 34

Part 5 Medical Treatment and Medical Research

Introduction

5.1 This Part is concerned with health-care issues, particularly the giving of treatment to those incapable of consenting to it, when such treatment can be lawfully given and what treatments, if any, should require special authorisation. Other allied topics are participation in medical research, taking organs from a living incapable person for the purpose of transplanting them into another person, and withholding or withdrawing treatment from patients who are unlikely to benefit from it. Proxy decision-makers, either guardians appointed by the court or attorneys appointed by the adults themselves, are discussed elsewhere[1], but we look in this Part at the role of such proxies in the health-care area. The effect to be given to statements by patients when capable as to their treatment if they become incapable (sometimes known as "advance directives" or "living wills") is also considered. Treatment is used in the remainder of this Part in a wide sense to include surgery, prescribing and administering drugs, preliminary examinations, nursing care, physiotherapy, taking samples, psychological and psychiatric procedures, dental and optical treatment and also procedures to promote and safeguard health such as screening and preventative medicine. "Doctor" is used to mean any person giving or proposing to give such treatment.

5.2 An incapable patient is one who is unable to make a decision relating to the treatment by reason of mental disorder or being wholly unable to communicate. Certain patients with learning difficulties, severe head injuries or dementia would be examples of the first category, while patients in a coma or unconscious would come into the second category. The inability to decide also must be related to the treatment in question. People who are able to decide whether to undergo some minor surgical operation may not be able to decide about sterilisation, abortion or cosmetic surgery where many conflicting factors have to be considered. The ability to come to a decision on the treatment in question depends to some extent on the person's ability to comprehend, from information supplied by the doctor or others, the nature of the proposed treatment and its effects and risks. The patient does not need to have been given an exhaustive evaluation of the treatment. In particular minimal risks need not be mentioned. What is required is that the patient is informed in broad terms of the nature of the proposed treatment[2].

Authority to treat incapable patients

5.3 Where a patient is unconscious, drunk or otherwise incapable of giving consent and is not known to have objected to receiving treatment it is widely accepted that doctors may give necessary treatment which cannot be reasonably delayed until the patient recovers capacity[3]. In addition the 1984 Act authorises certain categories of urgent treatment for mental disorder to be given to detained patients without their consent or a second opinion[4]. This doctrine of necessity applies in emergencies and to the temporarily incapacitated. Appropriate treatment had always been afforded to other incapable patients but the legal basis on which it was provided was somewhat uncertain. In 1989 in the case of *Re F (Mental Patient: Sterilisation)*[5] the House of Lords clarified the law relating to the treatment of permanently mentally incapacitated patients in England and Wales and considered the legal justification for such treatment.

5.4 The *F* case concerned the sterilisation of a 35 year old woman resident in a mental hospital who had the mental capacity of a very young child. Sterilisation was regarded as being in her best interests because she was having a sexual relationship with a fellow inmate. Pregnancy and birth of a child would, the doctors considered, cause her severe psychological harm. Other contraceptive methods were considered inappropriate. It was held that doctors were entitled under the common law to give treatment to patients who were incapable of consenting. As Lord Brandon said[6]:

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1. See Part 6 (guardians) and Part 3 (attorneys).
2. *Chatterton v Gerson* [1981] QB 432; see also *Sidaway v Governors of Bethlem Royal Hospital* [1985] AC 871 and *Moyes v Lothian Health Board* 1990 SLT 444.
3. Hoggett, *Mental Health Law*, (2nd edn) p 202; Mason and McCall-Smith, *Law and Medical Ethics* 4th edn p 220; British Medical Association, *Medical Treatment and Incapable Adults: Interim Guidelines for the Medical Profession* (1990), p 2; NHS Scotland, *A Guide to Consent to Examination, Investigation, Treatment or Operation* (1992), para 16.1.
4. S 102.
5. [1990] 2 AC 1.
6. At p 55.

"A doctor can lawfully operate on, or give other treatment to, adult patients who are incapable, for one reason or another, of consenting to his doing so, provided that the operation or other treatment concerned is in the best interests of such patients. The operation or other treatment will be in their best interests if, but only if, it is carried out in order either to save their lives or to ensure improvement or prevent deterioration in their physical or mental health".

In our discussion paper we were of the view that the House of Lords' decision would probably be followed in Scotland even though it is not necessary to invoke the concept of necessity here[1]. In English law there is no person capable of taking medical treatment decisions on behalf of a mentally incapacitated adult[2], so of necessity the court had to declare certain treatment to be lawful, but in Scotland a tutor-dative can be appointed with power to consent to treatment[3].

5.5 In our discussion paper[4] we unhesitatingly rejected the notion that the courts or some other body should always be involved in all treatment decisions for incapacitated patients, either directly or indirectly via the appointment of a tutor-dative with appropriate powers[5]. Nothing was said on consultation to require us to reconsider this. The courts or other body would be deluged with applications and necessary treatment would be delayed and made more expensive by such requirements. We then went on to consider what reforms, if any, were needed. One possibility discussed was that doctors should simply be left to treat patients in their best interests according to clinical judgment. This would be to adopt the line taken by the House of Lords in *Re F*. In our discussion paper in order to elicit views we put forward another option which included as an additional element involvement of the patient's nearest available relative from a short list of such relatives[6]. The nearest relative would have to be consulted in so far as it was reasonably practical to do so and the doctors would be required to take account of the relatives' views. The discussion paper also asked whether the court should have power to disqualify relatives who were unsuitable to be consulted. Requiring consultation with the nearest relative would not prevent the doctors from seeking the views of others with an interest in the patient's welfare and taking them into account also in deciding what treatment, if any, to give.

5.6 The Mental Welfare Commission and the Law Society commented that our proposal should not affect the statutory provisions relating to the treatment of mental disorder of patients liable to be detained[7]. These are contained in Part X of the 1984 Act and may be summarised as follows. A patient may be treated for his or her mental disorder without consent[8]. A patient may also be given urgent treatment where life or serious danger to health is at stake without consent or a second opinion[9]. Electro-convulsive therapy and medicines for mental disorder given for a period in excess of three months require either the patient's consent or a formal second opinion[10]. Psycho-surgery and implantation of hormones to reduce male sex drive require the patient's consent and a formal second opinion[11]. We fully agree and had intended that the proposals in our discussion paper relating to medical treatment should not apply to situations regulated by the 1984 Act, although this reservation appeared in the introduction to the section on medical treatment[12] rather than explicitly in each of our proposals. We deal later with "Part X treatments" in relation to incapable patients who are not detained. Other situations we also intended to exclude, since they were the subject of other different proposals were:-

(a) treatments specified by the Secretary of State as requiring the approval of a court.

(b) participation in medical research.

(c) transplantation of organs.

We discuss these and other exceptions later in this Part.

5.7 Consultation revealed a division of opinion. Although the majority of those responding were in favour of consulted relatives' views merely being taken into account some were in favour of the relatives' consent being required. The latter would not give relatives an absolute veto since it was accepted that doctors faced with a refusal to consent by the relatives concerned could go to the court for an order authorising them to proceed with treatment. Those favouring a requirement of consent argued that in the case of a competent patient his or her consent was required. In their view there should not

1. Para 3.8.
2. The *parens patriae* jurisdiction of the courts there was abolished in 1960.
3. *Usher's CB Petr* 1989 (unreported).
4. Para 3.13.
5. *Usher's CB Petr*; Adrian Ward, *Tutors to Adults: Developments*, 1992 SLT (News) 325.
6. Proposal 21, para 3.21.
7. These include those on leave of absence, but exclude certain short term detainees, see s 96.
8. S 103. This may include feeding by naso-gastric tube to prevent physical deterioration so that treatment for the mental disorder could be carried out; *B v Croydon Health Authority*, [1995] 1 All ER 683.
9. S 102.
10. S 98 and the Mental Health (Specified Treatments, Guardianship Duties etc) (Scotland) Regulations 1984; SI 1984/1494. The second opinion is given by a consultant nominated by the Mental Welfare Commission.
11. S 97 and the 1984 Regulations.
12. Para 3.2.

be a different requirement for patients incapable of consenting; a consent should have to be obtained from someone on the incapable patient's behalf. Another concern was that merely being required to take the relatives' views into account left the decision in the hands of the doctors. They might merely go through the motions of consultation since there were no sanctions proposed to compel them to take account of the views of those consulted. The Law Society suggested that consulted relatives should be entitled to register disagreement with the doctor but allow the treatment to go ahead nevertheless, or to disagree and require the matter to be referred to the court for a decision. The consulted relative should be given a standard form setting out the two options described above which the relative would complete and return to the doctor with the selected option indicated.

5.8 We would adhere to our proposal in the discussion paper that the views of relatives and others consulted should only be taken into account. Those consulted may have exploited or abused the patient, may have conflicting interests or may unreasonably withhold consent. Exploiters and abusers may not have been disqualified from acting as nearest relative nor may the doctors be aware of their behaviour or conflicting interests. We imagine that cases of irreconcilable differences between doctors and relatives would be rare because doctors would strive to achieve a consensus with relatives and others with an interest in the patients' welfare. If there was disagreement then we consider that it should be for the objectors to apply to the court for an order prohibiting treatment rather than for the doctors to have to apply for authority to proceed. Placing the onus on the objectors recognises the clinical judgement and professionalism of the doctors and their medical, ethical and legal duty to care for the patient as best they can. We note that our recommendation is consistent with the guidelines *Medical Treatment and Incapable Adults: Interim Guidelines for the Medical Profession* published by the British Medical Association in October 1990 in taking the views of the health-care team, relatives and friends of the patient into account.

5.9 Alzheimer Scotland - Action on Dementia and some others responding to our proposal observed that the doctors should also be required to take the patient's own views as to the proposed treatment into account. We agree wholeheartedly where communication with the patient is feasible. This requirement was implicit as part of our general approach to the mentally disabled. Even though the patient is unable to take a decision as to the treatment in question he or she may have wishes and feelings, current or past, that should be taken into account[1]. The situation where an incapable patient refuses treatment is a difficult one. We consider that if the doctors are satisfied that the patient is truly incapable of making a decision and that the refusal is irrational or mindless then they should be entitled to give appropriate treatment notwithstanding the patient's refusal. One organisation suggested that in such situations doctors should be required to go to court to seek authority to give treatment. We think that this would be unduly burdensome.

5.10 The issue of doctor-patient confidentiality was raised by a number of respondents. If the nearest relatives and others with an interest are to be consulted in a meaningful way then they will have to be adequately informed as to the patient's medical condition and other circumstances. This, it may be said, disadvantages mentally incapable patients compared with competent patients who are entitled to confidentiality. This distinction is inevitable unless doctors, contrary to our views, are to take decisions unaided. Doctors should, however, reveal to relatives only as much as is necessary for them to reach an informed decision upon the matter they are being consulted about.

5.11 The Mental Welfare Commission commented that our proposal gave doctors too much autonomy for serious treatments. It suggested that for a serious treatment the doctors should be required to obtain a second opinion from an independent practitioner skilled in that treatment, as recommended by the British Medical Association's *Interim Guidelines*[2]. In these guidelines a serious treatment is defined as having one or more of the following characteristics:-

"(a) Any treatment that contemplates an irreversible change in the patient;

(b) Any treatment that is a serious hazard;

(c) Any experimental treatment and all types of research;

(d) Any intervention which as a consequence may shorten the life of the patient;

(e) Any long term regime/intervention designed to effect a change in the mood or behaviour of the patient;

(f) Any treatment, notwithstanding that it does not possess one or more of the above characteristics, which should be regarded as serious."

We are not in favour of making a second opinion a legal requirement for the treatment of incapable adult patients except in certain cases, which we discuss later[3]. Our preference is for second opinions and consultations with colleagues to be regulated by guidelines or codes of practice issued by the medical and other professional organisations concerned. Furthermore, we doubt whether "serious treatments" could be defined with sufficient precision for legislative purposes.

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1. In certain circumstances previous statements may be determinative, see paras 5.41 to 5.59.
2. At p 6, see para 5.8 above.
3. Paras 5.25 and 5.26 for example.

5.12 Another suggestion to emerge from consultation was that the doctors should consult a mental health officer. This would provide a non-medical input where relatives were not reasonably available to be consulted or were unwilling to express a view. The views of a mental health officer could on occasion be very helpful, particularly where he or she knew the patient and the circumstances well. However, we are not in favour of making such consultation a statutory requirement in all cases. Doctors should be free to consult a mental health officer as someone with an interest in the patient's welfare, but should not be bound to do so.

5.13 One respondent suggested that the individual or organisation caring for the patient as well as the nearest relative should be required to be consulted and the views expressed taken into account. We welcome this helpful suggestion. The carer is likely to be as good a source of useful information and views as the nearest relative and the carer would also be a useful and indeed a natural person to consult in connection with those patients who had no reasonably available relatives or whose relatives were unconcerned with their treatment.

5.14 In our discussion paper we asked for views as to whether the existing common law relating to the medical treatment of incapable adults should be put into a new statute[1]. A majority of those responding were in favour of legislation even if no change were to be made. Many doctors were said to be ignorant of the current law and decisions such as *Re F (Mental Patient: Sterilisation)*[2] were not readily accessible to give guidance to those involved in treating patients. The law would, it was argued, be more available and succinct in legislation. Some of the medical respondents were concerned that legislation would be too restrictive. Legislation could prevent appropriate treatment being given and deficiencies in the statutory provisions would take some time to correct since Parliamentary proceedings would be required. The Scottish Council of the Royal College of General Practitioners suggested that non-binding professional guidelines and codes of practice would be of assistance in this area as an adjunct to legislation.

5.15 The approach we now favour takes the form of a new general statutory authority to doctors to give treatment to incapable patients. This authority, like all other authority directly affecting incapable adults within the scope of our report, would be exercisable in accordance with the general principles set out in Part 2 of our report. These general principles require any intervention to be for the benefit of the incapable adult in question and to be the option which is least restrictive of the adult's freedom consistent with achieving the purpose of the intervention. The intervenor would be required (in so far as was reasonable and practicable) to consult the adult, his or her nearest relative and primary carer and any guardian or attorney and take their views[3] into account as well as the views of any other person who seemed to have an interest and who made the views known to the intervenor. This approach confers some of the benefits of legislation without its restrictive effects and is broadly in line with the views of those responding to our proposals.

5.16 The assessment of a patient's capacity to give or withhold consent to a proposed treatment is a matter for the doctor concerned, using his or her own judgment guided by legal requirements and professional practice. Different doctors may reasonably come to a different view as to a particular patient's capacity. Authority to treat patients which was based on an objective test - whether the patient was incapable - would give little protection to doctors and might make them reluctant to give treatment lest another doctor or a court should come to the opposite conclusion later. We therefore consider that our recommended general authority should be available if, in the opinion of the doctor, the patient is incapable of making a decision regarding the treatment in question. The Age of Legal Capacity (Scotland) Act 1991 adopts a similar approach in relation to the capacity of children to consent to treatment[4].

5.17 We recommend that:

58. (1) A doctor should have authority to give treatment which is reasonable in the circumstances in order to safeguard or promote the health of a patient who, in the doctor's opinion, is incapable of making a decision relating to it.

(2) Treatment should include any surgical, medical, nursing, psychiatric, psychological, optical or dental treatment, procedure, examination or assessment. Treatment for mental disorder of incapable patients liable to be detained under the Mental Health (Scotland) Act 1984 should continue to be governed by Part X of that Act with the exception of psychosurgery which could be authorised by the sheriff under Recommendation 62.

(3) The general authority in paragraph (1) above should not apply to those matters more specifically dealt with in Recommendations 59 to 68.

Clause 37(1), (2)

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1. Proposal 20, para 3.11.
2. See para 5.4.
3. We discuss the effect of a written or oral statement made by the adult while capable as to future medical treatment when incapable at paras 5.41 to 5.59.
4. S 2(4).

Consulting the patient's nearest relative

5.18 In deciding whether to give treatment doctors would be required to consult (so far as reasonable and practicable) the nearest relative of a patient about proposed treatment which the patient is mentally incapable of deciding whether or not to accept[1]. In our discussion paper we noted that the 1984 Act contains detailed provisions about relatives in relation to detention in hospital or guardianship. Section 53(1) provides that "relative" means:-

(a) spouse

(b) child

(c) father or mother

(d) brother or sister

(e) grandparent

(f) grandchild

(g) uncle or aunt

(h) nephew or niece.

Briefly the nearest relative is the first listed relative who is caring for the patient or who was caring for the patient before admission to hospital or guardianship[2]. If no relative is or was caring for the patient the first listed relative is the nearest relative (and within the class of children or siblings priority depends on age)[3]. Relatives not resident in the British Islands, spouses living apart and persons under 18 are disregarded[4]. A spouse includes a cohabitant[5]. The sheriff may appoint one of the other relatives or any other person to act as nearest relative on cause shown[6].

5.19 Our provisional view in the discussion paper was that these provisions were unduly complex for the purposes of medical treatment and we put forward a shorter list[7]. Under our proposal the patient's nearest relative would be the first person reasonably available on the following list (in order of priority):-

(a) husband, wife or cohabiting partner

(b) a child over 18 years of age

(c) a parent

(d) a brother or sister.

Where the first available relative declined to give any views then the doctor was to be entitled to go to the next reasonably available relative in the list.

5.20 Many of those responding agreed with our proposed short list of relatives or suggested minor modifications. However, the Law Society and the National Schizophrenia Fellowship (Scotland) considered that the more detailed provisions in the 1984 Act should be applied. On reconsideration, we think there is considerable force in their view that consistency across the whole area of mental disability is very desirable. Adoption of the 1984 Act provisions would also meet the criticisms voiced by some respondents about our list that a definition of cohabiting partner and provisions regulating the order in which cohabiting partners and spouses should be consulted were also needed. Sections 53(4) and (5) of the 1984 Act deal with such matters. In Part 2 of this report we recommend[8] that the 1984 Act's provisions relating to nearest relatives and acting nearest relatives should be adopted for the purposes of consultation in relation to an intervention in the welfare or affairs of an incapable adult. There is no reason to adopt a different approach for medical treatment of incapable patients.

Treatments outwith the general authority

5.21 In the previous section we recommended that doctors and other health care professionals should have a general statutory authority to give treatment or to take steps to safeguard and promote the health of incapable patients. This general authority was however to be subject to various exceptions, which we now consider. Participation in research, organ

1. See para 5.15.
2. S 53(3).
3. S 53(3).
4. S 53(4).
5. S 53(5).
6. S 56.
7. Proposal 21(2) at para 3.21.
8. Recommendation 14, para 2.73.

transplants from incapable donors and withdrawal of life-support measures from patients in a persistent vegetative state are discussed separately. These matters would not fall within the general authority, since they are neither treatments nor do they safeguard or promote the patient's health.

5.22 In our discussion paper[1] we noted that many jurisdictions had recently introduced new legislation or practices to ensure that certain treatments on incapable patients had to be agreed by a court or similar body before they could be given. Examples include sterilisation (England and Wales, Germany, Victoria), abortion (Victoria) and any treatment carrying a risk of death or severe injury (Germany). Since our discussion paper was published the Parliamentary Assembly of the Council of Europe has published a recommendation[2] inviting the Committee of Ministers to adopt a recommendation on this subject based on rules designed to guarantee respect for the human rights of psychiatric patients. The rules deal, among other things, with "lobotomies" and electro-convulsive therapy. In Scotland there is no statutory or common law requirement that certain treatments require the consent of a court or similar body.

5.23 The justification for involving the courts or some similar body is that the specified treatments are controversial. The need for such treatment should be examined in a public forum where opposing views can be presented and evidence tested and evaluated. The decision to use such treatment should not simply be left to the doctors and the patient's family; there is a public interest in monitoring the use of such treatments and protecting those unable to protect themselves. In our discussion paper we were of the opinion that merely appointing a tutor-dative or some other proxy to consent to the treatment was insufficient, at least without procedure to ensure proper consideration and debate[3]. We proposed that a treatment prescribed by the Secretary of State should require the consent of a court before it could be carried out on an incapable patient (except in an emergency), and that the prescribed treatments should include sterilisation (other than for therapeutic reasons), abortion, electro-convulsive therapy, psychosurgery and the implantation of foetal tissue[4]. Views were invited on whether any other treatments should be specified. Our proposal was supported in principle by all those who commented. We have no hesitation in adhering to it. There are certain treatments or procedures which involve questions of value, fundamental human rights and social policy rather than mere medical views.

5.24 **Sterilisation.** There was no dissent about including sterilisation as a prescribed treatment requiring authorisation by a court. In the last few years some tutors-dative have been appointed to consent to the sterilisation of incapable women (other than for treatment of a medical condition)[5]. Some concern was expressed at the vagueness of our proposed exclusion of therapeutic sterilisations and it was suggested that more precision was necessary in describing the class of sterilisations that should not be required to be authorised by a court. Although sterilisation is normally thought of in terms of female sterilisation the same issues arise for male sterilisation. Since *Re F (Mental Patient: Sterilisation)* there have been cases in England and Wales where a declaration by the High Court was held unnecessary to authorise a hysterectomy because the patient suffered from heavy painful menstrual periods[6]. The hysterectomy was held to be a necessary operation for therapeutic purposes. The distinction we had in mind in using the term therapeutic was between sterilisations for avoidance of possible pregnancy or other social reasons and those to cure an existing disease of the reproductive organs. The distinction between therapeutic and non-therapeutic is not an easy one to draw and has been stated to be likely to lead to an arid semantic debate[7]. We conclude that focusing on treatment of an existing serious malfunction or disease would exclude those cases which should be allowed to proceed without prior authorisation by the court. Accordingly we recommend that:

59. Sterilisation of an adult incapable of consenting to it should require prior authorisation by a sheriff, unless the procedure is to be carried out to treat an existing serious malfunction or disease of the adult's reproductive organs.

Clause 37(4)(c)

5.25 **Electro-convulsive therapy.** Our proposal that electro-convulsive therapy (ECT) should require authorisation from the court before being carried out on a patient incapable of consenting to it was criticised by many respondents. Many medical commentators pointed out that ECT is a well-established, effective and safe treatment that has no irreversible effects when used in accordance with modern procedures. The Mental Welfare Commission said that there was no evidence that ECT causes any long-term tissue damage but it may impair past memories. It considered that it should be regarded as a serious treatment requiring a second opinion. On reconsideration we would agree that ECT should not require prior court approval. It would be anomalous if ECT for incapable informal patients required court approval while a second opinion was sufficient for detained patients[8]. Moreover, ECT is so frequently used that requiring court approval would

1. Para 3.24.
2. Recommendation 1235 (1994).
3. Para 3.25.
4. Proposal 22, para 3.28.
5. *D Petr* and *G Petr*: Adrian Ward *Tutors to Adults: Developments*, 1992 SLT (News) 325.
6. *Re E (a minor)* Times Law Reports, 22 February 1991; *Re G F (Medical Treatment)* [1992] 1 FLR 293.
7. *Re B* [1988] AC 199 Lord Bridge at p 205.
8. Under s 98, 1984 Act.

either lead to its use being curtailed or the courts being deluged with applications for approval. However, ECT on incapable patients should, in our view, be subject to some control. The fact that many respondents supported our proposal suggests that there is concern about unregulated use of ECT on incapable patients[1]. We note that section 98(1)(a)[2] of the 1984 Act provides that detained patients who are either incapable of consenting or refuse to consent may be given ECT provided a medical practitioner approved by the Mental Welfare Commission certifies, that having regard to the likelihood of its alleviating or preventing a deterioration of the patient's condition, it should be given. The Scottish Association for Mental Health suggested that if a person needs treatment for mental disorder but is incapable of consenting then he or she should be detained so that the safeguards in the 1984 Act would apply. We think it should not be necessary for incapable patients to be detained before treatment and that it would be better simply to extend section 98 to them. This would be in line with best current practice. The Royal College of Psychiatrists have recommended[3] that detention should be used for those incapable patients who resist being given ECT but that those who passively accept it may either be detained or given ECT after obtaining a second opinion and discussing the situation with the relatives. Extending section 98 would also result in a second opinion being required for drugs for mental disorder if more than three months has elapsed since the patient started taking them. A second opinion should be obtained whether or not the patient resists ECT or the drugs. We recommend that:

60. Section 98 of the Mental Health (Scotland) Act 1984, providing for an independent medical practitioner appointed by the Mental Welfare Commission to certify that electro-convulsive therapy and the giving of medicines for mental disorder for more than three months is an appropriate treatment, should be extended to incapable patients who are not liable to be detained under the Act.

Clause 37(5)

ECT is not mentioned specifically in the draft Bill but would be a treatment that the Secretary of State should prescribe. This is how it is dealt with in section 98 of the 1984 Act.

5.26 **Abortion.** Although there was support on consultation for including abortion in the list of treatments requiring prior court authorisation, we do not now favour this approach. We note that in the English case of *Re G (Mental Patient: Termination of Pregnancy)*[4] it was decided that a declaration from the High Court was not necessary for abortions because the Abortion Act 1967 contains appropriate safeguards. We agree with that general approach. There is also the practical considerations that abortion will generally have to be performed within a certain period. If court authority had to be sought the procedures for obtaining it would have to be speedy or (as we proposed in the discussion paper) there would have to be an exclusion for those abortions which were urgently necessary on medical grounds. Proper consideration of an application for authority to terminate a pregnancy with discussion of all the issues and alternatives is not likely to be consistent with speedy procedure. However, whilst we do not think that court authority should be required we think that some extra safeguard would be justifiable in the case of women incapable of consenting. We consider that the second opinion procedure recommended for electro-convulsive therapy and long term medication for mental disorder should be applied. We accordingly recommend that:

61. The termination of a pregnancy of a woman incapable of consenting to termination should be carried out only if it would be lawful under the Abortion Act 1967 in the case of a consenting patient and an independent medical practitioner appointed by the Mental Welfare Commission certifies that termination is appropriate.

Clause 37(5)(b)

5.27 **Psychosurgery.** Psychosurgery may at present be carried out on patients liable to be detained under the 1984 Act only if they are capable of consenting to it[5]. As far as non-detained incapable patients are concerned it is possible that psychosurgery could be performed on the basis of the doctors' common law authority (if the decision in *Re F (Mental Patient: Sterilisation)* were to be followed in Scotland) or the consent of a tutor-dative. In practice doctors would not perform psychosurgery on incapable patients without some specific authority and we doubt whether the court would appoint a tutor-dative for this purpose. In our discussion paper we considered that a prohibition on psychosurgery for incapable patients seemed too absolute and proposed that the treatment should be able to be carried out with the court's approval[6]. Since our discussion paper there have been a small number of operations carried out in Scotland; some on detained patients, the others on non-detained patients, all of whom have consented to such treatment.

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1. The recommendation of the Parliamentary Assembly of the Council of Europe mentioned in para 5.22 above suggests that ECT (and lobotomies) should require (a) the consent of the patient or a person chosen by him as his representative and (b) confirmation of the decision by a committee not composed exclusively of psychiatric experts. This seems unduly restrictive but it illustrates the concern felt on this topic.
2. In conjunction with the Mental Health (Specified Treatments, Guardianship Duties etc) (Scotland) Regulations 1984, SI 1984/1494, reg 3(2).
3. *The Practical Administration of ECT*, 1989.
4. Times Law Reports, 31 January 1991.
5. S 97. A medical practitioner appointed by the Mental Welfare Commission has to certify that the patient understands the nature and likely effects of the operation and consents to it and the patient's understanding and consent also has to be certified by two lay people appointed by the Commission.
6. Proposal 22, para 3.26.

5.28 The only dissent on consultation was from the Scottish Association for Mental Health. In its view if a person needs treatment for mental disorder and cannot consent to it because of mental incapacity, then he or she should be compulsorily detained in hospital and treated under the provisions of Part X of the 1984 Act. Compulsory detention under the 1984 Act would not advance matters in the case of psychosurgery, however, because in terms of section 97 a detained patient's consent is required. If the Association's comment is to be taken to mean an absolute prohibition of psychosurgery for all incapable patients then we would disagree. Those who are so profoundly mentally disordered that they are incapable of consenting to psychosurgery may well include patients who would most benefit from the operation. The operation should however never be performed on those who oppose or resist it. We note that a similar view has been expressed by a Scottish Office Good Practice Group (Chairman, Dr David Nichols) in its draft *Neurosurgery for Mental Disorder* report published in September 1994. New South Wales has recently enacted legislation[1] allowing psychosurgery to be carried out on incapable patients if a review board and the court approve. We have already noted the recommendation of the Parliamentary Assembly of the Council of Europe on this subject[2]. We recommend that:

62. Psychosurgery should be able to be carried out on a patient incapable of consenting to it (whether or not detained under the Mental Health (Scotland) Act 1984) but only if the court authorises it and the patient does not resist it.

Clause 37(4)(b)

5.29 **Other treatments.** We proposed that the implantation of foetal tissue into mentally incapable patients' brains should require authorisation from the court. While the majority of those responding agreed, some queried this treatment's inclusion as it was neither particularly risky nor posed ethical problems as far as the mentally incapable recipient was concerned. The controversy over its use is whether it is ethical to use material from foetuses for any patient. This ethical issue is not one which it is appropriate to address in this report.

5.30 In putting forward our proposal that certain treatments should require prior authorisation from the court we asked for views on what treatments should fall into this category besides sterilisation, psychosurgery, electro-convulsive therapy, abortion and implantation of foetal tissue[3]. Other treatments suggested by respondents included:

(a) long term contraception

(b) cosmetic surgery

(c) psychotropic drugs

(d) withdrawal of nutrition and hydration from a patient in a persistent vegetative state

(e) removal of teeth for biting

(f) continuation or withdrawal of narcotic drugs from mentally disabled addicts

(g) hormonal treatment for patient's libido

(h) physical restraint in connection with behaviour modification.

We have recommended earlier that giving drugs for the treatment of mental disorder for more than three months should require a second opinion[4]. We do not think that giving such drugs for a shorter period should warrant a second opinion, much less prior approval by the court. Hormonal treatment for the patient's libido given by means of an implant is governed by section 97 of the Mental Health (Scotland) Act 1984 and requires the patient's consent in the same way as psychosurgery[5]. We consider implant treatment should be available to incapable patients in the same way as we have recommended for psychosurgery[6]. Hormonal treatment given by injection or orally requires a second opinion under section 98 of the 1984 Act if the treatment extends for more than three months and we consider this should remain the position for detained patients and have recommended that section 98 be extended to informal incapable patients[7]. Withdrawal or withholding of life-support measures from incapable patients, such as those in a persistent vegetative state, is a complex and sensitive subject which we discuss at length later[8]. Long term contraception, cosmetic surgery, removal of teeth for biting and the withdrawal or continuation or narcotic drugs from incapable adults are not in our view sufficiently exceptional or problematic to warrant court involvement. However, the Secretary of State should be empowered to make

1. Mental Health Act 1990.
2. See footnote 2 to para 5.25 above.
3. Proposal 22(2), para 3.27.
4. Recommendation 60, para 5.25.
5. The Mental Health (Specified Treatments, Guardianship Duties etc) (Scotland) Regulations 1984 (SI 1984/1494), reg 3(1).
6. Recommendation 62, para 5.28.
7. Recommendation 60, para 5.25.
8. See paras 5.77-5.86.

regulations varying the list of prescribed treatments that require either prior court authority or a formal second opinion from an independent specialist. This would enable other treatments to be added to those we recommend if that was thought appropriate. We recommend that:

63. (1) Hormonal treatment for the patient's libido by means of an implant should be carried out on an incapable patient only if a court authorises it and the patient does not resist it.

(2) The Secretary of State should have power to make regulations prescribing other treatments which should require court approval or a second opinion.

Clause 37(4)(a), (5)(b)

5.31 Enable in responding to our proposal was concerned lest restraint and detention could be justified as treatment or therapy. The Centre for Studies in Mental Handicap also mentioned behaviour modification programmes as a possible special treatment requiring authorisation from the court. We consider that the general authority we recommend above for health care professionals should not include such action. If detention or forcible treatment is considered appropriate then the 1984 Act should be used. There should be an exemption to cover cases where forcible detention is necessary to avert serious harm to the patient. This should be a temporary power to be used in urgent situations, where there is no opportunity to use even the emergency detention provisions in the 1984 Act.

5.32 We recommend that:

64. The general authority to treat so as to safeguard and promote health in Recommendation 58 should not authorise restraint or detention of an incapable patient, except where urgently necessary to prevent serious harm to that patient.

Clause 37(3)(a)

5.33 In our discussion paper we saw a role for the courts in adjudicating disputes as to medical treatment for incapable patients, although we hoped that litigation would be rare. While the court is dealing with the dispute patients should be given treatment necessary to keep them alive and in a stable condition. Obviously once the court has come to a decision doctors should not be entitled by virtue of our recommended general statutory authority to take any action which is inconsistent with that decision. We recommend that:

65. Where a court has made a decision relating to the medical treatment of an incapable patient, doctors should not have any authority by virtue of Recommendation 58 to take any action that would be inconsistent with the court's decision. Pending the determination of an application to the court in relation to medical treatment doctors should have authority to give treatment necessary to save the patient's life or prevent a serious deterioration in his or her health, unless the court orders otherwise.

Clause 37(3)(b), (6) and (7)

Role of guardians and welfare attorneys in medical treatment decisions

5.34 Under our recommendations guardians and welfare attorneys could be appointed with powers in relation to personal welfare including medical treatment[1]. The question then arises as to what effect a decision by a guardian or attorney should have on treatments, other than those which require authorisation by the court or fall within Part X of the 1984 Act[2]. In practice it is the effect of a refusal of consent or a withholding of consent to treatment that is of greater legal significance. Neither a guardian nor an attorney can demand treatment that doctors are unwilling to provide on clinical grounds. The general statutory authority which we recommend would authorise doctors to give reasonable treatment in the circumstances and in arriving at a decision on treatment the doctors would be obliged under the general principles where reasonably practicable to consult any guardian or attorney.

5.35 We considered two options in relation to guardians[3] and attorneys[4] in our discussion paper.

(1) Doctors should be required to consult the guardian or attorney if aware of his or her existence in so far as it is reasonably practicable to do so. The views expressed should have to be taken into account.

(2) Doctors should be required to consult the guardian or attorney in so far as it is reasonably practicable to do so. If the guardian or attorney refuses to consent to the proposed treatment the doctors would be in the same position as if a competent patient had refused consent. Where the guardian or attorney could not be contacted or declined to

1. See Parts 6 and 3 respectively.
2. Consent by the guardian or attorney would be ineffective to authorise such treatments. They require court authority or a second opinion from an independent practitioner. See paras 5.21 to 5.30.
3. Para 3.15.
4. Paras 5.110 to 5.118 and Proposal 78(2), para 5.119.

express any view the doctors could proceed to give treatment which seemed to them clinically appropriate. Faced with a refusal to consent by the guardian or attorney doctors would have to apply to the court for authority to treat and, pending the determination of the application, should have authority to give treatment which was urgently necessary to save the patient's life or prevent serious deterioration in his or her health.

We consider the options in relation to guardians first before turning to welfare attorneys.

5.36 Consultation revealed a division of opinion. The arguments in favour of the first option are that no person should be entitled by refusing or withholding consent to veto clinically appropriate treatment proposed for an incapable adult patient, and that it enables doctors to disregard the views of an ill-informed or prejudiced guardian. It recognises the medical expertise of doctors. We were told that some of the most difficult cases are those where there is a division of opinion within the incapable patient's family as to what treatment should be provided. Giving the guardian a veto would encourage one relative to apply to become a guardian so as to impose his or her own views on the rest of the family and the doctors.

5.37 On the other hand, the guardian would have been appointed by the court after checks as to suitability and may indeed have been appointed specifically with power to take medical treatment decisions. Such a guardian ought to be more than a mere consultee - one whose views have merely to be taken into account. Strong minded or zealous doctors could simply go through the motions of consulting the guardian and taking account of the views without really doing so. The second option, which is that which applies to parents as guardians of their young children, is arguably a more suitable model for the guardians of incapable adults. However, parents have an enormous and continuing psychological and emotional interest in their children's welfare; the same will not necessarily be true of guardians of adults. Another argument against giving guardians a veto is that they are unlikely to be experienced in making difficult medical decisions in times of stress and, if the guardian was also a near relative, he or she might be too emotionally involved to make a sensible decision. Doctors, on the other hand, are more used to this and so it is arguably more appropriate for the final decision to rest with them.

5.38 The courts would be available to resolve any irreconcilable differences of opinion between doctors and guardians. Under the first option in paragraph 5.35 the guardian would have to go to court to have the doctors interdicted from treating the patient. The second option would require doctors who wish to treat despite a refusal of consent by the guardian to seek authority from the court to proceed. While litigation may have to be used for major cases, legal proceedings should not be the only or main "tie breaker" between doctors and guardians. Our preferred solution, which has evolved from discussions with representatives of some of the Royal Colleges in Scotland[1], lies between the two options outlined above, although it is somewhat closer to the first option. If no agreement can be reached between the doctors and the guardian as to the adult's treatment the doctors should have no authority to proceed until they have obtained a second opinion from an independent consultant skilled in that treatment. The consultant should have to be sought from a unit other than the one which the patient was in, should have to examine the patient, read the case notes and give the guardian an opportunity to discuss matters. Only if the independent consultant was of the opinion that the treatment was clinically appropriate and should be given considering all the circumstances should the doctors have authority to proceed. We understand that it should be possible to obtain such a second opinion within a day or so at the most, even in areas away from the main centres of population. Nevertheless, provision needs to be made for necessary treatment pending the obtaining of the second opinion. We consider that once the second opinion procedure has been initiated doctors should then be entitled to give any treatment necessary to save the patient's life or prevent any deterioration in the patient's health unless a court orders otherwise. This entitlement should last until the independent consultant's opinion is known.

5.39 Summing up the previous paragraphs we recommend that:

66. (1) The general statutory authority to give reasonable treatment in Recommendation 58 should not apply where the doctors are aware that the patient's guardian refuses to consent to the treatment in question. The doctors may proceed with treatment to which the guardian has refused consent only if they obtain an opinion from a consultant from a different unit skilled in that treatment to the effect that it is in all the circumstances (medical and non-medical) an appropriate treatment.

(2) In order to safeguard the patient's health until the opinion is obtained, doctors should have authority to give treatment necessary to save the patient's life or prevent any deterioration in his or her condition once the second opinion procedure has been initiated, unless a court has ordered otherwise.

Clause 38

1. The Royal College of Physicians of Edinburgh, The Royal College of Physicians and Surgeons of Glasgow and the Scottish Division of the Royal College of Psychiatrists.

5.40 We turn now to consider the role of an attorney with powers in the field of medical treatment. The options are the same as for guardians set out in paragraph 5.35. Briefly, the attorney would either have to consent to treatment or simply have his or her views taken into account. In our opinion the arguments for requiring the attorney's consent seem less strong than those in relation to guardians. The document of appointment may have been drawn up many years previously or it may have conferred power to make medical treatment decisions without any real thought about the circumstances that the patient is now in. The person selected as attorney may no longer be appropriate to take such decisions because he or she may have ceased to be closely involved with the patient or may have acquired a material conflict of interest. A person who wished to ensure that he or she would not be subjected to certain treatments when incapable could do this by means of an advance statement[1]. However, we do not consider that an attorney's position is so much weaker than that of a guardian to justify a different regime. We would therefore adopt the second opinion provisions recommended in the previous paragraph and accordingly recommend that:

67. Recommendation 66 should apply to welfare attorneys with powers in relation to the patient's medical treatment as it applies to guardians.

Clause 38

Advance statements

5.41 We turn now to deal with advance statements made by patients while competent concerning their future treatment. An advance statement becomes effective only when the doctors consider that the patient is unable, by reason of mental disorder, to make a decision in relation to the treatment under consideration or is unable to communicate. Advance statements are sometimes referred to as "living wills", "advance directions" or "advance directives". We prefer the term "advance statement": "living will" is confusing and uninformative and "advance directions" or "advance directives" implies that a person can direct certain treatment to be given, which is not the case. Many patients will simply set out in general terms their wishes and views in relation to future treatment. An advance statement may be self-contained or form part of a document such as a welfare power of attorney. In drawing up our recommendations in this area we have derived great benefit from discussions with the Law Commission for England and Wales and from having an observer on a Working Party which has drafted a code of practice in this area[2].

5.42 As we mentioned in the previous paragraph some advance statements merely set out the patient's views or wishes as to future treatment in a general way. The general principles which we have recommended in Part 2 of this report require doctors in considering what treatment to give to have regard to the past and present wishes and feelings of the patient. No further recommendations are required to deal with such "advisory" advance statements. Advance statements which consent in advance to future treatment are also adequately dealt with by our earlier recommendations in terms of which doctors and other health care professionals are to have a general statutory authority to treat incapable patients so as to safeguard or promote their health[3]. An advance consent would add nothing to this recommended authority, although it could be helpful as an indication of the patient's wishes and feelings. We have also recommended[4] that the general statutory authority should not apply to certain specified treatments such as sterilisation, psychosurgery or abortion. However, such specified treatments would be authorised if the prior authority of a court or, in certain cases, a confirmatory second opinion from an independent specialist was obtained. The patient's advance consent should not remove the need for involving the court or the second opinion specialist. A competent patient cannot demand to be given treatment which the doctors consider to be clinically or ethically inappropriate. Patients should not be able to use advance statements to demand such treatment in the future either. The advance statements which do give rise to legal problems are those which refuse clinically and ethically appropriate treatment. This is because of the clash between the patient's refusal and the doctor's duty of care in terms of which liability to criminal and civil proceedings may arise from failure to give adequate treatment. The paradigm case is the Jehovah's Witness who refuses blood transfusions in any circumstances even if death is the result of the transfusion not being given. In the rest of this section we therefore confine the discussion to advance refusals.

5.43 We did not deal explicitly with advance statements in our discussion paper but mentioned their use in other jurisdictions in our section on welfare attorneys. Since our discussion paper was published in 1991 there have been cases in England and Wales which have considered the effect of advance refusals. *Re T (Adult: Refusal of Treatment)*[5] concerned a pregnant woman injured in a car accident. After discussion with her mother, a Jehovah's Witness, she said she did not want a blood transfusion. Subsequently she signed a form refusing to consent to a blood transfusion but it was not explained to her that a transfusion might be necessary to save her life during or after the emergency Caesarian delivery that was to take place. Her condition deteriorated so that an emergency application was made to the court for a declaration that a blood transfusion would be lawful. This was duly given and the Official Solicitor as guardian *ad litem* for the patient later appealed. The Court of Appeal decided that the refusal was made without proper appreciation of the consequences

1. See Recommendation 68, para 5.50.
2. See para 5.46 for further details.
3. Recommendation 58, para 5.17.
4. Recommendation 58(3), para 5.17.
5. [1993] Fam 95.

and as a result of her mother's undue influence. It could therefore be disregarded. The right of capable patients to make decisions about their future treatment was upheld, even if the effect of the decision is that the patient will die. However, as Lord Donaldson said:[1]

> "If the factual situation falls outwith the scope of the refusal or if the assumption upon which it is based is falsified, the refusal ceases to be effective. The doctors are then faced with a situation in which the patient has made no decision and, he by then being unable to decide for himself, they have both the right and the duty to treat him in accordance with what in the exercise of their clinical judgment they consider to be his best interests".

Dicta in the subsequent case of *Airedale NHS Trust v Bland*[2] confirm the position regarding a patient's directions including the condition that doctors should ensure that the directions can be properly regarded as applicable in the circumstances that have occurred.

5.44 In *Re C (Adult: Refusal of Medical Treatment)*[3] a man with a gangrenous leg sought an injunction against the hospital to prevent it from amputating his leg. He refused consent when capable of doing so and wished effect to be given to that refusal should he subsequently become incapable. It was held that the High Court could rule by way of injunction or declaration that an individual is capable of refusing or consenting to medical treatment and could also determine the effect of a purported advance directive as to future medical treatment. The test of capacity is whether the patient sufficiently understands the nature, purpose and effect of the proposed treatment and the effect of an anticipatory refusal of treatment in the future. This test was satisfied in C's case and the injunction was granted.

5.45 The House of Lords Select Committee on Medical Ethics[4] commended the development of advance directives since their preparation could stimulate discussion between doctors and patients and the directives would assist the health-care team at the appropriate future date[5]. However, they concluded that legislation was unnecessary since in their view a doctor who acted in accordance with an advance direction would not be guilty of negligence or any criminal offence[6]. They recommended instead that a code of practice should be drawn up jointly by the professional organisations involved in order to assist their members[7].

5.46 The current law in England and Wales that an advance refusal is binding is qualified by the further rules that the factual situation facing the doctors must be within the scope of the refusal, the assumptions upon which it is based must not be falsified, and the patient must have been capable at the time of making the refusal. This may well also be the law in Scotland although it is not possible to state this with certainty in the absence of any authoritative statements by the courts. We consider that legislation setting out the position in Scotland regarding advance refusals would be helpful to doctors and other health-care professionals facing the difficult decision as to what, if any, treatment to give to incapable patients who have refused some or all treatment in advance. Any legislation will, however, require to be supplemented with further guidance in a code of practice or similar document. Following a recommendation from the House of Lords Select Committee on Medical Ethics a Code of Practice *Advance Statements about Medical Treatment*[8] was produced by the British Medical Association in collaboration with the Royal College of Physicians, the Royal College of Nursing and the Royal College of General Practitioners.

5.47 Should an advance refusal have to be in writing and if so should any special formalities have to be observed? In England and Wales an oral advance refusal is regarded as effective and the same is probably true in Scotland. It has to be recognised that there are dangers in relying on oral refusals. First, the doctor may not remember the precise terms of the refusal at the time when the treatment decision is being made. Second, the oral statement may well have been made to a person other than the treating doctor because of duty rotas and patients being moved to different parts of the hospital for different aspects of their treatment. Without some form of writing, even in the patient's case notes or records, it would be difficult to ensure that the treating doctors were aware of the terms of the oral advance refusal. Finally, the act of writing down an advance refusal focuses the patient's mind and helps the patient to set out the terms of the refusal in a more precise and hopefully more helpful way. However, we have come to the conclusion that there should not be undue formality in this area and that to insist on writing may deny effect to the undoubted wishes of a patient. Suppose, for example, a patient in a hospital made a clear and explicit refusal orally to a doctor in the presence of others. Clearly legal effect should be given to such a refusal in line with the patient's expectations. While we consider effect should be given

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1. At p 114.
2. [1993] AC 789.
3. [1994] 1 All ER 819.
4. Their report was published in 1994 as HL Paper 21-I.
5. Report, para 263.
6. Report, para 264.
7. Report, para 265.
8. Published April 1995.

to clear oral refusals we would encourage patients who wish to make advance refusals to do so in writing. The task of making a written refusal could be simplified by the provision of printed forms in which blanks could be filled in or boxes ticked.

5.48 An advance refusal of appropriate treatment will involve a clash between the doctor's duty of care to the patient and the patient's own wishes. We understand that some doctors tend to treat even if the treatment will not increase the patient's quality of life. In some cases this is done for fear of being sued for negligence. Other doctors have a conscientious objection to withholding treatment, particularly life saving treatment[1]. We would reject the notion that doctors should regard advance refusals as advisory and simply take them into account in deciding how to treat incapable patients. The principle of patient autonomy requires more weight to be given to the wishes of patients. The present law in England and Wales and probably also in Scotland is that (under certain conditions and with certain exceptions) an advance refusal is binding and not merely advisory. It would be a retrograde step to recommend giving advance refusals a lesser status than they currently enjoy. We start from the accepted position that a competent patient is entitled to refuse any treatment, even if the result is death[2]. Respect for patient autonomy demands in our view that they should in general be entitled to refuse in advance treatment that may be offered to them at a future date when they are incapable, and that the refusal should have the same effect as that of a competent patient in relation to present treatment. Put another way, an advance refusal of treatment made when capable should survive any subsequent loss of capacity in much the same way as we have recommended for welfare attorneys[3]. The general authority of doctors to treat incapable patients which we have previously recommended should not apply in the face of an advance refusal. It therefore follows that a doctor should be protected from any criminal, civil or disciplinary liability if he or she withheld treatment in accordance with an advance refusal which he or she reasonably believed was valid and applicable, but should be liable if he or she gave treatment which had been validly refused in advance. Although this should be the norm there are certain conditions and certain treatments where a different approach should be taken. These are discussed further below.

5.49 Our recommendation that an advance refusal should be binding rather than merely advisory is made on the assumption that the refusal was validly made by a patient with capacity to do so. Capacity entails understanding the nature of the refusal and the likely consequences, in broad terms at least, for one's health and well-being of accepting or refusing the treatment in question. Capacity is presumed so that the onus would be on those seeking to deny effect to the refusal to rebut the presumption. Undue influence should also be an invalidating factor. If it could be established, as in *Re T (Adult: Refusal of Treatment)*[4], that the patient had been unduly influenced by others in making the advance refusal, then the refusal should not be treated as binding.

5.50 We recommend that:

68. (1) Legislation should be introduced making it clear that, subject to certain exceptions dealt with in Recommendations 69 to 73, a valid refusal made by a competent patient of treatment that may be offered in the future when he or she is not mentally capable should have the effect that doctors have no authority to give the treatment in question.

(2) Doctors should not be liable for withholding treatment in accordance with a refusal which they reasonably believe was validly made and is applicable in the circumstances, or for giving treatment contrary to the terms of a refusal that they reasonably believe is neither valid nor applicable.

(3) A refusal should be effective whether it is in writing or oral. A written refusal should have to be signed by the patient but should not have to be witnessed or made in any particular form.

Clause 40

5.51 An advance refusal should have to apply to the treatment in question and to the circumstances in which the patient finds himself or herself before it is regarded as having binding effect. It will be a question of construction in each case whether these two criteria are met. In some cases, like the absolute refusal of a Jehovah's Witness to have a blood transfusion in any circumstances, the terms of the advance refusal admit no doubt. But a refusal of cardiopulmonary resuscitation "should I become severely demented" will require the patient's present condition to be assessed to see whether it amounts to severe dementia. Another problem of construction would arise where the refusal referred to specified treatments for a particular condition, but due to advances in medicine the doctors were proposing to use a somewhat different treatment. Drafting refusals in more general terms could avoid such problems.

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1. The British Medical Association's Code, *Advance Statements about Medical Treatments*, pp 35 and 36 advises that in such circumstances doctors should hand over the treatment of the patient to colleagues. If this is not possible they must comply with a valid refusal.
2. Patients who are detained under the 1984 Act can be compulsorily treated for their mental disorder, see para 5.56.
3. See para 3.5.
4. See para 5.43 above.

Exceptions to binding nature of advance statements

5.52 **Radical change in circumstances.** Even if an advance refusal was validly made and is applicable to the circumstances that exist we consider that there are still situations where doctors should be entitled to treat notwithstanding the refusal. Doctors can discuss treatment with a competent patient so that any refusal of treatment will have been made in the knowledge of the consequences. Doctors faced with an advance refusal made by a now incompetent patient have no opportunity for dialogue. There may have been substantial advances in medical treatment since the refusal was made. An example which was cited to us is a refusal of renal dialysis by a Jehovah's Witness because this used to involve periodical blood transfusions. Now there is a drug, erythropoetin, which makes transfusions unnecessary. Patients may find themselves in vastly different circumstances from those existing when they made the advance refusal. It is not easy for individuals to foresee how they are going to think and feel about treatments when their condition may be radically different in the future. Ill people often make different treatment decisions from those who are in good health. For example, a single man who enjoys sport might make an advance refusal of antibiotics and other life-saving treatment if he were to become confined to a wheelchair by physical disability. Should doctors years later when he is indeed in that condition but married and with dependent children be bound not to treat pneumonia which has rendered him incapable of reconsidering his old refusal?

5.53 In some such cases we consider that the balancing of patient autonomy and the medical duty of care should result in doctors being allowed to treat notwithstanding a valid and applicable advance refusal. A radical change in circumstances ought to be regarded as destroying the basis on which the refusal was made. The patient's medical condition should not be regarded as such a circumstance because many advance statements are made for the very purpose of dealing with changes in medical condition. Encouraging people to review their advance refusals from time to time may help prevent such problems, but inevitably some will not have followed this advice. We would not base an exclusion on a material change of circumstances alone since what matters is the effect, or presumed effect, of such a change on the patient's intentions. We prefer to use the formula of whether there is reason to believe that the patient would have changed his or her mind in the light of the new conditions and would now accept the treatment. This formula also allows doctors to take account of indications from the patient falling short of revocation of the refusal, or statements by others of what the patient said or did while still competent which indicate a change of mind. We note that the Council of Europe's draft[1] Bioethics Convention adopts a cautious approach to this question. Article 9 provides that:

> "The previously expressed wishes relating to a medical intervention by a patient who is not, at the time of the intervention, in a state to express his wishes shall be taken into account."

The Parliamentary Assembly has since adopted an Opinion which rejected an amendment which would make previously expressed wishes "determinant"[2]. We therefore recommend that:

69. Doctors should be entitled to disregard a valid and applicable advance refusal if, by reason of a material change of circumstances since the refusal was made (other than a change in the patient's medical condition), they reasonably believe that the patient if competent would now accept the treatment in question.

Clause 40(6)

5.54 **Life-saving treatment.** The public interest in preserving the life and health of citizens does not prevent a competent patient from refusing life sustaining treatment but any doubt is to be resolved in favour of the preservation of life[3]. Refusal of treatment that could save the patient's life is such a serious matter for all concerned that we think the patient should be required to make it clear that the refusal is still to apply even in such circumstances. The reference to death need not be express so long as the maker's intention is clear. A refusal of blood transfusions in any circumstances would obviously include the case where failure to give a transfusion would result in the patient's death. We recommend that:

70. An advance refusal of treatment which if not given would endanger the patient's life should be followed only if the terms of the refusal make it clear that the patient intended the refusal to apply in such circumstances.

Clause 40(7)(a)

5.55 **Basic care.** Some jurisdictions prevent a welfare attorney refusing basic care for the adult such as normal feeding, normal hygiene and relief of severe pain[4]. We would adopt this approach for advance refusals. It would be contrary to public policy and the interests of other patients in the hospital or other institution if doctors, nurses and other health-care professionals were obliged to neglect patients to such an extent that they were left filthy or in agony. The provision of food and drink which is available for consumption by the patient in a normal fashion is not something which could be

1. Draft of July 1994. The full title of the draft is the "Draft Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the application of Biology and Medicine: Bioethics Convention".
2. Opinion No 184 adopted by the Assembly on 2 February 1995.
3. *Re T (Adult: Refusal of Treatment)* [1993] Fam 95 at p 112.
4. Uniform Rights of the Terminally Ill Act (America): Durable Power of Attorney Health Care Act 1983 (California).

refused by an advance statement because it is not a medical treatment. The question of withholding nutrition and hydration by naso-gastric tubes or other artificial means from patients will be dealt with later[1]. We recommend that:

71. An advance refusal should be ineffective to the extent that it refuses normal hygiene or the relief of severe pain.

Clause 40(7)(b)

5.56 **Detained patients and treatment of mental disorder.** Patients who are detained under the 1984 Act may be treated for their mental disorder against their will. Section 103 permits treatment for mental disorder to be given without a patient's consent provided the treatment is given by or under the direction of the responsible medical officer. Section 98 authorises electro-convulsive therapy and drugs for more than three months if a second opinion specialist certifies that it would be appropriate in the circumstances. It has to be accepted that detention, which can be ordered for a mentally disordered person only after certain medical and legal procedures set down in the 1984 Act have been followed, carries with it the possibility of compulsory treatment for mental disorder which cannot be refused by way of an advance refusal. We recommend that:

72. An advance refusal should be ineffective in relation to a detained patient to the extent that it refuses any treatment for mental disorder which under Part X of the Mental Health (Scotland) Act 1984 can be given to the patient notwithstanding absence of consent.

Clause 40(7)(c)

5.57 **Endangering viable foetus.** A woman with a 30 week old foetus who is in a coma following a motoring accident is being fed artificially with the intention of delivering the baby by caesarian section at the due date. There is no argument between the doctors and the husband that she should be treated in this way and no advance statement had been made[2]. In similar circumstances should a woman be entitled to refuse in advance treatment necessary to keep her and her unborn baby alive? This is a very controversial issue. It can be argued that the existence of a foetus should make no difference to the right of a competent woman to decide what treatment she will have in the future. We accept that people may decline future treatment which will endanger their own lives provided they address their minds to this issue, but it seems to us that endangering the life of another adds another dimension the effect of which ought to outweigh patient autonomy. We are fortified in our conclusion by the fact that the majority of states in America limit the effectiveness of advance refusals during pregnancy[3]. Furthermore, in the English case of *Re S (Adult: Refusal of Treatment)*[4] a refusal to consent to a caesarian section by a woman in labour who was capable of making the decision was overruled by the High Court, although it has to be said that this decision has been widely criticised.

5.58 An advance refusal should not be ineffective during the whole of the woman's pregnancy for that would be too great an interference with her autonomy and her right to choose her future treatment. But as we stated in the previous paragraph the policy considerations are different once refusal endangers the life of the foetus. This pre-supposes that the foetus is viable when the treatment is under consideration. The Abortion Act 1967[5] prohibits the abortion of a foetus aged 24 or more weeks save in exceptional circumstances. We would adopt this time limit as the test for viability since the public policy considerations in advance refusals and abortions are similar. We therefore recommend that:

73. An advance refusal of treatment by a female patient should be ineffective to the extent that it refuses treatment which if not given would endanger the life of a foetus, aged 24 weeks or more, which she is carrying.

Clause 40(7)(d)

Revocation of advance statements

5.59 An advance statement once made should be capable of being revoked subsequently by the adult concerned. A revocation would be valid if capacity existed at the time of revocation. We recommended earlier[6] that it should be competent to make an advance statement either orally or in writing signed by the adult. We would adopt the same approach for revocations. The arguments in favour of giving effect to oral revocations seem to be stronger than those for advance statements. A revocation may be made in circumstances where there is little opportunity for writing and there is not the same danger of its terms being misunderstood or mistransmitted to other doctors. We also think it should be competent to empower a welfare attorney to revoke the adult's advance statement. This power should, however, have to be conferred expressly: a welfare attorney with general powers should not be able to override an advance statement. We do not think

1. See paras 5.77 to 5.86.
2. These were the facts of a case reported in The Times, 6 April 1995. Under our recommendations the provision of artificial nutrition and other life-sustaining treatment in such a case would be covered by the general authority already recommended. See Clause 38(1) of the draft Bill. We are assuming that the treatments and procedures adopted would be regarded as "reasonable in the circumstances to safeguard ... the physical .... health" of the woman.
3. T Klosterman, *Analysis of Health Care Directive Legislation in the United States* (1992) p 12.
4. [1993] Fam 123.
5. S 1(1) as amended by s 37(1) of the Human Fertilisation and Embryology Act 1990.
6. Recommendation 68, para 5.50.

that a guardian should be entitled to revoke an advance statement since capable adults ought to be secure in the knowledge that their statements will not be overridden by persons they have not expressly authorised to take such a step. For similar reasons the court should not have power to override by way of an intervention order. We recommend that:

74. An advance refusal should be capable of being revoked by the adult concerned and his or her welfare attorney (if expressly empowered to do so). The revocation may be oral or in writing signed by the person making the revocation.

Clause 40(2), (3)

Organ donation

5.60 Transplantation of a non-regenerative organ (a kidney for example) from a living incapable adult is not treatment to safeguard and promote the health of that adult. Accordingly, it would not fall under the general statutory authority of doctors to provide medical treatment that we have recommended in Recommendation 58 above. As we pointed out in our discussion paper the legality of transplants where the donor is incapable of consenting is not clear[1]. The power of a tutor-dative to consent on behalf of the incapable adult may well be limited to procedures that carry only a minimal risk to the donor such as a skin graft or a blood donation. Suggestions have been made in recent English cases that organ donation from living incapable individuals should require the prior authority of the court[2].

5.61 In our discussion paper[3] we set out the arguments for and against allowing transplantation of non-regenerative tissue from a living adult mentally incapable of giving consent and asked for views as to whether such transplantation should be permitted and, if so, under what conditions. Transplantation to a close relative arguably confers an indirect benefit on the incapable donor. The donor may be distressed by the critical illness of the recipient and the death or serious illness of the recipient may deprive the donor of a carer. Transplantation can also be justified on public interest grounds in alleviating pain and suffering where this can be done without causing substantial harm to others. On the other hand, a mentally disabled person's health and wellbeing is no less worthy of consideration than that of any other person. The temptation to regard incapable people merely as a source of spare parts must be firmly resisted.

5.62 A sizeable minority of those responding to our request for views thought that such transplants should be prohibited altogether. The majority view was that the procedure should be allowable in exceptional cases. Among the conditions suggested were prior approval by the court, the unavailability of a suitable organ from any other source, the unavailability of any alternative suitable treatment, and that the death or continued serious ill-health of the recipient would severely diminish the quality of the donor's life. We have had further discussions with those involved with transplants in practice. We understand that recent advances in surgery and drug therapy to prevent rejection enable successful transplants to be achieved with organs from dead bodies and that transplants from living donors now form only a small proportion of all those undertaken. The British Medical Association's view is that it is not appropriate for "live, non-autonomous individuals to donate non-regenerative tissue or organs"[4]. This prohibition does not seem to result in patients being left untreated. Finally, as far as kidney donation is concerned, transplantation cannot be regarded as involving a minimal or low risk to the donor. We have come to the view that no changes are required in this area.

Medical research

5.63 We turn now to consider medical research using people who are incapable of consenting to take part in it. Our previous recommendation[5] giving doctors and other health care professionals a statutory authority to act to safeguard and promote the health of incapable patients applies only to treatment and not to research. The distinction between medical research and medical practice is not an easy one to make. The distinguishing feature of research is the intention of the doctor. We would adopt the analysis in the report of the Royal College of Physicians of London *Guidelines on the Practice of Ethics Committees in Medical Research involving Human Subjects*, which states[6]:

> "The distinction derives from the intent. In medical practice the sole intention is to benefit the individual patient consulting the clinician, not to gain knowledge of general benefit, though such knowledge may incidentally emerge from the clinical experience gained. In medical research the primary intention is to advance knowledge so that patients in general may benefit; the individual patient may or may not benefit directly".

5.64 The above definition of research includes observational research - seeing how people behave in certain situations, and research using patients' medical or other records. Such research raises issues of confidentiality and privacy and

1. Para 3.60.
2. *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 at pp 33 and 52; *Re W (A Minor) (Medical Treatment)* [1992] 4 All ER 627 at 649 (organ donation by a child).
3. Paras 3.60 to 3.62.
4. *Medical Ethics Today*, para 1:7.1.2.
5. Recommendation 58, para 5.17.
6. Second edition (1990), para 3.1.

therefore requires approval by a local research ethics committee, but because no consent is required from the patients concerned there are no special issues arising in connection with incapable patients. We are therefore content to leave the regulation of such research to the existing regime and exclude it from the ambit of this report.

5.65 There is virtually no authority in Scotland as to the legality of research on people incapable of consenting to their participation. A tutor-dative with appropriate powers could give consent but only a handful of people in Scotland have had tutors-dative appointed to them. The case of *Re F (Mental Patient: Sterilisation)*[1] which justifies treatment of mentally incapable patients without their consent in England and Wales, and which would probably be followed by Scottish Courts, is limited to treatments carried out to save the patients' lives or ensure improvement or prevent deterioration in their physical or mental health, and so could not be used to justify research. We consider that there should be legislative authority and regulation of research on mentally incapable people in place of the present legal near-vacuum.

5.66 In our discussion paper we put forward the ethical case for allowing research to be carried out on people incapable of consenting to their participation[2]. Research adds to medical knowledge and leads to improved treatments or ways of preventing illnesses or diseases or enables the care of the incapable to be improved. Provided the risks to a non-consenting participant are minimal there is a public interest in allowing research to be carried out. Indeed it has been stated that it is unethical to fail to do research since otherwise present and future patients would be deprived of the possibility of better treatment[3]. One or two bodies and a couple of individual respondents were opposed to any research being done on those incapable of consenting, but most agreed with our proposal that research should be allowed provided there were proper safeguards in place to protect participants. We would adhere in principle to our original proposal. Knowledge of the causes or treatment of incapacity may be obtainable only by research on those affected by it and such knowledge, while it may be of little or no direct benefit to the participants concerned, might be of benefit to the incapacitated in general. We note that many bodies connected with medical research support the inclusion of incapacitated subjects in projects[4].

5.67 We proposed in our discussion paper that research on the incapacitated should be lawful providing it was rigorously controlled and subject to strict conditions. Proposal 26 required **all** of the following conditions to be satisfied:

(a) The research was into incapacity of the kind suffered by the subject.

(b) The research entailed only an insubstantial foreseeable risk to the subject's physical or mental health. Views were invited on what should constitute an insubstantial risk.

(c) The research had been approved by the appropriate local research ethics committee.

(d) Written consent had been given by the subject's nearest relative unless the subject had a tutor-dative or personal guardian. The nearest relative should be the first relative reasonably available out of the following list:

  (i) husband, wife or cohabiting partner.

  (ii) an adult child.

  (iii) a parent.

  (iv) a brother or sister.

(e) Where the subject had a tutor-dative or personal guardian whose terms of appointment include power to consent to medical research, written consent had been given by the tutor-dative or personal guardian.

(f) Before seeking consent from a relative, tutor-dative or personal guardian the researchers had explained to him or her the purpose of the research, the procedures to be used and the foreseeable risks to participants.

(g) The subject did not object to participating in the research.

We implicitly assumed that any proposed research would have to be both medically useful and scientifically valid.

5.68 The first condition - that any research should be into incapacity of the kind suffered by the subject - was generally agreed by those responding to our proposal. Sense Scotland, an organisation for the deaf blind, suggested research should

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1. [1990] 2 AC 1.
2. Paras 3.37-3.59 and Proposal 26, para 3.59.
3. Royal College of Psychiatrists Guidelines 1990, p 48.
4. British Medical Association, *Medical Ethics Today* 1993 pp 214-5; Medical Research Council, *The Ethical Conduct of Research on the Mentally Incapacitated* 1991 pp 12-15; Royal College of Physicians of London, *Research Involving Patients* 1990 Recommendations 27 and 32; Royal College of Psychiatrists Guidelines, Psychiatric Bulletin (1990) 14 pp 48-61; Council of Europe, Recommendation of the Committee of Ministers No R(90) 3 of 3 February 1990; The Medicines (Application for Grant of Product Licences - Products for Human Use) Regulations 1993, SI 1993/2538, implements a European Directive (91/507/EEC) which requires compliance with "good clinical practice" in testing medicinal products on people. Earlier guidelines by the European Commission which led to the regulations required the consent in writing of subjects in non-therapeutic studies.

also be allowed into the subject's physical condition. We would not be in favour of medical research being carried out on incapable subjects which could just as well be carried out on those capable of consenting and indeed we now recommend that this should be built into the conditions for research[1]. However, in the case of deaf blind people research into the causes of deaf blindness and ways of communicating with the deaf blind ought to be allowed. The extended meaning of incapacity adopted in this report which includes inability to communicate should meet the concerns of organisations like Sense Scotland, while maintaining the basic condition as to the purpose of the research. One medical organisation considered that the proposed condition was too strict since it would exclude research into Hepatitis B among residents of institutions or research into thyroid diseases in Downs Syndrome people. We do not find the first example a compelling one as there should be plenty of institutions where inmates are capable of consenting which could be used for Hepatitis B research. If there was an outbreak of disease in an institution where there were incapable residents then any investigation would be a public health matter rather than medical research. The second example suggests that a slightly wider formula should be adopted than that we used in our original proposal. We consider that physical symptoms or disorders which may be associated with the potential subject's mental disorder should also be capable of being researched. Medical researchers in subsequent discussions with us indicated that some further categories would be needed to allow much useful research to continue. For example, patients who have undergone major surgery are temporarily incapacitated either as a result of the surgery or drugs for relief of pain. Research into their bodily functions or methods of caring for them in this state is arguably neither research into their incapacity nor into an associated physical disorder. We accept this and consider that research into the care of incapable people should also be permitted. This would allow research into nursing or other methods of looking after the permanently incapacitated as well as temporary unconscious patients.

5.69 The second condition proposed was that the research entailed only an insubstantial foreseeable risk to the subject's physical or mental health. Views were invited on what should constitute an insubstantial risk. We rejected the notion of balancing the risks and discomfort against the likely benefits since that could authorise very harmful experiments where the research was likely to produce substantial advances in knowledge. Our condition was generally agreed and several definitions of insubstantial risk offered. The National Board for Nursing, Midwifery and Health Visiting for Scotland thought that it was inappropriate to further define what constitutes an insubstantial risk as it depended on the research being done and the condition of the potential participants. We agree but would substitute "minimal risk" for "insubstantial risk" as the former seems to be a well understood concept amongst health-care professionals. Minimal risk is regarded as covering a small chance of a trivial reaction or distress and a very remote chance of serious injury or death, comparable to flying as a passenger in a scheduled aircraft[2]. Moreover, our recommendation that any research involving incapable subjects has to be approved by a Scottish Ethics Committee would enable that committee to decide whether in any particular research project the procedures posed more than a minimal foreseeable risk to the participants. The Council of Europe's draft Bioethics Convention[3] refers to medical research where there is a negligible risk and minimal burden for the individual concerned. We think that the reference to minimal burden is useful. Research may involve no foreseeable risk but if it is very uncomfortable for the adult concerned, as it would be if, for example, it involved attaching him or her to measuring apparatus in a restrictive way for long periods, then it ought not to be allowed.

5.70 Our third condition was that the research should have to be approved by the appropriate local research ethics committee. This was agreed by all those who were in favour of research being carried out at all on the incapacitated. We now think it would be better to have a Scottish Committee to look at all research on incapable people. Such research raises more ethical issues than comparable research on those able to consent and should be considered by a prestigious national committee. Furthermore, it is often difficult to obtain sufficient incapable people within the area of a local committee, especially as some committees are now constituted on a hospital trust basis rather than a health board basis. Applications may have to be made to many different local ethics committees which may take different views and impose different requirements. A Scottish Committee would assist in promoting a uniform response. We do not see the Scottish Committee as being a complete substitute for the local committees, but it should be the first stage in acquiring ethical approval. The Scottish Committee should consider the research proposal in principle. It may thereafter be necessary to approach local committees for approval of detailed aspects, such as the content of information sheets to be given to those consenting on behalf of the incapable participants. In order to avoid delay in gaining approval of small scale single hospital studies the Scottish Committee should be able to delegate some matters to local committees and issue guidelines. Provided the proposed project was within the area dealt with by the guidelines it would be regarded as having the Scottish Committee's approval and therefore should only require submission to the appropriate local committee.

5.71 The Scottish Committee should be set up by the Secretary of State for Scotland. To that end the Secretary of State should have power to make regulations dealing with the composition of the Committee and its procedures. Members of the Committee would be appointed by the Secretary of State. We do not make any detailed recommendations about the composition of the Committee or its procedures as we think that these should be decided by the Secretary of State after

1. Article 6 of the Council of Europe's draft Bioethics Convention (see para 5.53) includes a proviso that "equally effective research may not be carried out on subjects with full capacity".
2. Report of the Royal College of Physicians of London, *Research Involving Patients*, (1990), para 5.11.
3. Article 6. See para 5.53 above.

further consultation. However, we do consider that the Committee should have a substantial lay element in order to allay public concern about research being carried out on a very vulnerable section of the community.

5.72 In our discussion paper we proposed that consent to an incapable person's participation in the research should have to be obtained from his or her tutor-dative, personal guardian or close relative. Where the person had a tutor-dative or personal guardian with powers to consent to research then consent should have to be obtained from that person rather than a close relative. Close relative was defined as being spouse, cohabiting partner, adult child, parent, brother or sister. While all those respondents in favour of allowing research on incapable people were in favour of consent having to be obtained, there was some division of opinion as to the proper source of that consent. Several medical respondents made the point that most potential participants would not have a guardian with power to consent to participation and many do not have close relatives either. Our proposal, it was said, would unduly hamper research particularly into chronic mental disorders. The availability of relatives would be enhanced if the longer list of relatives used in the 1984 Act[1] were to be adopted, as we now think it should, but even so potentially suitable participants would have to be excluded. Among the suggestions made by respondents were that consent should be capable of being given by "an independent other" or a senior nurse or social worker who had known the person for some time and had no involvement with the research. We consider this to be a useful notion. Although "an independent individual who has known the incapable person for some time" is somewhat vague we do not think, given the variety of environments in which potential subjects could be living, specifying holders of posts would be useful. The independence is of vital importance and the individual should be of sufficient standing to be in a position to refuse consent. The Scottish Committee could monitor the types of people who are asked to give consent and could issue guidelines. In deciding whether or not to give consent the independent individual should take account of the past and present wishes and feelings of the incapacitated person in so far as they can be ascertained. Welfare attorneys[2] with suitable powers should also be able to give consent. It should also be competent for capable adults to consent in advance to research being carried out on them when they are incapable.

5.73 Before seeking consent from a proxy (guardian, welfare attorney, relative or independent individual) those conducting the research should be required to explain in readily understandable terms the purpose of the research, the procedures to be used and the foreseeable risks to participants. Once given the consent should be capable of being withdrawn at any time.

5.74 The final condition we proposed for an incapable person's inclusion in a research project was that he or she does not object to participating in the research. This was generally approved but some respondents considered that it suggested that the person was capable of deciding whether to participate. We accept this criticism and would adopt a formula based on unwillingness to participate instead. This would cover those who resisted as well as those who by words or gestures showed that they did not wish to participate.

5.75 In response to our proposal three commentators suggested that research involving incapacitated people should also require prior authorisation from a court in addition to fulfilment of all the other conditions proposed. We disagree; use of the courts is in our view inappropriate and impracticable. Courts are not the appropriate forum to decide on whether a particular research project should be carried out. Such a matter raises issues of medical ethics and the likely advancement of medical knowledge, neither of which the courts have expertise in. Furthermore, the courts would largely duplicate the work of the proposed Scottish Committee. Finally, there would be likely to be a considerable number of applications increasing the workload of already hard-pressed courts.

5.76 Summing up this section we recommend that:

75. It should be lawful to carry out research on an adult who is incapable of consenting to participate only if all of the following conditions are satisfied:

(a) the research is into the causes, treatment or care of the adult's incapacity or associated physical symptoms or disease,

(b) the research entails only a minimal foreseeable risk and minimal discomfort to the adult,

(c) the research could not be carried out equally effectively on subjects capable of consenting,

(d) the research project has been approved by a Scottish Committee set up by the Secretary of State for Scotland in accordance with regulations made by the Secretary of State,

(e) written consent has been obtained from the adult while capable or from the adult's guardian or welfare attorney. Where the adult has no guardian or welfare attorney with appropriate powers written consent should be obtained from the adult's nearest relative as defined in sections 53 to 57 of the Mental Health (Scotland) Act 1984. If the nearest relative is not readily available then written

1. See paras 2.68 to 2.73 for a further discussion of "nearest relative".
2. See Part 3.

consent should be sought from an independent individual who knows the adult well and is not involved with the research. The person from whom consent is sought should be given an explanation of what is involved in the proposed research, and

(f) the adult does not appear unwilling to participate in the research.

Clause 39

Withholding or withdrawing medical treatment

5.77 Advances in medical science have made it possible to keep patients alive by means of various life support systems or treatments although such measures do not improve their underlying condition. The measures may indeed be seen in some cases as only making the process of dying undignified and prolonged[1]. One situation which has been highlighted in recent years is that involving patients in a persistent vegetative state (PVS). PVS patients have an irrecoverably functionless cerebral cortex. They have no consciousness and are unable to think, feel or respond in a meaningful (as distinct from a reflex) way to their surroundings. Although they can breathe and digest naturally they generally have to be fed artificially (by means of a naso-gastric tube or other device) because they lack the swallowing reflex required for normal eating and drinking. With artificial feeding and other appropriate measures PVS patients may live in an insentient state for many years without any hope of recovery.

5.78 We have had the benefit of discussions with Professor Bryan Jennett, an acknowledged expert on PVS and with representatives of some of the Scottish Royal Colleges[2]. It has been made clear to us that PVS patients form only a small fraction of those for whom treatment-limiting decisions have to be made. A treatment-limiting decision may take the form of withholding treatment, for example not giving cardio-pulmonary resuscitation to a patient whose death from cancer is imminent and inevitable; or withdrawing treatment such as ventilation from an accident victim in intensive care where it is clear that no recovery is possible. In *Airedale NHS Trust v Bland*[3] the House of Lords held that there was no absolute obligation on doctors to prolong an incapable patient's life regardless of the circumstances or quality of life. Medical treatment, including artificial nutrition and hydration or antibiotics, could be lawfully withheld from an incapable patient even though the result would be the patient's death, provided responsible and competent medical opinion was of the view that continuing provision was futile and would not confer any benefit on the patient. We fully agree with these statements. However, it is not certain that they represent Scottish law, although it is very probable that Scottish courts would follow the House of Lords since no peculiarity of English law was involved and the case was decided on public policy grounds.

5.79 We have come to the conclusion that it would be helpful to have a new statutory provision which made it clear that under the law of Scotland the doctor's duty of care does not extend to providing treatment to incapable patients which is likely to be of no benefit to them, and that it is not necessarily of benefit to patients to keep them alive as long as possible. Other considerations, such as the quality of life and the peacefulness and dignity of the dying process should also be taken into account, in accordance with current good medical practice. Current good medical practice also involves the doctors consulting with colleagues and the patient's family in so far as it is practicable to do so and taking account of their views. This should continue to be a requirement.

5.80 The general principle that there should be no intervention unless it is likely to provide a benefit to the patient may give rise to doubts where withdrawal or discontinuance of treatment is under consideration. If the intervention is taken to be the discontinuance then a discontinuance which results in the patient's death might not be regarded as something that is likely to benefit the patient. We consider that for the purposes of the operation of the principle the intervention in such circumstances is the continuance of treatment so that if continuing the treatment is futile or unlikely to benefit the patient then it would be in accordance with the general principles to discontinue or withdraw it.

5.81 We recommend that:

76. In order to clarify the position regarding withholding or withdrawing medical treatment from incapable patients in Scotland there should be new statutory provisions to the effect that it should be lawful to withhold or withdraw treatment that in the reasonable opinion of the doctors concerned would be unlikely to benefit the patient. Prolongation of an incapable patient's life regardless of the circumstances should not necessarily be regarded as benefitting that patient.

Clause 41(1), (4) and (5)

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1. In Recommendation 779 (1976) on the rights of the sick and dying the Parliamentary Assembly of the Council of Europe referred (in para 10, II) to the legal dangers for members of the medical profession when they have refrained from effecting artificial measures to prolong the death process in the case of terminal patients whose lives cannot be saved by present-day medicine".
2. The Royal College of Physicians of Edinburgh, The Royal College of Physicians and Surgeons of Glasgow and the Scottish Division of the Royal College of Psychiatrists.
3. [1993] AC 789.

It would follow from the fact that any withholding or withdrawal of treatment in accordance with the new statutory provisions would be lawful that doctors and others making and participating in such decisions would not thereby incur any liability. We think that this clear statutory immunity from criminal, civil or disciplinary proceedings would encourage doctors not to provide futile treatment defensively and would enhance the quality of life for terminally ill patients.

5.82 We would again stress that the general principles which under our recommendations would apply to any intervention under the Act would require regard to be paid to the past wishes of the adult so far as they could be ascertained and to the views of the nearest relative and primary carer in so far as it is reasonable and practicable to do so. The views of any guardian or welfare attorney with relevant powers would also have to be taken into account, in so far as it is reasonable and practicable to do so[1]. We realise that there are situations where it is not possible to obtain any of these views but we believe the draft Bill takes that fully into account. We should add that an advance statement by the adult might apply and might make resort to the statutory authority to withhold or withdraw treatment unnecessary.

5.83 Should the withdrawal of certain life supporting treatments or measures require prior authority from a court? Such a requirement exists, at least as a matter of recommended practice, in England and Wales in relation to PVS patients. The House of Lords in the *Bland* case decided that doctors should for the time being as a matter of practice apply to the High Court for a declaration that withholding nutrition and hydration supplied by artificial means would be lawful[2]. The Official Solicitor has issued a practice note on applications[3]. There should be at least two neurological reports on the patient submitted with the application, one of which will have been commissioned by the Official Solicitor, who is to be invited to act as guardian *ad litem*. The views of the next of kin and the patient's previously expressed views, if any, are very important. The views of a relative opposing withholding treatment are however not determinative[4]. The Law Commission has recommended that this practice should continue but that the Secretary of State should be given power to make regulations in the future which would enable authority to withdraw to be obtained from a duly appointed independent medical practitioner[5]. After careful and prolonged deliberation we have decided against imposing such a requirement.

5.84 The advantage of involving the court is that the decision is being made in an open forum rather than by the doctors and the patient's family in private. There is a public interest in monitoring treatment-limiting decisions which may have fatal consequences and in protecting incapable patients who are unable to protect themselves. Moreover, a declarator that a proposed withholding or withdrawing was lawful would offer complete advance immunity to the doctors and others involved[6].

5.85 On the other hand legal proceedings bring unwelcome publicity and additional stresses to the patient's family and involve much expense. Legal proceedings may be necessary if there is a dispute but if there is no dispute the court will not hear any opposing views and unless it takes a pro-active role will have to proceed on the basis of statements and reports submitted to it in connection with the application. In these cases the courts will have a purely formal role. Another factor that has weighed with us is that the Master of the Rolls in the Court of Appeal[7] and four out of the five judges in the House of Lords[8] suggested in the *Bland* case that applications to the court in every case in England and Wales might be a temporary measure. Once a body of experience and practice had built up, they thought that guidelines could be issued limiting applications to those cases where there was some special need. As we have already noted the Law Commission has recommended that the Secretary of State be given power to introduce an alternative system of authorising withdrawing of artificial nutrition and hydration from PVS patients. It would be a pity for Scotland to follow the present practice in England and Wales only to have to change yet again a few years later. Finally, requiring every treatment withholding or withdrawing decision to have to be ratified by the courts would add considerably to their work load. It seems to us unprincipled to single out PVS patients or other cases which have attracted great publicity as requiring court proceedings, while allowing other equally difficult and harrowing treatment-limiting decisions to be made by doctors and the families of patients and exposing those who make such difficult decisions to the possibility of criminal or other proceedings.

5.86 In exceptional cases, for example, where there is a dispute as to whether treatment should be withheld or withdrawn, or where there is a particularly delicate situation in which the medical team involved feel that an authoritative decision on the legal position is needed before irreversible action is taken, the courts may have to be asked for a declarator. In

1. See Clause 1(4) of the draft Bill.
2. See for example *Frenchay Healthcare NHS Trust v S* [1994] 1 WLR 601; *Swindon and Marlborough NHS Trust v S*, The Guardian 10 December 1994 and Current Law December 1994, 590.
3. The latest version was issued in March 1994.
4. *Re G*, 22 November 1994 (Family Division, unreported). Patient's wife and doctors in favour of withholding, mother against; declaration granted that withholding would be lawful.
5. *Report on Medical Incapacity*, para 6.21. If the patient had a guardian or welfare attorney consent to withholding could be given by them.
6. We understand that an application to the Court of Session in connection with withholding artificial life support measures from a PVS patient in a Scottish hospital has recently been made.
7. [1993] AC 789, 815.
8. Lords Keith of Kinkel, Goff of Chievley, Lowry and Browne-Wilkinson at pp 859, 873, 875 and 885 respectively.

such cases the Court of Session rather than the sheriff courts would be an appropriate forum. The application should have to be intimated to the Lord Advocate who would then have an opportunity to appear representing the public interest. We recommend that:

77. (1) **In difficult and exceptional cases resort to the Court of Session should be possible for a declarator whether a withholding or withdrawing of medical treatment from an incapable adult was or would be lawful or unlawful.**

(2) **Any person claiming an interest in the incapable adult's welfare should be entitled to apply for a declarator and the application should have to be intimated to the Lord Advocate for the public interest.**

Clause 41(3), (6)