
CONSULTATION PAPER

ON

VULNERABLE ADULTS AND THE LAW: CAPACITY

(LRC CP 37-2005)

IRELAND

The Law Reform Commission

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THE LAW REFORM COMMISSION

Background

The Law Reform Commission is an independent statutory body whose main aim is to keep the law under review and to make practical proposals for its reform. It was established on 20 October 1975, pursuant to section 3 of the *Law Reform Commission Act 1975*.

The Commission's Second Programme for Law Reform, prepared in consultation with the Attorney General, was approved by the Government and copies were laid before both Houses of the Oireachtas in December 2000. The Commission also works on matters which are referred to it on occasion by the Attorney General under the terms of the 1975 Act.

To date, the Commission has published seventy one Reports containing proposals for reform of the law; eleven Working Papers; thirty six Consultation Papers; a number of specialised Papers for limited circulation; An Examination of the Law of Bail; and twenty five Annual Reports in accordance with section 6 of the 1975 Act. A full list of its publications is contained in the Appendix to this Consultation Paper.

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INTRODUCTION

Background

1. This *Consultation Paper on Vulnerable Adults and the Law: Capacity* is the second in a series of two consultation papers published by the Law Reform Commission which address the subject of vulnerable groups and the law.¹ The first was the *Consultation Paper on Law and the Elderly* which was published in June 2003.² The *Consultation Paper on Law and the Elderly* made provisional recommendations concerning legal mechanisms for the protection of older people. The recommendations made by the Commission included a new substitute decision-making regime for the appointment of family members and friends to engage in assisted and substitute decision-making where an adult lacks capacity to make a decision. The Consultation Paper also recommended the establishment of an Office of the Public Guardian as a supervisory authority.

2. The focus of the *Consultation Paper on Law and the Elderly* was to make recommendations in relation to older persons. However, the Commission acknowledged that:

“while the improvements we recommend are made with elderly people in mind, they are also relevant to other adults with decision making disabilities or who otherwise need protection. The Commission has not analysed the issues involved for other adults but considers that the proposed

¹ ‘Vulnerable Groups and the Law’ was identified as a subject for consideration in the Law Reform Commission’s *Second Programme for examination of certain branches of the law with a view to their reform: 2000 - 2007* (2000) PN 9459.

² Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003).

system could be adapted to their needs without much modification.”³

3. Following the publication of the *Consultation Paper on Law and the Elderly*, the Commission held a public seminar on 17 November 2003.⁴ On the basis of views expressed at the seminar and submissions received by the Commission on the *Consultation Paper on Law and the Elderly*, the Commission made the decision to prepare and publish a second consultation paper which would focus on legal capacity issues relevant to all adults with limited decision-making, not just older adults.

4. Legal rules concerning capacity have traditionally functioned as a means of protecting those persons who are deemed unable to make decisions with legal consequences. In certain circumstances incapacity is imposed by operation of law. In the past, married women could not, as general rule, enter into any contract.⁵ Today the major limitation on capacity imposed by operation of law relates to minority: under section 2 of the *Age of Majority Act 1985*, persons under 18 who have not married are minors in law and generally do not have legal capacity.⁶ Parents are generally the joint legal guardians of a child’s person and estate while the child is under the age of 18 and have the legal capacity to make decisions affecting the child’s welfare.⁷

5. When a person reaches adulthood at 18, parents or guardians no longer have the legal right to make decisions on their behalf. The law presumes that the adult has the capacity which the law requires to make legal decisions unless this is shown not to be the case. The focus of this Consultation Paper is on reviewing how legal

³ Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at 2.

⁴ Law Reform Commission *Seminar Paper on Consultation Paper: Law and the Elderly* (LRC SP 2-2003) (November 2003).

⁵ *Cahill v Cahill* (1883) 8 App. Ca. 420. This incapacity was removed by the *Married Women’s Status Act 1957*.

⁶ The scope of this Consultation Paper is limited to the legal capacity of adults.

⁷ Section 6 of the *Guardianship of Infants Act 1964* (as amended).

capacity of persons aged 18 and above is defined in a number of key areas of decision-making – capacity to enter into a contract, capacity to enter into relationships and capacity to make healthcare decisions, and also the existing substitute decision mechanisms of wardship and enduring powers of attorney.⁸

Outline of this Paper

Part A: The Capacity Concept

6. Chapter 1, “Capacity in Context”, places the subject of legal capacity in a general context through providing an overview of the type of situations in which adults commonly experience limited decision-making ability – intellectual disability, mental illness, dementia, acquired brain injury, and inability to communicate. The chapter discusses the shift from a medical to a social model of disability which places the emphasis on ability rather than disability. This chapter also locates a review of the law on capacity against the backdrop of relevant constitutional and human rights considerations.

7. Chapter 2, “Legal Capacity: Towards a Functional Approach”, reviews salient features of the debate on the status, outcome and functional approaches to capacity. The chapter favours the “functional” approach to capacity which assesses an individual’s capacity in a manner which is both issue-specific and time-specific. Intrinsic to this approach is an understanding that the fact that a person has a disability should not lead to an assumption that they lack the legal capacity to make a particular decision.

8. Chapter 3, “Legislative Reform”, recommends the enactment of capacity legislation in order to provide a coherent uniform set of principles to govern the determination of legal capacity in a wide range of different situations. Recommendations are made in relation to how capacity should be defined. These recommendations are designed to pave the way for the establishment of a legislative substitute and assisted decision-making scheme for adults who lack

⁸ Other relevant areas which are not given specific consideration in this Consultation Paper include capacity to litigate, capacity to vote and capacity to serve on a jury.

capacity as recommended by the Commission in the *Consultation Paper on Law and the Elderly*.

9. Chapter 4, “Review of Existing Mechanisms to Address Loss of Capacity”, reviews wardship and enduring powers of attorney, the existing legal mechanisms which are designed to address lack of capacity. It focuses on the need for appropriate procedural safeguards in relation to making a determination as to whether a person has legal capacity.

Part B Specific Areas of Decision-Making

10. Chapter 5, “Capacity to Contract”, deals with the discrete area of the law relating to the capacity of an adult with limited decision-making ability to enter into everyday contracts. There is a need for a balance to be struck in the law between the goal of facilitating persons with limited decision-making ability to live their lives as independently as possible, and the countervailing need to protect both vulnerable adults, and also, good faith suppliers who do not suspect that a customer does not appreciate the implications of a transaction.

11. Chapter 6, “Personal Relationships”, deals with issues surrounding capacity to enter relationships. This includes a consideration of capacity to enter sexual relationships and capacity to marry. The chapter also contains an overview of the subject of non-consensual sterilisation of people with intellectual disabilities.

12. Chapter 7, “Healthcare Decisions”, concerns the capacity to give informed consent or to decline to consent to proposed treatment. It considers the practical and legal difficulties which arise where an adult is considered not to have the required capacity to make the decision. The chapter recommends that capacity legislation should provide the Minister for Health with the power to set up a working group to produce guidelines for medical professionals in relation to capacity issues relating to healthcare decisions.

Report

13. This Consultation Paper is intended to form the basis for discussion and accordingly the recommendations made are provisional in nature. Following further consideration of the issues

and consultation with interested parties, the Commission will make its final recommendations in respect of this *Consultation Paper on Vulnerable Adults and the Law: Capacity* and the *Consultation Paper on Law and the Elderly* (CP23-2003) in the form of a *Report on Vulnerable Adults and the Law*. Submissions on the provisional recommendations contained in this Consultation Paper are welcome. In order that the Commission's final report on *Vulnerable Adults and the Law* may be made available as soon as possible, those who wish to do so are requested to send their submissions in writing by post to the Commission or by email to info@lawreform.ie by **31 August 2005**.

PART A THE CONCEPT OF CAPACITY

CHAPTER 1 CAPACITY IN CONTEXT

A Introduction

1.01 In general terms, a person's capacity refers to their ability to perform a given task. A vulnerable adult may be capable of buying groceries but may not have the capacity to appreciate what is involved in getting a bank loan. In a legal context, capacity is used to refer to a person's ability in law to make a decision with legal consequences. Capacity, in the legal sense, is a threshold requirement for persons to have the power to make enforceable decisions for themselves. It has been said that capacity is "the pivotal issue in balancing the right to autonomy in decision making and the right to protection from harm."¹ The issue of adult legal capacity can arise in a wide range of everyday situations such as buying a car, making a will,² deciding to get married and making a decision on whether to have an operation recommended by a doctor. The courts have developed different tests for capacity in separate contexts; a finding that a person lacks capacity in one context will not necessarily lead to the same finding in another context.

1.02 This Consultation Paper is concerned with considering how legal capacity is defined and applied in a number of major areas in which decision-making capacity may arise for adults.³ In focusing on

¹ British Medical Association and the Law Society *Assessment of Mental Capacity: Guidance for Doctors and Lawyers* (2nd ed 2004) at 3.

² See Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at Chapter 2.

³ The capacity of a person to be subjected to legal liability for torts or crimes is outside the scope of this Consultation Paper. The Law Reform Commission has previously published a *Report on the Liability in Tort of Mentally Disabled Persons* (LRC 18-1985), a *Report on Sexual Offences against the Mentally Handicapped* (LRC 33-1990), and a *Report on Oaths and Affirmations* (LRC 34-1990).

legal capacity issues, this Consultation Paper examines how the law currently deals with the decision-making ability of vulnerable adults and makes recommendations for reform. The recommendations in this Consultation Paper are designed to complement the provisional recommendations in the Commission's *Consultation Paper on Law and the Elderly* concerning the establishment of a new framework for the appointment of substitute decision-makers on behalf of adults who lack capacity.⁴

1.03 Part B of this Chapter outlines the circumstances in which adults commonly experience a lack of decision-making capacity. Part C considers the changing perceptions of disability in Ireland which reflect a global shift in thinking away from a medical model towards a social understanding of disability. Part D puts capacity issues in the context of relevant human and constitutional rights.

B Limits on Decision-Making Ability

1.04 To be autonomous and capable of self-determination is a large part of what humans cherish in terms of liberty and independence. Part of being an adult is the right to make decisions independently, although in reality many of us make them interdependently by consulting with friends and family. As we are all unique individuals, each person's decision-making ability is different. An individual's decision-making ability may vary depending on factors such as the nature and consequences of the decision to be made, the person's intellectual ability, relevant knowledge and experience, psychological factors and external factors such as the time frame in which the decision needs to be made.

1.05 However, some adults have a decision-making ability which is permanently or temporarily limited so that they may not have the capacity to make certain decisions. Most commonly an adult with limited decision-making ability may have an intellectual disability, some form of dementia, mental illness, acquired brain injury or an

⁴ Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at Chapter 6. See further the Introduction to this Consultation Paper.

inability to communicate their decisions. It is these vulnerable adults with whom this Consultation Paper is largely concerned.

(1) Intellectual Disability

1.06 There is no universally accepted definition of intellectual disability.⁵ One definition is “the presence of a significantly reduced ability to understand new and complex information and to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning).”⁶ Although the term ‘intellectual disability’ (or ‘learning disability’) is generally used with reference to a greater than average difficulty in learning, within that frame the term is applied to describe people within a very wide range of ability. With intellectual disability, the spectrum of disability extends from people with mild difficulty in learning to those with more profound disabilities. Some adults with an intellectual disability lead independent lives within the community while some are entirely dependent on others and require intensive levels of care and support.⁷ Thus while some adults with an intellectual disability reside in an independent or semi-independent setting with the ability to make important decisions for themselves or in consultation with others,⁸ other individuals have limited scope to exercise personal autonomy in their daily lives. The decision-making capacity of adults with intellectual disability may depend in part on factors such as their experience of and opportunities to make or participate in decisions relevant to their life.

1.07 The National Intellectual Disability Database was established in 1995 to provide information to the Department of Health, the health services and voluntary agencies providing service to persons with intellectual disability and their families. The database contains

⁵ In Ireland, the term ‘intellectual disability’ has widely replaced ‘mental handicap’ or ‘mental retardation’.

⁶ Irish College of Psychiatrists *Proposed Model for the Delivery of a Mental Health Service to People with Intellectual Disability* (Occasional Paper OP58 2004) at 10.

⁷ See World Health Organisation *Report on Ageing and Intellectual Disabilities* (Geneva 2000).

⁸ For example, through service providers who provide empowerment programmes for adults with intellectual disability.

information on every person with an intellectual disability who is receiving a service connected to their intellectual disability or who requires or is expected to require such a service. There were 25,557 people registered in the National Intellectual Disability Database in 2003⁹ representing a prevalence rate of intellectual disability of 6.52 per 1,000 population. 36.5% of cases in 2003 were classified as mild, 37.4% as moderate, 15.6% as severe and 4.2% as profound.¹⁰ For the 17,006 adults aged 20 and above on the National Intellectual Disability Database in 2003, 7,556 lived in a home setting, 510 lived independently, 199 lived semi-independently and 7,681 were resident in a residential centre, group community home or other full-time facility. 11 were of no fixed abode.¹¹

(2) Dementia

1.08 Dementia is an umbrella term used to describe a collection of symptoms caused by degenerative changes in the brain characterised by the loss of cognitive and social function and behavioural changes that affect ability to think, speak, reason, remember and move. Having a form of dementia does not in itself mean that a person will not have the capacity to make decisions and manage their affairs. However, as the illness progresses their memory, comprehension and judgement may be affected, and consequently their decision-making capacity in some or many areas may be impaired.¹²

1.09 It is estimated that approximately 33,000 people in the Republic of Ireland have dementia, most of whom have Alzheimer's Disease, the most common cause of dementia which represents about 60% of all cases.¹³ Persons with Parkinson's disease and Huntington's disease may develop dementia late in the disease. With

⁹ National Intellectual Database Committee *Annual Report 2003* (Health Research Board 2004) Appendix B.

¹⁰ 6.3% were categorised as 'not verified': National Intellectual Database Committee *Annual Report 2003* (Health Research Board 2004) at Table 2.1.

¹¹ There was insufficient information on the residential circumstances of 1,049 adults in this age category.

¹² See Weiner "Legal and Ethical Issues for Patients with Dementia and their Families" *Geriatric Times* Jan/Feb 2004 Vol V Issue 1.

¹³ Source: The Alzheimer Society of Ireland.

persons suffering from a degenerative illness, the decline in capacity may be gradual and the extent difficult to pinpoint.

1.10 The incidence of dementia increases with age. The National Council of Ageing and Older People has projected that by 2021, the percentage of older males will have risen from 9.7% in 2002 to between 13.9 % and 14.1 % while the percentage of older females will have risen from 12.5 % in 2002 to between 15.8% and 16.4%.¹⁴ As a result the number of adults with some form of dementia is also likely to increase.

(3) Mental Illness

1.11 A person suffering from mental illness experiences severe and distressing psychological symptoms to the extent that normal functioning is seriously impaired, and some form of help is usually needed for recovery.¹⁵ The *Mental Health Act 2001*, which is designed to deal with involuntary psychiatric admissions,¹⁶ describes mental illness for the purposes of the legislation as:

“a state of mind of a person which affects the person’s thinking, perceiving, emotion or judgment and which seriously impairs the mental function of the person to the extent that he or she requires care or medical treatment in his or her own interest or in the interests of other persons.”¹⁷

1.12 The cause of mental illness is a widely debated subject on which there is no clear consensus. Social, biological and psychological factors may all play a part.¹⁸ The positive promotion of mental well-being is expected to form a key aspect of the national policy framework for mental health services which is being produced

¹⁴ National Council of Ageing and Older People *Population Ageing in Ireland 2002-2021* (Report no. 81) (2004) at 2.

¹⁵ Source: Mental Health Ireland.

¹⁶ The subject of involuntary psychiatric admission is outside the scope of this Consultation Paper. See further Mills “The Mental Health Act 2001: Involuntary psychiatric treatment and detention” (2003) 8(1) BR 42.

¹⁷ Section 3(2) of the *Mental Health Act 2001*.

¹⁸ See The British Psychological Society *Recent Advances in Understanding Mental Illness and Psychotic Experiences* (2000).

by the Expert Group on Mental Health Policy.¹⁹ Common types of mental illness include depression, bipolar disorder (formerly referred to as manic depression) and schizophrenia. A person may experience mental illness on a once-off basis or it may be experienced on an episodic or cyclical basis in which a period of mental illness is followed by a period of remission. The spectrum is wide in terms of the effect on the individual. For some people the illness may be enduring and without remission. While undergoing an episode of mental illness, a person's cognitive functioning may be impaired and they may find it difficult to make decisions or to carry them through. Alternatively, the person may make inappropriate decisions which they would not make when they were well.

1.13 There is little centralised data available on the prevalence of mental illness in Ireland.²⁰ Such information as is available tends to be based on admissions to hospitals. There were 23,234 in-patient admissions to psychiatric hospitals in Ireland in 2003.²¹ However, many persons suffering from mental illness do not require hospitalisation and may be treated by their medical practitioner who may prescribe medication and/or counselling. Others do not seek professional help. It is therefore difficult to calculate accurately the prevalence of mental health problems in Ireland but the figure of 'one in four' is regularly cited as a guesstimate of the proportion of people who will experience mental illness in their lifetime.²²

(4) Acquired Brain Injury

1.14 Acquired brain injury is a non-progressive injury to the brain which occurs after birth. An acquired brain injury can occur in a

¹⁹ An Expert Group on Mental Health Policy was established in August 2003 to produce a national policy framework for mental health services: see www.mentalhealthpolicy.ie. See further Healy "Mental health rethink signalled" *The Irish Times* 21 April 2005 at 11.

²⁰ The National Disability Authority has called for questions on disability to be included in the census: O'Brien "Authority calls for national study on disability" *The Irish Times* 27 May 2004.

²¹ *Report of the Inspector of Mental Hospitals for the year ending 31 December 2003* (PRN 2424) (Stationery Office 2004) at 1.

²² See Amnesty International (Irish Section) *Mental Illness: The Neglected Quarter* (Dublin 2003).

variety of different situations. The injury may arise due to trauma in an accident, or as a result of a stroke, brain haemorrhage or brain surgery. Headway Ireland, the national head injuries association, estimates that more than 10,000 people sustain a brain injury annually and more than 7,000 suffer a stroke.²³

1.15 An acquired brain injury may impact on a person's capacity since cognitive functioning may be affected through difficulties in concentrating, communicating, memory problems and problems in relation to reasoning and other executive or planning functions.²⁴ The level of recovery varies depending on the individual case and will depend on factors such as the type and severity of the head injury and its medical management including the provision of occupational therapy.²⁵

(5) *Inability to Communicate Decisions*

1.16 A person who is unable to communicate their wishes is unable to participate in a decision which requires an action by another person. In this instance the person's cognitive ability may be unaffected but they are unable to communicate their views in a manner which can be understood. A lack of fluent speech or ability to write will not be a bar to communicating with other people if other methods of non-verbal communication are possible.

1.17 People who have suffered a stroke may suffer from speech impairment where the fluency of speech is lost. It may be possible for a speech therapist to assist in formulating a means of communication.²⁶ 'Locked-in syndrome' is a rare neurological disorder characterised by complete paralysis of voluntary muscles in all parts of the body except for those which control eye movement. Individuals with locked-in syndrome are conscious and can think and reason but are unable to speak or move although communication may be possible with blinking eye movements.

²³ Headway Ireland: www.headwayireland.ie.

²⁴ See McEnroe *Head Injury Management* (Headway Ireland 1994).

²⁵ *Ibid.*

²⁶ See Enderby, "The Testamentary Capacity of Dysphasic Patients" (1994) 62 *Medico-Legal Journal* 70.

1.18 A person will be unable to communicate their wishes if they are unconscious on a temporary or lasting basis.

C Changing Perceptions of Disability

(1) *Move from a Medical Model to a Social Model*

1.19 One of the challenges which a review of the law on capacity presents is to achieve an appropriate balance between the traditional focus on protection for the vulnerable and the ideological shift in disability policy towards an emphasis on autonomy, capacity and empowerment.²⁷

1.20 A fundamental shift has been taking place away from a medical model of disability towards a social and rights-based model.²⁸ The medical model of disability focuses on impairment from a medical perspective. The alternative social or human rights model focuses on the dignity of the human being and on issues of integration. The goal of the human rights-based model is to build an inclusive society which respects the dignity and equality of all human beings regardless of difference. The move from a medical to a social model of disability entails a corresponding emphasis on ability rather than disability.

1.21 Allied with the change from a medical to a social model of disability is a gradual, less discernible shift away from what may be termed “benign paternalism”. Benign paternalism treats adults who are deemed to lack capacity as similar to children in the sense of the parent deciding what is best for them because they know best. The

²⁷ See Lush “Capacity” in Whitehouse (ed) *Society of Trust and Estate Practitioners Finance and the Law for the Older Client* (Lexis Nexis 2002) at D1.3; King “Paternalism and the Law: Taking a Closer Look” (2004) 4 UCCLR 134.

²⁸ See Quinn and Degener *Human Rights and Disability* (United Nations HR/PUB/02/01 2002) Chapter 1, Commission on the Status of People with Disabilities *A Strategy for Equality: Report of the Commission on the Status of People with Disabilities* (1996) at 2.2; Disability Legislation Consultation Group *Equal Citizens – Proposals for Core Elements of Disability Legislation* (Disability Legislation Consultation Group 2003) at Part IV. These changes are evident in the *Disability Bill 2004* and the *Comhairle (Amendment) Bill 2004*.

force of paternalism is undermined by a growing recognition that all adults, including those living with a disability, have a right to autonomy and self-determination.

1.22 The Commission on the Status of People with Disabilities published a seminal report in 1996 which was designed to be a blueprint for the removal of barriers facing people with disabilities in Irish society.²⁹ The report noted the move away from a medical model of disability to a social model.³⁰ The Commission on the Status of People with Disabilities stated:

“Unfortunately, the way in which the law presently defines and constitutes people with disabilities frequently uses archaic and offensive language, relies heavily on a medical concept of disability; and reinforces the dependency and stigma associated with disability.”³¹

1.23 Following on from the recommendations of the report of the Commission on the Status of People with Disabilities, the National Disability Authority (“the NDA”) was established by the *National Disability Authority Act 1999* as an independent organisation to promote the rights of people with disabilities.³²

²⁹ Commission on the Status of People with Disabilities *A Strategy for Equality: Report of the Commission on the Status of People with Disabilities* (1996). See also Department of Justice, Equality and Law Reform *Towards Equal Citizenship: Progress Report on the Implementation of the Recommendations of the Commission on the Status of People with Disabilities* (Stationery Office 2000).

³⁰ This change of emphasis from a medical view of disability to a social approach is evident in the United Nations’ *Standard Rules for the Equalisation of Opportunities for People with Disabilities* General Assembly Resolution 48/96 of 20 December 1993.

³¹ Commission on the Status of People with Disabilities *A Strategy for Equality: Report of the Commission on the Status of People with Disabilities* (1996) at paragraph 2.1.

³² Other organisations with relevant functions include the Equality Tribunal, the Mental Health Commission, the Inspector of Mental Hospitals, the Ombudsman, and the Human Rights Commission.

(2) *Recent Legislative Developments*

1.24 In recent years there have been a number of legislative developments in the disability sector promoting the interests of vulnerable adults. These include the *Employment Equality Acts 1998 to 2004*, the *Equal Status Acts 2000 to 2004*³³ and the *Mental Health Act 2001*. The most significant recent development in disability law in Ireland is the publication of the *Disability Bill 2004*.³⁴ The 2004 Bill is part of a National Disability Strategy launched in September 2004. In the Second Stage debate on the Bill in the Dáil, Mr Frank Fahey, the Minister of State at the Department of Justice, Equality and Law Reform stated:

“The [national disability] strategy represents a commitment by Government to drive forward a significant evolution in policy and provision for people with disabilities, which has gathered momentum in recent years. Among the established building blocks are the strong anti-discrimination framework of employment equality³⁵ and equal status legislation,³⁶ the policy of mainstreaming for people with disabilities in recent years.³⁷ These notable milestones set the context for the national disability strategy and the Bill.”³⁸

1.25 The *Disability Bill 2004* provides for an entitlement of persons with a disability to an assessment of need which will result in the compilation of a services statement listing the services they

³³ See paragraphs 5.30 to 5.32 below.

³⁴ For background to the 2004 Bill, in particular the absence of a rights-based approach in the *Disability Bill 2001* see: Disability Legislation Consultation Group *Equal Citizens: Proposals for Core Elements of Disability Legislation* (2003).

³⁵ The *Employment Equality Acts 1998 to 2004*.

³⁶ The *Equal Status Acts 2000 to 2004*. See paragraphs 5.30 to 5.32 below.

³⁷ In 2000 a mainstreaming initiative was launched to require public bodies to end segregation of services by integrating their services for people with disabilities with those for other citizens.

³⁸ Vol. 591 No.5 Dáil Eireann Parliamentary Debates 4 November 2004 Col. 1373.

require.³⁹ The *Comhairle (Amendment) Bill 2004* is designed to give Comhairle a role in relation to the introduction of a personal advocacy service specifically aimed at people with disabilities.

D Capacity and Human Rights

1.26 A finding that a person lacks capacity results in the restriction or removal of fundamental human rights. In this sense the issues of capacity and rights are inextricably linked.⁴⁰ These human rights include the right to equality and non-discrimination; the right to bodily integrity; the right to protection of the person; the right to personal liberty; family rights; the right to personal and marital privacy; the right not to be subjected to inhuman and degrading treatment and property rights. Human dignity is at the core of the concept of human rights. Indeed, in a more general sense, if one accepts that the focus of human rights is generally about increasing autonomy then the connection between the two issues becomes even more apparent. There are a great many human rights instruments which apply directly or indirectly to persons with intellectual disability and mental illness.⁴¹

(1) Constitutional Considerations

(a) Constitutional rights unaffected by lack of capacity

1.27 The fact that an adult has a partial, more serious, or even complete lack of decision-making capacity does not entail a

³⁹ Many commentators have pointed out that a statutory entitlement to an assessment of need would be devoid of practical effect if there was no guarantee built into the legislation to ensure that the relevant services required would be provided to the individual: see generally National Disability Authority *NDA Response to the Disability Bill 2004 and the Comhairle (Amendment) Bill 2004* (2004).

⁴⁰ In the Law Reform Commission's *Seminar Paper Consultation Paper on Law and the Elderly* (LRC SP2-2003) it was stated "law does not operate in a vacuum and that any system of protection raises issues not only of basic human rights but also wider social issues in relation to the appropriate response of society to dealing with its vulnerable citizens" (at 2).

⁴¹ See generally Lachwitz and Breitenbach *Human Rights and Intellectual Disability* (Inclusion International 2002).

corresponding loss of constitutional rights on their part. Under Article 40.3.1° of the Constitution the State is charged with protecting from unjust attack “as best it may” and vindicating “the life, person, good name and property rights of every citizen.” The Supreme Court decision in *In re a Ward of Court (No.2)*⁴² concerned the withdrawal of artificial feeding and nutrition from a woman who had been in what was termed ‘a near persistent vegetative state’ (PVS) for more than 20 years arising from complications following a gynaecological operation. Hamilton CJ stated:

“The loss by an individual of his or her mental capacity does not result in any diminution of his or her personal rights recognised by the Constitution, including the right to life, the right to bodily integrity, the right to privacy, including self-determination,⁴³ and the right to refuse medical care or treatment. The ward is entitled to have all these rights respected, defended, vindicated and protected from unjust attack and they are in no way lessened or diminished by reason of her incapacity.”⁴⁴

(b) *Constitutional Rights relevant to Capacity Issues*

(I) *Privacy*

1.28 To the extent that the law on capacity impacts on the autonomy of individuals to make choices in relation to how to live their lives, the constitutional right to privacy is relevant. The right to privacy has been described as “the right to be let alone”⁴⁵ and this understanding carries with it an aspect of freedom and autonomy. Although the citizen’s constitutional right to privacy may be

⁴² [1996] 2 IR 79. See further paragraph 7.52 *ff* below.

⁴³ It is not clear whether Hamilton CJ considered that the right to self-determination should be independently recognised as an unspecified right under Article 40.3.1° of the Constitution.

⁴⁴ *Ibid* at 126.

⁴⁵ Brandeis “*The Right to Privacy*” (1890) 4 Harv L. Rev 193.

interfered with where the common good requires it, the full scope of privacy law has yet to be explored under Irish constitutional law.⁴⁶

1.29 The right to privacy has been recognised by the courts as an unenumerated right⁴⁷ guaranteed by Article 40.3.1° of the Constitution. The Supreme Court in *Norris v Attorney General*⁴⁸ held that a right to privacy inheres in each citizen as an unenumerated right under Article 40.3.1° of the Constitution. Henchy J's formulation of the scope of the right was broad. He stated that the right of privacy could be taken to refer collectively to "a complex of rights which vary in nature, purpose and range (each necessarily being a facet of the citizen's core of individuality within the constitutional order)".⁴⁹ In *Kennedy v Ireland*⁵⁰ Hamilton P treated the right of privacy as an unenumerated personal right flowing from "the Christian and democratic nature of the State" and referred to its role in ensuring "the dignity and freedom of an individual in a democratic society."⁵¹ He went on to state that it is not an unqualified right - the exercise of the right to privacy may be "restricted by the constitutional rights of others, or by the common good, and it is subject to the requirements of public order and morality."⁵²

(II) Dignity

1.30 An underlying tenet of democracy is respect for human dignity.⁵³ In the present context, the dignity of the individual is central to any consideration of capacity issues.

⁴⁶ See Walley "Privacy Law in Ireland: A Jurisprudential Cinderella" (1999) 3(1) IIPR 6.

⁴⁷ See *Ryan v Attorney General* [1965] IR 294.

⁴⁸ [1984] IR 36. A constitutional right to marital privacy was recognised by the Supreme Court in *McGee v Attorney General* [1974] IR 284.

⁴⁹ [1984] IR 36, 71.

⁵⁰ [1987] IR 587.

⁵¹ [1987] IR 587, 592. See also *Foy v An t-Ard Chlaraitheoir* (McKechnie J) 9 July 2002; *Bailey v Flood* (Supreme Court) 14 April 2000.

⁵² *Kennedy v Ireland* [1987] IR 587, 592.

⁵³ See Forde *Constitutional Law* (2nd ed First Law 2004) at 373.

1.31 The right to respect for dignity is not specified as a fundamental right in the Constitution but the Preamble to the Constitution states that an objective of the Constitution is to promote the common good so that the “dignity and freedom of the individual may be assured.” In *McKinley v Minister for Defence*⁵⁴ Hederman J stated that Articles 40 and 41 of the Constitution should be construed in accordance with the Preamble to the Constitution in order that “the dignity and freedom of the individual might be assured.” In *Re a Ward of Court (No.2)*⁵⁵ Denham J stated “[a]n unspecified right under the Constitution to all persons as human persons is dignity – to be treated with dignity.” This approach was also evident in McKechnie J’s judgment in *Foy v An t-Ard Chlaraitheoir*⁵⁶ where he concluded that the State must accord the right to dignity the same entitlement as the right of privacy.⁵⁷

(III) *Equality before the Law*

1.32 Respect for human dignity is also evident in the equality guarantee in Article 40.1.⁵⁸ The courts have regarded Article 40.1 as having its basis in human dignity.⁵⁹ However, in considering legal capacity issues it is important to note that the guarantee of equality contained in Article 40.1 is not absolute. Article 40.1 provides that equality before the law “shall not be held to mean that the State shall not in its enactments have due regard to differences of capacity,

⁵⁴ [1992] 2 IR 333, 349.

⁵⁵ [1996] 2 IR 79, 163.

⁵⁶ High Court (McKechnie J) 9 July 2002.

⁵⁷ The dignity of the individual is also acknowledged in *In re Offences Against the State (Amendment) Bill 1940* [1940] IR 470 and in *In re Clarke* [1950] IR 235.

⁵⁸ The *Employment Equality Acts 1998 to 2004* and the *Equal Status Acts 2000 to 2004* go further in specifically enumerating disability as a prohibited ground of discrimination. Article 20 of the *Charter of Fundamental Rights for the European Union* (see further paragraph 1.45 below) also enshrines equality before the law and Article 21 lists disability as a prohibited ground of discrimination.

⁵⁹ *Quinn’s Supermarket v Attorney General* [1972] IR 1, 14 *per* Walsh J. This rationale for Article 40.1 was approved by the Supreme Court in *An Blascaod Mor Teoranta v Commissioners of Public Works (No.3)* [2000] 1 IR 6.

physical and moral, and of social function”. Thus involuntary psychiatric detention under the *Mental Treatment Act 1945* was upheld in *In re Clarke*.⁶⁰ In that case O’Byrne J stated:

“The existence of mental infirmity is too widespread to be overlooked, and was, no doubt, present to the minds of the draughtsmen when it was proclaimed in Article 40.1 of the Constitution that, though all citizens, as human beings, are to be held equal before the law, the State may have regard to difference of capacity, physical and moral, and of social function.”⁶¹

1.33 Although legislation may have regard to differences in capacity, it must not create what amounts to invidious discrimination.⁶² Furthermore, under the principle of proportionality, a distinction may be unconstitutional if it is excessive.⁶³ Both the *Employment Equality Acts 1998 to 2004* and the *Equal Status Acts 2000 to 2004*⁶⁴ prohibit discrimination on the grounds of disability.⁶⁵ Article 40.3.2° provides that the State shall, in particular, by its laws

⁶⁰ [1950] IR 235. See also *Re Keogh* High Court (Finnegan P) 15 October 2002 where it was held that Article 40.1 permitted differences of capacity be taken into account in a wardship inquiry. See further paragraph 4.18 below.

⁶¹ [1950] IR 235, 247-248.

⁶² *O’B v S* [1972] IR 144; *Brennan v Attorney General* [1983] ILRM 449; *Re Article 26 of the Constitution and the Employment Equality Bill, 1996* [1997] 2 IR 321; *Re Article 26 of the Constitution and the Planning and Development Bill, 1999* [2000] 2 IR 321.

⁶³ *Quinn’s Supermarket Ltd v Attorney General* [1972] IR 1; *O’Brien v Manufacturing Engineering Co Ltd* [1973] IR 334. See generally Hogan and Whyte *J.M. Kelly: The Irish Constitution* (4th ed Butterworths 2003) at paragraph 7.2.64 ff.

⁶⁴ See further paragraph 5.30-5.32 below.

⁶⁵ The majority of the Review Group on the Constitution and the Commission on the Status of People with Disabilities had recommended the more fundamental course of disability and other grounds of prohibited discrimination being expressly listed in Article 40.1: see *Report of the Constitution Review Group* (Pn 2632 Government Publications 1996) at 220 – 243; Commission on the Status of People with Disabilities *A Strategy for Equality: Report of the Commission on the Status of People with Disabilities* (1996) at paragraph 2.7.

protect from unjust attack “as it best it may” and vindicate the life, person, good name and property rights⁶⁶ of every citizen.

(2) Council of Europe

(a) The European Convention on Human Rights

1.34 The Council of Europe *Convention for the Protection of Human Rights and Fundamental Freedoms*⁶⁷ (“ECHR”) sets out a comprehensive listing of civil and political rights. Of particular relevance to legal capacity are Article 8, which concerns respect for private and family life,⁶⁸ and Article 12, which concerns the right to marry and found a family.⁶⁹ Article 14 of the ECHR provides that the enjoyment of the rights and freedoms set out in the ECHR shall be without discrimination on any grounds.⁷⁰ The European Court of Human Rights has stated on several occasions that it regards the ECHR as a living instrument which will be interpreted in light of changing social attitudes.⁷¹

1.35 The ECHR is binding on Ireland but does not form part of domestic law. Rather than directly incorporating the Constitution into domestic law, the *European Convention on Human Rights Act 2003*

⁶⁶ See *Re Article 26 of the Constitution and the Health (Amendment) (No.2) Bill 2004* Supreme Court 16 February 2005.

⁶⁷ 4 November 1950, E.T.S. No. 005.

⁶⁸ See paragraphs 6.07 and 6.21 below. Personal autonomy and dignity are aspects of the right to respect for private life guaranteed by Article 8 of the ECHR: *Pretty v United Kingdom* (2002) 35 EHRR 1.

⁶⁹ See paragraph 6.08 below.

⁷⁰ Disability is not specifically listed in the enumerated grounds of prohibited discrimination in Article 14 of the ECHR but is generally regarded as coming within the words “or other status” in Article 14. See Spellissy “European Convention on Human Rights - Potential Implications for Disability Rights in Ireland” in Independent Law Centres Networks *Celebrating the European Convention on Human Rights Act 2003: Airey v Ireland 25 years on* (2004).

⁷¹ See Connolly “The European Convention on Human Rights” in Heffernan (ed) *Human Rights: A European Perspective* (Round Hall 1994) at 44.

(“ECHR Act 2003”)⁷² adopted a model of interpretative incorporation. Section 2(1) of the ECHR Act 2003 requires the courts to interpret and apply legislation and rules of law in so far as possible in a manner compatible with the ECHR and section 4 requires “judicial notice” to be taken of relevant case law of the European Court of Human Rights. Section 3(1) requires “every organ of State” to perform its functions in compliance with the ECHR. Nevertheless it is clear that the ECHR Act 2003 is subject to the primacy of the Constitution.⁷³

1.36 Section 5 of the ECHR Act 2003 permits a court to make a declaration of incompatibility stating that a statutory provision or rule of law is incompatible with the State’s obligations under the ECHR. However, a declaration of incompatibility “shall not affect the validity, continuing operation or enforcement of the rule in question.” Under section 3(2) a person who has suffered loss, injury or damage as a result of breach of section 3(1) of the ECHR Act 2003 may, if no other remedy in damages is available, seek to recover damages following a declaration of incompatibility being obtained in the High Court.

(b) *Council of Europe Recommendation on the Legal Protection of Vulnerable Adults*

1.37 The Council of Europe has the power to adopt Recommendations directed to Member State governments in relation to policy formulation. Although such Recommendations are not legally binding, they would be regarded as indicative of best practice in the particular area. In 1999 the Council of Europe adopted a recommendation in relation to the legal protection of vulnerable adults (“the Recommendation”).⁷⁴

⁷² See generally Kilkelly (ed) *ECHR and Irish Law* (Jordans 2004); Independent Law Centres Networks *Celebrating the European Convention on Human Rights Act 2003: Airey v Ireland 25 years on* (2004).

⁷³ See the Long Title to the *European Convention on Human Rights Act 2003*; Hogan “Incorporation of the ECHR: Some Issues of Methodology and Process”, in Kilkelly (ed) *ECHR and Irish Law* (Jordans 2004).

⁷⁴ *Recommendation no. R(99)4 of the Committee of Ministers to Member States on Principles Concerning the Legal Protection of Incapable Adults* (adopted 23 February 1999). See also *Report of Group of Specialists on Incapable and other Vulnerable Adults* (CJ-S-MI, 21 January 1997).

1.38 The text of the Recommendation emphasises the fundamental principle of respect for the dignity of each person as a human being. Principle 2(1) of the Governing Principles set out in the Recommendation requires a flexible legal approach to capacity. Principle 2(1) states:

“The measures of protection and other legal arrangements available for the protection of the personal and economic interests of incapable adults should be sufficient, in scope or flexibility, to enable a suitable response to be made to different degrees of incapacity and various situations.”

1.39 Principle 3 of the Governing Principles set out in the Recommendation is concerned with maximum preservation of legal capacity:

“1. The legislative framework should, so far as possible, recognise that different degrees of incapacity may exist and that incapacity may vary from time to time. Accordingly, a measure of protection should not result automatically in a complete removal of legal capacity.

2. In particular, a measure of protection should not automatically deprive the person concerned of the right to vote, or to make a will, or to consent to any intervention in the health field, or to make decisions of a personal character at any time when his capacity permits him or her to do so.

3. Consideration should be given to legal arrangements whereby, even when representation in a particular area is necessary, the adult may be permitted, with the representative’s consent, to undertake specific acts or acts in a specific area.

4. Whenever possible the adult should be enabled to enter into legally effective transactions of an everyday nature.”

(3) *United Nations*

1.40 Article 1 of the United Nations organisation’s 1948 *Universal Declaration of Human Rights* states: “All humans are born free and

equal in dignity and rights.”⁷⁵ In 1990 Ireland became a party to the *International Covenant on Civil and Political Rights* (ICCPR)⁷⁶ which proceeds on the basis of a recognition in the Preamble of the inherent dignity and equality of individuals. Ireland also became a party to the *International Covenant on Economic, Social and Cultural Rights*⁷⁷ in 1990.

(a) *Declaration on the Rights of Mentally Retarded Persons*

1.41 In 1971 the General Assembly of the UN adopted a *Declaration on the Rights of Mentally Retarded Persons*⁷⁸ which emphasises the goal of the development of ability and social integration. Article 1 sets out that persons with severe mental illness or intellectual disabilities have, to the maximum degree of feasibility, the same rights as other human beings. The Declaration requires that any restriction on rights must be subject to appropriate legal safeguards to prevent abuse.⁷⁹

(b) *Resolution on Principles for the Protection of Persons with Mental Illness*

1.42 In relation to establishing a lack of legal capacity, the *General Assembly Resolution on Principles for the Protection of Persons with Mental Illness 1991* states:

“Any decision that, by means of his or her mental illness, a person lacks legal capacity, and any decision that, in

⁷⁵ The *UN Declaration of Human Rights* is not binding but operates as “a common standard of achievement for all peoples and all nations”. However, the Covenants create binding obligations for the States which have ratified or acceded to them. See Quinn and Degener *Human Rights and Disability: The current use and future potential of United Nations instruments in the context of disability* (United Nations 2002).

⁷⁶ (999 UNTS 171). See also the *Declaration on the Rights of Disabled Persons* (1975). Article 3 emphasises that persons with a disability have an inherent right to respect for their human dignity and equal rights to their fellow citizens of the same age.

⁷⁷ (993 UNTS 3).

⁷⁸ General Assembly Resolution 2856 (XXVI) of 20 December 1971.

⁷⁹ *Ibid* Article 7.

consequence of such incapacity, a personal representative shall be appointed, shall be made only after a fair hearing by an independent and impartial tribunal established by domestic law. The person whose capacity is at issue shall be entitled to be represented by a counsel⁸⁰

(c) *Older Persons*

1.43 In relation to older persons, both the 1982 *International Plan on Ageing*⁸¹ and the *United Nations Principles for Older Persons, 1991*⁸² emphasise the principles of independence, participation, self-fulfilment and dignity.

(d) *Draft UN Disability Convention*

1.44 Progress has been made towards the adoption of a UN Disability Convention.⁸³ This would follow the trend in other UN treaties towards particular protection of a group.⁸⁴ In 2001 the General Assembly adopted a resolution on a “Comprehensive and integral international convention to promote and protect the rights and dignity of persons with disabilities”.⁸⁵ In January 2004, a draft version of the Convention was produced by the Ad Hoc Committee on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities.⁸⁶ The review process is ongoing.

⁸⁰ General Assembly Resolution 46/119 of 17 December 1991, Article 3, principle 1, paragraph 6.

⁸¹ Endorsed by the UN General Assembly in 1982, Resolution 37/51.

⁸² Adopted 1991, Resolution 46/91.

⁸³ See Despouy *Human Rights and Disabled Persons* (United Nations 1993) at paragraph 280-281; Quinn and Degener “Expanding the system: the debate about a disability-specific convention”, in Degener and Quinn *Human Rights and Disability* (United Nations 2002).

⁸⁴ See, for example, the UN *Convention on the Rights of the Child* (1989) and the *International Convention on the Elimination of All Forms of Racial Discrimination* (1966).

⁸⁵ General Assembly Resolution 56/168 of 19 December 2001.

⁸⁶ During its fourth session the Ad Hoc Committee concluded a first reading of the draft text of the Convention: see *Report of Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection*

(4) *The EU Charter of Fundamental Rights*

1.45 The *Charter of Fundamental Rights for the European Union* was agreed in 2000 as part of the ‘Nice Treaty’.⁸⁷ It includes all the rights covered by the *European Convention on Human Rights* including respect for human dignity,⁸⁸ and respect for physical and mental integrity.

E Conclusions

1.46 The Commission is concerned that the law on capacity should reflect changing perceptions of disability as outlined in this chapter. The law should thus be framed to reflect an emphasis on capacity rather than lack of capacity and should be enabling rather than restrictive in nature. In this way, any legislative scheme addressing capacity will be more likely to comply with relevant constitutional law and international human rights standards in this area.⁸⁹

1.47 *The Commission recommends that the law on capacity should reflect an emphasis on capacity rather than lack of capacity and should be enabling rather than restrictive in nature, thus ensuring that it complies with relevant constitutional and human rights standards.*

and Promotion of the Rights and Dignity of Persons with Disabilities on its fourth session (A/59/360 2004).

⁸⁷ OJ No. 364/1 (2000).

⁸⁸ Article 1 of the Nice Treaty.

⁸⁹ See Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at paragraph 6.08-6.09.

CHAPTER 2 LEGAL CAPACITY: TOWARDS A FUNCTIONAL APPROACH

A **Introduction**

2.01 As will have been apparent from the discussion in Chapter 1, issues of legal capacity have far-reaching practical consequences in everyday life. They are therefore of immediate concern in relation to adults with limited decision-making ability,¹ their carers and other people with whom they come into contact. Before examining the legal rules which govern a person's legal capacity in Part C of this chapter, it is instructive to turn our attention first in Part B to the debate on how the concept of capacity itself should be understood. This chapter sets the scene for the more detailed review of legal capacity in selected areas of decision-making in the chapters which follow.

B **The Debate on Capacity**

2.02 The discussion on approaches to capacity in this Part will inform the later discussion in this Consultation Paper of the appropriate legal understanding of capacity, particularly where an adult's decision-making capacity is in some way limited. Discussion on how capacity should be understood has for the most part arisen in medical ethics jurisprudence concerning consent to medical treatment and research. However, more recently there has been increasing interest in the question of how legal capacity should be understood within the context of the search for a substitute decision-making model for adults who lack capacity.²

¹ See paragraph 1.04 *ff* above.

² See Scottish Law Commission *Mentally Disabled Adults: Legal Arrangements for Managing their Welfare and Finances* (Discussion

2.03 The major capacity models, known as the ‘status approach’, the ‘outcome approach’ and the ‘functional approach’ are considered below. The lines between the different approaches to capacity are often blurred in practice.

(1) The Status Approach

2.04 The status approach to capacity involves making a decision on a person’s legal capacity based on the presence or absence of certain characteristics. It usually involves an across-the-board assessment of a person’s capacity based on disability rather than capacity in relation to the particular decision being made at a particular time. Under this approach, for example, a person who is on a long-stay psychiatric ward may be automatically denied capacity to make a will or to vote without regard to their actual capabilities.

2.05 The effect of a status approach is illustrated by the Canadian case *Clark v Clark*.³ The case concerned a 20 year old man with cerebral palsy and an intellectual disability who had been living in a residential centre from the age of two. He had a severe physical disability, used a wheelchair and could not speak. However, he had learned to communicate through a system known as Blissymbols. Arrangements were made for him to visit several L’Arche placement homes as a first step to a possible move on from the residential centre. He was keen to do so and signed a consent form to the trip. However, because his parents objected to the trip and any future transfer to a placement home, the trip was cancelled. The father feared that his son could not cope outside the centre and applied for a declaration that his son was a mentally incompetent person.

Paper No. 1994 1991); Scottish Law Commission *Report on Incapable Adults* (No. 151 1995); Law Commission of England and Wales *Mentally Incapacitated Adults and Decision-making: An Overview* (Consultation Paper No. 119 1991); Law Commission of England and Wales *Mentally Incapacitated Adults and Decision-making: A New Jurisdiction* (Consultation Paper No. 128 1993); Law Commission of England and Wales *Mentally Incapacitated Adults and Decision-making: Medical Treatment and Research* (Consultation Paper No. 129 1993); Law Commission of England and Wales *Mental Incapacity* (Report No. 231 1995); *Adults with Incapacity (Scotland) Act 2000*; English *Mental Capacity Act 2005*.

³ [1982] 40 O.R. (2d) 383.

2.06 Matheson J held that the son's obvious and severe physical disability was irrelevant to a determination of his mental capacity. The judge was satisfied that the young man was able to communicate effectively, was fully aware of his surroundings and knew what he wanted. He was entitled to take a risk by deciding to try living in a placement home. In effect, the court rejected a status approach, which looked only at the severe disability, and looked instead at the capacity to make the particular decision at issue.

2.07 The status approach to capacity is evident in the Wards of Court system⁴ and in respect of enduring powers of attorney under the *Powers of Attorney Act 1996*,⁵ both of which make a broad assessment of general legal capacity which amounts to making a status decision on capacity.

2.08 A status approach to capacity has particular potential to operate inequitably in relation to persons whose capacity fluctuates, for example, persons who have long periods of capacity alternating with shorter periods where cognitive ability is significantly impaired by an episode of mental illness. This was acknowledged by the Commission in its *Seminar Paper on Law and Elderly*.⁶

2.09 The status approach was rejected by the Law Commission of England and Wales in its *Report on Mental Incapacity* as being "out of tune with the policy aim of enabling and encouraging people to take for themselves any decision which they have capacity to take."⁷

2.10 Despite the obvious shortcomings of assessing an individual's capacity based on a once-off look at their status generally, any criticism of such an approach is subject to the caveat that in practice there will be cases where a person does not have the cognitive ability required to make any decisions with legal consequences for themselves. This will arise, for example, where a person is in what is

⁴ See Chapter 4 below.

⁵ *Ibid.*

⁶ Law Reform Commission *Seminar Paper on Law and the Elderly* (LRC SP2-2003) at 7.

⁷ Law Commission of England and Wales *Mental Incapacity* (No. 231 1995) at paragraph 3.3.

known as a persistent vegetative state⁸ or coma, or where dementia has advanced to such an extent that decision making ability is minimal and there is no prospect of regaining lost capacity. In such circumstances the requirement to make a fresh assessment of capacity every time a matter arises which requires a decision may be regarded as unnecessary.⁹

(2) *The Outcome Approach*

2.11 The outcome approach makes a decision on an individual's capacity based on an assessment of the consequences of their decision-making choices.¹⁰ The result of the choice is regarded as an indicator of the person's capacity. Under this standard, a person who makes a decision that reflects values which are not widely held or which rejects conventional wisdom is found to lack capacity.¹¹ This necessarily involves superimposing subjectivity and rationality in making the relevant analysis. Under this approach, in the area of healthcare decisions,¹² if a patient rejects a doctor's recommendations, the danger is that there will be a greater tendency to find that they lack capacity.

2.12 The Law Commission of England and Wales did not favour this approach to capacity on the basis that it "penalises individuality and demands conformity at the expense of personal autonomy."¹³ Although the outcomes of a decision may provide information on a person's understanding or lack of understanding, the outcome should not be conclusive of capacity. This was the approach taken by the

⁸ See *Re A Ward of Court (No.2)* [1996] 2 IR 79.

⁹ See Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at paragraph 1.22.

¹⁰ See Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at paragraph 1.20.

¹¹ See President's Commission for the Study of Ethical Problems in Medicine and Biomedical Healthcare Research *Making Healthcare Decisions: A Report on the Ethical and Legal Implications of Informed Consent in the Patient – Practitioner Relationship* Volume One (New York 1982) at 170.

¹² See Chapter 7 below.

¹³ Law Commission of England and Wales *Mental Incapacity* (No. 231 1995) at paragraph 3.4.

Court of Appeal in the leading English case on legal capacity *Masterman-Lister v Brutton & Co.*¹⁴

2.13 An illustration of circumstances where there may be a predisposition towards an outcome approach is found in the English High Court decision in *Re C (Adult: Refusal of Medical Treatment)*.¹⁵ In that case a 68 year old patient who had paranoid schizophrenia and was serving a term of imprisonment developed gangrene in his foot. The surgeon's view was that he was likely to face imminent death if his leg was not amputated below the knee. The patient's view was that he would rather die with two feet than live with one. At trial the judge found that the patient was suffering from grandiose delusions that he was a doctor but nevertheless had accepted the possibility of death as a consequence of retaining the limb. Thorpe J regarded the test for capacity as being whether C's capacity was so reduced by his chronic mental illness that he does not sufficiently understand the nature, purpose and effects of amputation. He concluded that, although C's general capacity had been impaired by schizophrenia, it was not established that he did not sufficiently understand the nature, purpose and effects of the treatment he refused. C therefore obtained an injunction preventing amputation by the hospital without his consent. This case implicitly rejected status and outcome approaches to capacity in favour of a functional approach.

(3) *The Functional Approach*

2.14 A functional model of capacity represents the most widely accepted modern capacity model and thus merits particular attention in this Consultation Paper.

2.15 As previously indicated, much of the discourse on the approach to capacity has arisen in the context of healthcare decisions. In the US, a major report in this area by the President's Commission found:

“Decision-making capacity is specific to each particular decision. Although some people lack this capacity for all decisions, many are incapacitated in more limited ways and

¹⁴ [2003] 3 All ER 162, 190. See further paragraph 2.23ff below.

¹⁵ [1994] 1 All ER 819.

are capable of making some decisions but not others. The concept of capacity is best understood and applied in a functional manner. That is, the presence or absence of capacity does not depend on a person's status or on the decision reached, but on that individual's actual functioning in situations in which a decision about healthcare is to be made."¹⁶

2.16 In contrast to the status approach, the functional approach to capacity recognises that legal capacity issues arise in a specific factual context, such as capacity to make a will,¹⁷ the right to marry¹⁸ or the ability to consent to or refuse medical treatment.¹⁹ Therefore the assessment of capacity should also be narrowed to the particular decision which needs to be made. The fundamental premise behind a functional view of capacity is that the fact that a person belongs to a category of people who are often unable to make decisions for their own wellbeing may open the possibility of a lack of decisional capacity - but it does not of itself resolve the matter.²⁰ Furthermore, an assessment that a person lacks legal capacity in relation to one decision does not mean that they necessarily lack legal capacity in relation to a different type of decision. An issue-specific, 'functional' approach to capacity²¹ assesses a person's capacity to make a particular decision. As a result the conception of capacity is in direct contrast to the all-or-nothing approach to capacity which tends to prevail under the status approach. Furthermore, the individual

¹⁶ See President's Commission for the Study of Ethical Problems in Medicine and Biomedical Healthcare Research *Making Healthcare Decisions A Report on the Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship* Volume One (New York 1982) at 3.

¹⁷ See Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at Chapter 2.

¹⁸ See Chapter 6 below.

¹⁹ See Chapter 7 below.

²⁰ See President's Commission for the Study of Ethical Problems in Medicine and Biomedical Healthcare Research *Making Healthcare Decisions: A Report on the Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship* *op cit* fn16 at 170 *ff.*

²¹ See Law Commission of England and Wales *Mental Incapacity* (No 231 1995).

assessment of capacity which characterises the functional approach has the resulting benefit of involving a proportionate, minimum incursion on an individual's decision-making autonomy.

2.17 The application of the functional approach's issue-specific understanding of capacity is evident in *Re Beaney*.²² This case concerned the validity of the transfer by a woman suffering from advanced senile dementia of her home to her daughter as a gift.²³ Martin Nourse QC, sitting as a deputy judge of the Chancery Division, stated:

“The degree or extent of understanding required in respect of any instrument is relative to the particular transaction which it is to effect. In the case of a will the degree required is always high. In the case of a contract, a deed made for consideration or a gift *inter vivos*, the degree varies with the circumstances of the transaction.”²⁴

It was held that the woman was not capable of understanding, and did not understand, that she was making an absolute gift of the property to her daughter when she signed the deed of transfer.

2.18 Another example of the diverse understanding of decision-making inherent in the functional model is *Park v Park*.²⁵ In this case a man of advanced years who married and executed a will on the same day was found to have had the capacity to marry but to have lacked the capacity to make a will.

2.19 A further aspect of a functional approach is that, both legally and conceptually, capacity is not treated as fixed for all time. Instead capacity is envisaged as time-specific as well as issue-specific. As noted by the Law Commission of England and Wales in its *Report on*

²² [1978] 2 All ER 595.

²³ On capacity to make a gift see further Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at paragraph 1.07.

²⁴ [1978] 2 All ER 595, 601.

²⁵ [1953] 2 All ER 408.

*Mental Incapacity*²⁶ “most people, unless in a coma, are able to make at least some decisions for themselves and may have levels of capacity that vary from week to week or even from hour to hour”.

2.20 Capacity legislation enshrining the so-called functional approach to capacity was recommended by the Law Commission of England and Wales.²⁷ The subsequent paper of the then Lord Chancellor’s Department *Making Decisions* described the practical effect of the functional approach in the following terms:

“This approach ... avoids generalisations which may involve unnecessary intrusion in the affairs of the individual. For example, a person may be able to decide that they want to have contact with a particular relative, but may not be able to understand the nature of a particular financial contract on which a decision is needed. The functional approach would indicate that the first decision is one for which the person had capacity, whereas the second decision is one for which s/he did not. The approach thus allows the maximum decision-making powers possible.”²⁸

2.21 In reflecting on the proposed content of a *Mental Capacity Bill* for England and Wales, the UK Government accepted the importance of recognising the issue of “general incapacity” within the context of a primary endorsement of the functional approach to capacity.²⁹ Similar reservations were expressed by the current Master of the Court of Protection of England and Wales in his comment:

²⁶ Law Commission of England and Wales *Mental Incapacity* (No 231 1995) at paragraph 3.5.

²⁷ Law Commission of England and Wales *Mental Incapacity* (No. 231 of 1995). See also Lord Chancellor’s Department *Who Decides? Making decisions on behalf of mentally incapacitated adults* (CM 3808) (The Stationery Office 1997) at paragraph 3.6.

²⁸ Lord Chancellor’s Department *Making Decisions* (CM 4465) (1999) at paragraph 3.7.

²⁹ Department for Constitutional Affairs *The Government Response to the Scrutiny Committee’s Report on the draft Mental Incapacity Bill* (2004) at 9, Recommendation 11. See also paragraph 2.10 above.

“The Law Commission’s functional approach to capacity is ideally suited for one-off transactions, such as entering into a contract, making a will or signing a power of attorney. Such decisions are largely based on understanding the nature and effect of that particular transaction, but it is less obvious whether this approach is suitable for the wider, more generic range of activities in managing one’s property and affairs ...”³⁰

2.22 The *Adults with Incapacity (Scotland) Act 2000* approaches capacity in a functional manner. In place of a ‘status’ view of capacity, it introduced a recognition that the capacity which an adult possesses should be encouraged and safeguarded. The recently *Mental Capacity Act 2005* for England and Wales also adopts a decision-specific, functional approach to capacity.

2.23 The recent decision of the Court of Appeal in *Masterman-Lister v Brutton & Co*³¹ entailed a decisive endorsement of a functional, issue-specific approach to capacity. In this case, the plaintiff was 17 when, in 1980, he was involved in an accident when his motorcycle collided with a milk float. As a result he suffered severe brain damage and was unable to continue his work. A personal injury claim against the driver of the milk float in respect of the accident was settled 7 years later. However, 6 years after the settlement the plaintiff decided to sue the solicitors’ firm which had acted for him on the basis that as he lacked the capacity at the time to manage his property and affairs, the settlement should have received the approval of the court.

2.24 At trial, Wright J found that since 1983 at the latest the plaintiff had been fully capable of managing his property and affairs having made enough of a recovery from the brain injury.³² On appeal to the Court of Appeal, Kennedy LJ referred to the issue-specific nature of the test for capacity and “the requirement to consider the question of capacity in relation to the particular transaction (its nature and complexity) in respect of which the decisions as to capacity fall

³⁰ Lush “Masterman-Lister and the Capacity to Manage One’s Property and Affairs” (2002) 3 *Elder Law and Finance* 73 at 75-76.

³¹ [2003] 3 All ER 162.

³² [2002] EWHC 417.

to be made.” The Court of Appeal reviewed relevant authorities and concluded that, in law, capacity depends on time and context. Thus, a decision as to capacity in one context does not bind a court which has to consider the issue in a different context. In this case the Court had to consider whether the plaintiff was capable of understanding, with the assistance of explanations in broad terms and simple language, the issues on which consent or a decision would be needed in order to pursue legal proceedings. Kennedy LJ stated that while the final decision on capacity rests with the court, in almost every case the court will need medical evidence to guide it. The Court regarded capacity as requiring:

“the ability to recognise a problem, obtain and receive, understand and retain relevant information, including advice; the ability to weigh the information and advice (including that derived from advice) in the balance in reaching a decision, and the ability to communicate that decision.”³³

2.25 The Court of Appeal affirmed the approach of the trial judge, holding that he had given proper weight to the medical evidence as to the effects of the head injury. Chadwick LJ stated that although outcomes can reflect capacity, it is capacity not outcomes which is important. Therefore while imprudent decision-making does not in itself prove a lack of capacity, it may raise the issue for consideration. In this light, evidence of the plaintiff’s loss of a pressure cooker valve and regular overstocking of a freezer - which was submitted in order to prove that the plaintiff had memory problems - were viewed by the court as mishaps which could happen to anyone.

2.26 The significance of this case for the law on capacity is threefold. First it contained a thorough review of the authorities on legal capacity in different contexts. Secondly, the Court of Appeal held that a functional approach represents the correct legal approach in making decisions on legal capacity. Thirdly, in an Irish context, where there is a dearth of cases on the law of capacity, the decision provides persuasive authority for this jurisdiction.

³³ [2003] 3 All ER 182, paragraph 26.

C General Legal Principles on Capacity

2.27 There is no one generally applicable definition of capacity at common law or in statute. Indeed, there is no single statute governing capacity issues, and the most frequent references to capacity in Irish law arise in the context of legislative references to persons “of unsound mind”.³⁴ The principles discussed below are gleaned from case law in different contexts in which capacity issues arise.

(1) *The Legal Presumption of Capacity*

2.28 The courts have held in a variety of different contexts³⁵ that an adult is presumed to have legal capacity unless the contrary is proved.³⁶ A presumption of capacity accommodates fluctuating capacity and lucid intervals and goes hand in glove with a functional approach to capacity. A consequence of the presumption of capacity is that the burden of proving a lack of capacity rests on those who raise it.³⁷

2.29 Thus an adult is presumed to have the capacity to consent to medical treatment,³⁸ to make a will (testamentary capacity),³⁹ to make a gift⁴⁰ and to manage their own property and affairs.⁴¹ The level of understanding required will depend on the nature and complexity of the transaction. Section 18(1) of the *Personal Injuries Assessment*

³⁴ See for example, the Wards of Court regime discussed in Chapter 4 below.

³⁵ In the area of contractual capacity, a presumption of capacity does not operate: see paragraph 5.04 below.

³⁶ See Scottish Law Commission *Mentally Disabled Adults – Legal Arrangements for Managing their Welfare and Finances* (Discussion Paper No. 94 1991) at paragraph 7.4 *ff*; Law Commission of England and Wales *Mentally Incapacitated Adults and Decision-Making: An Overview* (Law Com No 119 1991) at paragraph 2.10.

³⁷ See paragraph 2.32 below.

³⁸ See Chapter 7 below.

³⁹ *Bankes v Goodfellow* (1870) LR 5 QB 549. See further Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at Chapter 2.

⁴⁰ *Re Beaney* [1978] 2 All ER 595.

⁴¹ *Masterman-Lister v Brutton and Co.* [2003] 3 All ER 162.

Board Act 2003 contains a statutory presumption of capacity in relation to the claimant and respondent to personal injury claims covered by the legislation.⁴²

2.30 The Scottish Law Commission said of the presumption of capacity:

“Clearly there must be a presumption of competence and because the degree of understanding required varies enormously according to the type of legal transaction involved it is only sensible to consider capacity in relation to each particular transaction.”⁴³

2.31 While there is a general legal presumption of capacity there is no single definition of capacity which can be applied in all contexts.

(2) *Proving that a Person Lacks Legal Capacity*

2.32 Generally speaking, if it is alleged that a person lacks the capacity to make a decision with legal consequences, the onus of proving this is on the person who alleges the lack of capacity.⁴⁴ The standard of proof is the usual standard in civil proceedings - proof on the balance of probabilities.

2.33 Originally at common law, once it had been proved that a person lacked capacity, a presumption of continuance operated – the lack of capacity was presumed to continue until the contrary was proved.⁴⁵ However, a presumption of continuance was rejected by the

⁴² Section 18(3) of the *Personal Injuries Assessment Board Act 2003* provides that if the Personal Injuries Assessment Board is provided with a written medical opinion to the effect that the person is “not of sound mind” the presumption of capacity “shall be regarded as rebutted”.

⁴³ Scottish Law Commission *Mentally Disabled Adults – Legal Arrangements for Managing their Welfare and Finances* (Discussion Paper No. 94 1991) at paragraph 7.7.

⁴⁴ *Masterman-Lister v Brutton & Co.* [2003] 3 All ER 162. See paragraph 2.23 *ff* above.

⁴⁵ *Attorney-General v Parnter* (1792) 3 Bro CC 441; *Hassard v Smith* (1872) IR 6 Eq 429. See Lush ‘Capacity’ in Whitehouse (ed) *Society of Trust and Estate Practitioners Finance and the Law for the Older Client* (LexisNexis 2002) at D1.5.

Court of Appeal in *Masterman-Lister v Brutton and Co.*⁴⁶ In that case the plaintiff had sustained a head injury in an accident. It was contended that, where there was evidence that as a result the plaintiff was incapable of managing his property or affairs for a time, a presumption of continuance could be relied on to avoid having to prove that he lacked capacity to manage his affairs at a later stage. This was rejected by the Court of Appeal. Kennedy LJ stated: “Of course, if there is clear evidence of incapacity for a considerable period then the burden of proof may be more easily discharged, but it remains on whoever asserts incapacity.”⁴⁷ Therefore, in all circumstances where incapacity is asserted, it must be proved.

D Conclusions

2.34 Any approach by the law to restrict capacity is set against the background of human rights law and constitutional considerations outlined in Chapter 1.⁴⁸ In this regard, a core consideration when examining the merits of a particular model for determining capacity is the impact that its application is likely to have on the right of an adult to self-determination.⁴⁹

2.35 The Commission approves of Gordon and Verdun-Jones’ characterisation of capacity and incapacity as “extremes on a continuum.”⁵⁰ It is generally not appropriate for decision-making capacity to be regarded in stark terms of either being present or absent. A more subtle approach which accords with a social model of disability is called for.⁵¹ With this objective in mind, the Commission

⁴⁶ [2003] 3 All ER 162. See paragraph 2.23 *ff* above.

⁴⁷ [2003] 3 All ER 162, 169.

⁴⁸ See paragraph 1.26 *ff* above.

⁴⁹ Self-determination relates to an individual’s exercise of the capacity to form, revise and pursue personal plans for life. See generally Dworkin *Autonomy and Informed Consent: The Theory and Practice of Autonomy* (Cambridge University Press 1988).

⁵⁰ Gordon and Verdun-Jones *Adult Guardianship Law in Canada* (Carswell 1992) at 6-35.

⁵¹ See paragraph 1.19 *ff* above.

has reviewed the status, outcome and functional approaches to capacity.

2.36 Failure to make prudent or sensible decisions should not of itself lead to a characterisation of a person as lacking capacity since a badge of capacity is the right to make decisions autonomously in whatever manner one chooses within the confines of the law. For this reason, the Commission does not regard the outcome approach to capacity as capable of forming a stand-alone approach to capacity. In the words of John Stuart Mill:

“There is no reason that all human existence should be constructed on some one or some small number of patterns. If a person possesses any tolerable amount of common sense and experience, his own mode of laying out his existence is best, not because it is the best in itself, but because it is his own mode.”⁵²

2.37 The Commission also considers that the status approach is unsuitable as a primary approach to capacity because its all-or-nothing conception of capacity is objectionable for being unnecessarily disabling in effect. The fact that a person has a disability which commonly means that a person will not be able to make decisions for themselves may signify a potential lack of capacity but it should not be decisive of the issue. The Commission is nevertheless cognisant of the fact that in certain situations a person may have no decision-making capacity nor any real prospect of gaining capacity in a particular area of decision-making.

2.38 The Commission therefore favours a predominantly functional approach to matters of legal capacity. A functional approach would allow decision-making capacity to be assessed in relation to a particular decision at the time the decision is to be made. This understanding of capacity accords with the principle of maximum preservation of capacity articulated in the Council of Europe’s *Recommendation on Principles concerning the Legal*

⁵² John Stuart Mill *On Liberty and Other Essays* (Oxford University Press 1991) at 75.

Protection of Vulnerable Adults.⁵³ The policy guidelines set out in the Council of Europe Recommendation favour a flexible approach to capacity which recognises different degrees of incapacity and the importance of the context in which the question arises. Choosing the functional approach as the preferred capacity model is also consistent with the leading English decision on capacity in *Masterman-Lister v Brutton & Co*⁵⁴ and with recent legislative trends in the area of capacity in other common law jurisdictions including Scotland's *Adults with Incapacity (Scotland) Act 2000* and the English *Mental Capacity Act 2005*.⁵⁵

2.39 While an issue-specific and time-specific functional approach commends itself as the primary approach to capacity, the Commission notes that in certain exceptional circumstances where an adult's lack of capacity is profound and likely to endure, a new functional determination of capacity in a particular area of decision-making may be unnecessary every time that class of decision arises.⁵⁶

2.40 *The Commission recommends that a predominantly functional approach should be taken to the issue of legal capacity. This would involve consideration of a person's capacity in relation to the particular decision to be made at the time it is to be made. The Commission also recognises that where an adult's lack of capacity is*

⁵³ Council of Europe Committee of Ministers *Recommendation No. R (99) on Principles Concerning the Legal Protection of Incapable Adults* (23 February 1999). See paragraph 1.37 ff above.

⁵⁴ [2003] 3 All ER 162. See paragraph 2.23 ff above.

⁵⁵ See also South African Law Reform Commission *Assisted Decision-making: Adults with Impaired Decision-making Capacity* (Discussion Paper 105) (January 2004) which includes a draft bill embracing a functional, cognitive ability approach to capacity.

⁵⁶ See paragraphs 2.10 and 2.21 above.

profound and enduring, a new functional determination may be unnecessary in every situation in which a decision has to be made.

CHAPTER 3 LEGISLATIVE REFORM

A Introduction

3.01 A finding that an adult has legal capacity means that they have the autonomy to make a decision on that particular area of their life. By contrast, a finding that an adult lacks legal capacity has serious consequences for their autonomy because such a finding involves limiting their right to self-determination. Given the implications of a decision on capacity, certainty and transparency in the law on capacity are important. This chapter examines the desirability of enacting capacity legislation to provide a coherent set of principles to govern legal capacity.

3.02 Part B of this chapter considers the benefits of enacting capacity legislation. Part C examines the appropriate legislative approach.

B The Potential Role of Capacity Legislation

3.03 There are strong arguments in favour of the enactment of legislation specifically dealing with legal capacity. These relate particularly to the role which legislation could play in creating certainty in relation to the law on capacity and its potential to promote and safeguard the interests of vulnerable adults.¹

3.04 In recent years many countries have enacted legislation to deal with capacity and substitute decision-making including New Zealand,² territories in Australia,³ Canada⁴ and Germany.⁵ Other

¹ See House of Lords / House of Commons Joint Committee *Report on the Draft Mental Incapacity Bill* (HL Paper 189-1 HC 1083-1) (HMSO 2003) at 14.

² *Protection of Personal and Property Rights Act 1988*.

countries are contemplating such legislation.⁶ The *Adults with Incapacity (Scotland) Act 2000* was enacted in order to establish a comprehensive modern scheme to deal with issues of capacity and substitute decision-making based on a functional understanding of capacity.⁷ It also involved the establishment of a Public Guardian. The *Mental Capacity Act 2005* for England and Wales received the Royal Assent on 7 April 2005.⁸ This legislation has its origins in the work of the English Law Commission in this area.⁹ The English Law Commission recommended that “[t]he ‘group of holes’ within which people who lack mental capacity must now exist should be replaced with a carefully designed and well-constructed legal basket.”¹⁰ The *Mental Capacity Act 2005* was designed to be enabling in nature and, like the Scottish legislation, is based on a functional understanding of capacity. The *Mental Capacity Act 2005* also establishes a Court of Protection, which will have jurisdiction in relation to the *Mental Capacity Act 2005*, and a Public Guardian.

³ See, for example, *Guardianship Act 1997* (New South Wales) and *Adult Guardianship Act 2004* (Northwest Territories).

⁴ See, for example, Ontario’s *Consent to Treatment Act 1995*, *Substitute Decisions Act 1995* and *Advocacy Act 1995*.

⁵ *Betreuungsgesetz 1990*.

⁶ See, for example, South African Law Reform Commission *Assisted Decision-making: Adults with Impaired Decision-making Capacity* (Discussion Paper 105) (January 2004).

⁷ See Scottish Law Commission *Mentally Disabled Adults: Legal Arrangements for Managing their Welfare and Finances* (Discussion Paper No. 94) (1991); Scottish Law Commission *Report on Incapable Adults* (No. 151) (1995); *Ward Adult Incapacity* (W. Green / Sweet & Maxwell 2003).

⁸ See also Department for Constitutional Affairs *Mental Capacity Bill: Draft Code of Practice* (2004).

⁹ See Law Commission *Mentally Incapacitated Adults and Decision-making: Medical Treatment and Research* (No. 129 1993); Law Commission *Mental Incapacity* (Report No. 231 HMSO 1995); Lord Chancellor’s Department *Who Decides? Making Decisions on Behalf of Mentally Incapacitated Adults* (December 1997) (Cm 3803); *Report of the Joint Committee on the Draft Mental Incapacity Bill* (HL Paper 189-1 HC 1083-1) (The Stationery Office 2003).

¹⁰ Law Commission *Mental Incapacity op cit* fn9 at paragraph 2.51.

(1) Lack of Systematic Guidelines Addressing Legal Capacity

3.05 To date judicial and legislative consideration of legal capacity has been piecemeal rather than systematic.¹¹ Outside a number of discrete areas of decision-making, for example, the capacity to make a will¹² and ex-post facto judicial analysis of capacity to marry in the context of nullity cases,¹³ there has been little modern judicial consideration of capacity issues by the Irish courts.¹⁴ Thus while in some areas the law on what capacity entails is well-developed, in other areas such as wardship,¹⁵ there is a dearth of judicial authorities on the crucial issue of how capacity should be understood and defined. A consequence of this is a large measure of legal and popular uncertainty as to (a) the right of adults whose decision making capacity is limited to make decisions with legal consequences; and (b) the validity of decisions made on behalf of such adults by parents and carers.

3.06 It might be argued that capacity issues could continue to be dealt with by the courts on a case by case basis. However, in the Commission's view, there are strong counter-arguments. First, practical hurdles frequently present themselves in terms of a vulnerable adult being aware of their rights and having the necessary assistance and legal representation to enforce them. This means that such cases are likely to remain rare. Secondly, at a more fundamental level, case law will, in any event, only deal with specific cases rather than generally applicable principles.¹⁶ Thirdly, supervisory structures

¹¹ The law on selected capacity issues is examined in Chapters 4-7 of this Consultation Paper.

¹² See Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003), Chapter 2.

¹³ See paragraph 6.29 *ff* below.

¹⁴ The Supreme Court decision in *Re a Ward of Court (No.2)* [1996] 2 IR 79 is a notable exception. See paragraph 1.27 above; paragraph 7.52 *ff* below.

¹⁵ See Chapter 4 below.

¹⁶ "Litigation as a tool for law reform tends to chaos rather than coherence." The Rt. Hon. Baroness Hale of Richmond "Law Maker or Law Reformer: what is a Law Lady for?" John Maurice Memorial Lecture (2005) at 6.

such as an Office of the Public Guardian can only be put in place by primary legislation.¹⁷

3.07 The following description of the law in relation to capacity and substitute decision making, made in relation to the Scottish legal position prior to the enactment of the *Adults with Incapacity (Scotland) Act 2000*, also seems apt in the Irish context:

“The law we have inherited looks like an archaeological site with an assortment of buildings from various eras in various states of disrepair, in various degrees unsuitable for modern living, totally uncoordinated in layout and unstandardised in design, with many complete gaps and dodgy areas where one can tread only with uncertainty and trepidation...”¹⁸

The equal applicability of these comments to this jurisdiction is apparent from the review in succeeding chapters of this Consultation Paper of the law on wardship, powers of attorney, capacity to contract, capacity to enter personal relationships and capacity to make healthcare decisions.

3.08 The desirability of enacting legislation was recognised by the Disability Legislation Consultation Group:

“There is considerable concern about the minimal legal provision for supported decision-making, informed consent and rights. Separate legislation is needed to identify the competence of vulnerable adults and particularly adults unable to make decisions on their own behalf, to provide protection for those who lack competence.”¹⁹

¹⁷ See Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at Chapter 6.

¹⁸ Comments made by Adrian Ward at a seminar in relation to the situation in Scotland prior to the enactment of the *Adults with Incapacity (Scotland) Act 2000*: see Ward *Adult Incapacity* (Edinburgh 2003) (W. Green /Sweet & Maxwell) at 31.

¹⁹ Disability Legislation Consultation Group *Equal Citizens: Proposals for Core Elements of Disability Legislation* (2003), Part IV at 33.

Reform on capacity and substitute decision-making other jurisdictions has been described as follows:

“Increasingly in other jurisdictions the site has been cleared and a new structure erected, designed to meet modern needs in ways which accord with modern circumstances, perceptions and values. The best of these new structures are designed to be effective, efficient, accessible and user-friendly; clearly laid out and based on consistent application of clear and important basic principles.”²⁰

3.09 As the law stands there is no uniform understanding of capacity which is applicable in all decision-making contexts. In the Commission’s view, a clear legislative code would fill this void and would as a consequence reduce existing legal uncertainty as to how capacity should be conceived. In particular, the enactment of capacity legislation would offer the opportunity to put in place a functional understanding of capacity which will inform any assessment of a person’s legal capacity.²¹

(2) *Promotion of Interests of Vulnerable Adults*

3.10 The normative potential for capacity legislation should not be underestimated. The enactment of capacity legislation would serve to promote the interests of vulnerable adults who are in danger of having their rights and interests overlooked or actively disregarded. Legislation could assist in safeguarding the rights of vulnerable adults by specifically identifying the right of every adult to have their personal level of decision making capacity respected and maximised. Legislative embodiment of this approach would assist in shifting from a medical to a human rights model of disability.²² The enactment of capacity legislation would also provide the opportunity to include a rights-based framework which would emphasise the importance of working both to recognise and to maximise the decision-making

²⁰ Comments made by Adrian Ward at a seminar in relation to the situation in Scotland prior to the enactment of the *Adults with Incapacity (Scotland) Act 2000*: see Ward *Adult Incapacity* (Edinburgh 2003) (W. Green /Sweet & Maxwell) at 31.

²¹ See further Chapter 2 above.

²² See paragraph 1.19 *ff* above.

capacity of adults whose decision-making ability is limited. It would also permit the establishment of a systematic structure for dealing with legal capacity issues as well as facilitating provisions to safeguard the interests of adults with limited decision-making capacity.

3.11 A finding that a person lacks the capacity to make a decision immediately raises the issue of who can assist them to make the decision or make the decision in their place. In this regard this Consultation Paper and the *Consultation Paper on Law and the Elderly*²³ should be viewed as two sides of the same coin. Developing legislative rules on capacity would pave the way for a cohesive legislative assisted decision-making scheme of the type envisaged in the *Consultation Paper on Law and the Elderly*. While this Consultation Paper focuses on the concept of legal capacity, it is envisaged that the proposed capacity legislation would also deal with assisted and substitute decision-making and the recommendations in this area made by the Law Reform Commission in the *Consultation Paper on Law and the Elderly*. The structure of the capacity legislation, including provisions concerning substitute and assisted decision-making and the establishment of an Office of the Public Guardian recommended in the *Consultation Paper on Law and the Elderly*, will be drawn together in the Commission's proposed Report on Vulnerable Adults and the Law.²⁴

3.12 *The Commission recommends the enactment of capacity legislation for the following reasons:*

- *Existing legislative and judicial consideration of capacity matters has been piecemeal rather than systematic and wide-ranging;*
- *The law on capacity should be clear, transparent and accessible;*

²³ Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003), Chapter 6.

²⁴ See paragraphs 3.13 - 3.14 below.

- *Capacity legislation would permit a coherent uniform legislative understanding of legal capacity to be put in place which would apply in all situations;*
- *Capacity legislation could seek to achieve an appropriate balance between autonomy and protection by promoting the interests of vulnerable adults;*
- *Capacity legislation would also be an appropriate vehicle to deal with the consequences of a finding of lack of capacity, in particular through making provision for substitute and assisted decision-making structures of the type envisaged in the Commission's Consultation Paper on Law and the Elderly.*

C Legislative Approach

(1) Structure of Capacity Legislation

3.13 The Commission acknowledges that drafting legislation in the area of capacity, which affects civil rights, is a complex normative task. The Commission envisages that legislation in this area would provide a comprehensive framework which could be structured around provisions which can be broadly categorised as

- (i) provisions concerning the definition of legal capacity;
- (ii) provisions concerning substitute and assisted decision-making where an adult lacks capacity including principles to which substitute and assisting decision-makers must adhere;
- (iii) provisions concerning regulation and supervision.

3.14 Substitute and assisted decision-making where a person lacks capacity, and the associated regulation and supervision by a Public Guardian were considered in the Commission's *Consultation Paper on Law and the Elderly*.²⁵ In keeping with the focus of this Consultation Paper, the remainder of this chapter examines key issues concerning the development of a statutory definition of capacity and

²⁵ See further Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at Chapter 6.

related issues. The Commission's proposed Report on Vulnerable Adults and the Law will draw together all three aspects. The Report will address the appropriate procedural and institutional framework to implement the principles contained in this Consultation Paper and the earlier *Consultation Paper on Law and the Elderly*.

(2) Methodology

3.15 The Commission's view is that where existing common law principles concerning legal capacity can be restated in any proposed legislation, this should be done.²⁶ The drafting of capacity legislation also provides an important opportunity to make improvements and adaptations to the law. This is particularly the case where:

- gaps in the existing law have resulted in legal uncertainty;
- the law has not kept pace with contemporary understanding of disability in a manner which emphasises and promotes capacity;²⁷ or
- existing procedures for determining capacity do not reflect best practice under administrative and human rights law.²⁸

(3) Terminology

3.16 Much of the terminology traditionally used to describe persons who lack legal capacity is objectionable and outdated.²⁹ The Commission is particularly mindful that terms such as 'person of unsound mind' are inappropriate, objectionable and stigmatising. Furthermore, such phrases are opaque.³⁰

²⁶ See, for example, paragraph 5.41 - 5.42 below.

²⁷ See, for example, the discussion on wardship in Chapter 4 below.

²⁸ See generally Chapter 1 above and Chapter 4 below.

²⁹ See *Dolan v Registrar of Wards of Court* High Court (Kelly J) 19 March 2004 (*ex tempore*) discussed at paragraph 4.19 - 4.20 below.

³⁰ In *Winterwerp v The Netherlands* (1979-80) 2 EHRR 387, paragraph 37, the European Court of Human Rights stated that the term "unsound mind" should not be used as a means to incarcerate persons who were simply socially deviant or who held unpopular political views. See further paragraph 4.12 *ff* below.

3.17 The Commission on the Status of People with Disabilities stated:

“It is important that definitions of disability should use language which reflects the rights of people with disabilities to be treated as full citizens and included in all aspects of society. All definitions of disability should be reviewed and inappropriate and inoffensive language replaced. In the light of the Commission’s view that disability is primarily a social rather than a medical construct, it is inappropriate that definitions of disability should rely solely on medical definitions or medical evidence. Finally, definitions of disability should encourage self-determination and autonomy of people with disabilities rather than reinforce dependency.”³¹

The Commission endorses this view in the context of drafting capacity legislation. The Commission therefore concludes that capacity legislation should be drafted in terms which are enabling rather than restrictive in nature.

3.18 *The Commission recommends that the proposed capacity legislation should use appropriate terminology to refer to persons who lack legal capacity.*

3.19 *The Commission recommends that the proposed capacity legislation should be drafted in terms which are enabling rather than restrictive in nature.*

(4) A Statutory Statement of Presumed Capacity

3.20 A legal presumption that an adult is capable of making decisions autonomously is consistent with a social rather than a medical model of disability.³² Indeed, the common law presumption

³¹ Commission on the Status of People with Disabilities *A Strategy for Equality: Report of the Commission on the Status of People with Disabilities* (1996) at 2.2. See also Department of Justice, Equality and Law Reform *Towards Equal Citizenship: Progress Report on the Implementation of the Recommendations of the Commission on the Status of People with Disabilities* (Stationery Office 2000) at 13-14.

³² See paragraph 1.19 *ff* above.

that an adult has capacity³³ respects the generally held belief that adults are entitled to live in the manner they wish and to accept or refuse support, assistance or protection so long as they do not harm others and are capable of making decisions about these matters. Moreover, the presumption of capacity respects the principle of minimum intervention. In addition, the presumption of capacity dovetails well with the functional approach to capacity which this Consultation Paper favours.³⁴

3.21 It is common in other jurisdictions where capacity and guardianship/adult protection legislation has been enacted for a statutory statement of the presumption of capacity to be included in the legislation.³⁵ In the Canadian province of British Columbia, section 3(1) of the *Adult Guardianship Act RSBC 1996* encapsulates a presumption of capacity which is drafted to reflect the spectrum in which decision-making arises:

“Until the contrary is demonstrated, every adult is presumed to be capable of making decisions about personal care, health care, legal matters or about the adult’s financial affairs, business affairs or assets.”

3.22 The Law Commission of England and Wales, in recommending capacity legislation, was of the view that it would be helpful if legislation set out a rebuttable presumption of capacity.³⁶ This has been included in the *Mental Capacity Act 2005*.³⁷ By contrast, the *Adults with Incapacity (Scotland) Act 2000* proceeds from the basis of the continuing application of the common law

³³ See paragraph 2.28 *ff* above.

³⁴ See paragraph 2.40 *ff* above.

³⁵ See, for example, section 3 of Saskatchewan’s *The Adult Guardianship and Co-decision-making Act 2000*, section 1(1) of the Nova Scotia’s *Guardianship and Trusteeship Act 1994*, section 7(a) of Queensland’s *Guardianship and Administration Act 2000*.

³⁶ Law Commission of England and Wales *Mental Incapacity* (No 231 1995) at paragraph 3.2.

³⁷ Section 1(2) of the *Mental Capacity Act 2005* states that “[a] person must be assumed to have capacity unless it is established that he lacks capacity.”

presumption of capacity in respect of persons over 16³⁸ and a general presumption of capacity is not expressly set out in the legislation.

3.23 Having considered these different approaches, the Commission favours the inclusion of a statement of a positive presumption of capacity as the cornerstone of the proposed capacity legislation.³⁹ An express statutory statement of the common law evidentiary presumption would assist in the creation of a clear and certain code in respect of capacity. Furthermore, a statutory statement of presumed capacity would conform with the Commission's belief that any such legislation should be couched in terms that are enabling rather than restrictive in nature.

3.24 As noted above,⁴⁰ the continued existence of the common law 'presumption of continuance' has been put in doubt by the decision of the English Court of Appeal in *Masterman-Lister v Brutton and Co.*⁴¹ The Commission considers that a presumption of continuance is inconsistent with the preferred functional, issue-specific and time-specific approach to capacity. The inclusion of a statutory statement of presumption of capacity, when combined with a functional approach to the definition of capacity, should have the effect of removing any doubt in this regard.

3.25 *The Commission recommends that the proposed capacity legislation should set out a rebuttable presumption of capacity to the effect that every adult is presumed, until the contrary is demonstrated, to be capable of making decisions affecting them.*

(5) A Statutory Definition of Capacity

3.26 Detailed discussion of specific methodology and tools for undertaking an assessment of capacity has largely arisen in the particular context of assessing capacity to make healthcare

³⁸ Under the *Age of Legal Capacity (Scotland) Act 1991*, a person over the age of 16 is deemed to be an adult.

³⁹ See Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at paragraph 1.23.

⁴⁰ See paragraph 2.33 above.

⁴¹ [2002] 3 All ER 162.

decisions.⁴² Indeed there is no one uniformly accepted test to assess decision-making ability.⁴³ Rather more consensus exists in relation to the different general approaches which may be taken to capacity.⁴⁴

3.27 Reflecting the fact that individual capacity cannot be simply captured by an all-embracing scientific test, recent capacity legislation in other jurisdictions does not attempt to set out specific methodology for the assessment of capacity. Rather, the trend is for such legislation to provide a broad definition of capacity in the form of guiding principles which assist in making a decision on an adult's capacity to make a particular decision. For example, the English *Mental Capacity Act 2005* provides a general statutory definition of capacity in the form of guiding principles which give a broad definition of how capacity is to be understood. Additional guidance will be given in a code of practice to accompany the legislation when it comes into force.⁴⁵

3.28 The Commission is conscious that the assessment of capacity is a complex issue which must be carried out in relation to each adult as an individual.⁴⁶ Based on a detailed review of the Irish position in relation to legal capacity in a number of key areas⁴⁷ and of trends in other jurisdictions, the Commission considers that rather than being unduly prescriptive, it would be beneficial for capacity legislation to contain a broad statutory definition of capacity which would apply in a wide range of situations.

⁴² See paragraph 7.24 below.

⁴³ The search for a single test of capacity has been likened to the search for the Holy Grail: Roth, Meisel and Lidz "Test of Competency to Consent to Medical Treatment" (1977) 134 *American Journal of Psychiatry* 279; Kapp "Evaluating Decision-making Capacity in the Elderly: A Review of Recent Literature" in DeJowski (ed) *Protecting Judgment-Impaired Adults* (New York 1990) at N7.

⁴⁴ See Chapter 2 above.

⁴⁵ See Department for Constitutional Affairs *Mental Capacity Bill: Draft Code of Practice* (2004).

⁴⁶ The discrete area of assessment of capacity to make healthcare decisions is considered at paragraphs 7.18 *ff* and 7.90 *ff* below.

⁴⁷ See Chapters 4-7 below.

3.29 *The Commission recommends that capacity legislation should contain a statutory definition of capacity.*

3.30 Formulating an appropriate test for capacity is crucial, because a decision that a person lacks capacity will be the gateway to a removal of autonomy and to another person having responsibility to make or to assist in the making of the relevant decision. Furthermore, it is important that any definition of capacity is one which can be easily understood and applied.⁴⁸ There are three main approaches to statutorily defining legal capacity – two are negatively defined in terms of lack of capacity, the other defines capacity in positive terms.

(a) *Defining lack of capacity in terms of causation*

A causation-centred or diagnostic understanding of incapacity focuses on the cause of a person's decision-making disability and usually involves a definition of incapacity rather than capacity. The *Consultation Paper on Law and the Elderly*⁴⁹ invited views on whether general legal incapacity should be defined to exist where an adult is suffering from a mental disorder or a mental disability and, because of that disorder or disability, is unable to make personal and health care decisions and/or to manage property and affairs.

3.31 In a number of jurisdictions lack of capacity is predicated on a mental disability pre-condition – the legislation requires that the decision-making disability be caused by 'mental disability', 'mental illness' or 'mental disorder'. This mental disorder requirement appears in the Australian State of Victoria's *Guardianship and Administration Board Act 1986* and the *Adults with Incapacity (Scotland) Act 2000*. The *Adults with Incapacity (Scotland) Act 2000* defines incapacity by reference to the existence of a mental disorder or inability to communicate because of a physical disability which affects decision-making ability. Section 1(6) defines "incapable" as

⁴⁸ The formulation of guiding principles for persons assessing capacity and making substitute decisions will be examined in the Commission's final report on *Vulnerable Adults and the Law*.

⁴⁹ Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at paragraph 1.54.

meaning:

“incapable of (a) acting; or (b) making decisions; or (c) communicating decisions; or (d) understanding decisions; or (e) retaining decisions ... by reason of mental disorder or an inability to communicate....”

3.32 Commentators have criticised the mental disorder precondition in the Scottish legislation. While the use of the concept of mental disorder is understandable in mental health legislation, which is primarily concerned with the imposition of compulsory measures and thus requires strict definitions, capacity legislation requires “a broad gateway to possible use of enabling and empowering provisions.”⁵⁰ In the United States the general trend in dealing with the issue of capacity is a movement away from a determination of mental status and towards measurement of the ability to function in society.⁵¹

3.33 Section 2(1) of the English *Mental Capacity Act 2005* regards a person as lacking capacity in relation to a matter if “at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.” Section 3(1) states that a person satisfying this definition will be treated as unable to make a decision for himself if he is unable:

- “(a) to understand the information relevant to the decision,
- (b) to retain that information,
- (c) to use or weigh that information as part of the process of making the decision, or
- (d) to communicate his decision (whether by talking, using sign language or any other means).”

⁵⁰ Patrick and Ward *Mental Health (Scotland) Act 1984 and Adults with Incapacity (Scotland) Act 2000* (Sweet and Maxwell Edinburgh 2001) at 187.

⁵¹ See Begley and Jeffreys *Representing the Elderly Client* (Panel 2000 loose-leaf updated) at paragraph 2.65.

3.34 Defining ‘mental disorder’ is not a simple matter for doctors or lawyers. One commentator on mental health law has described the difficulty in the following terms:

“With a physical disease or disability, the doctor can presuppose a state of perfect or ‘normal’ bodily health (however unusual that may be) and point to the ways in which the patient’s condition falls short of that. A state of perfect mental health is probably unattainable and certainly cannot be defined. The doctor has instead to presuppose some average standard for normal intellectual, social or emotional functions, and it is not enough that the patient deviates from this. For some deviations will be in the better-than-average direction; even if it is clear that the patient’s capacities are below the supposed average, the problem still arises of how far below that supposed average is sufficiently abnormal, among the range of possible variations, to be labelled a disorder.”⁵²

These difficulties do not assist in defining the presence or absence of a medical disorder. However, in any event, there are strong arguments that the use of mental disorder labels in the context of assessing a person’s capacity in law does not fit with a social as opposed to the medical model of disability. As the Commission noted in the *Consultation Paper on Law and the Elderly*,⁵³ “the existence of a defined mental incapacity does not necessarily mean that legal capacity is impaired or lost.”

3.35 The following comment of Berghmans and Widdershoven made in the context of medical treatment and research illustrates the changing attitude to capacity:

“In recent years, legal definitions of (mental) capacity have moved from viewing mental capacity as a global, all-embracing condition, to a more specific condition restricted to particular realms of decision-making. This means that diagnostic categories (e.g. schizophrenia, Alzheimer’s disease,

⁵² Hoggett *Mental Health* (1976) at 59.

⁵³ Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at paragraph 1.28.

depression etc...) as such cannot decide the issue of decision-making capacity. Particular functional abilities that may be considered relevant for mental capacity (e.g. understanding, practical reasoning) are logically independent of most diagnostic and descriptive categories. This means that capacity always has to be considered in connection to a particular decision.”⁵⁴

3.36 In the *Seminar Paper on the Consultation Paper on Law and the Elderly*, the Commission commented on this issue as follows:

“One view is that to focus on the cause of decision-making incapacity is unhelpful – any definition of mental disorder may be too narrow to reflect an evolving understanding of mental disability which may defy any neat classification. Intellectual impairments have a range of different causes and the nature and the existence of a particular illness or disability may have a wide spectrum in terms of the effect on the individual. It may be considered that the term ‘mental disorder’ is not appropriate to persons with learning disabilities, emotional disorders and brain damage. In short, a focus on mental disorder/mental disability labels may detract from a fair analysis of the fundamental issue of a person’s decision-making ability.”⁵⁵

3.37 The South African Law Reform Commission has recently recommended against a causative reference to mental disability in capacity legislation.⁵⁶ It was influenced in this context by a desire to avoid complex definitions of mental illness and to avoid discriminatory labelling of persons who lack capacity by declaring them to be mentally ill or incapable.

⁵⁴ Berghmans and Widdershoven “Ethical Perspective on Decision-Making Capacity and Consent for Treatment and Research” (2003) 22 Med Law 391 at 394. See generally Law Commission *Mentally Incapacitated Adults and Decision-Making: An Overview* (Consultation Paper No.119 HMSO 1991).

⁵⁵ Law Reform Commission *Seminar Paper on Law and the Elderly* (LRC SP2-2003) at 9.

⁵⁶ South African Law Reform Commission *Assisted Decision-making: Adults with Impaired Decision-making Capacity* (Discussion Paper 105) (January 2004) at 81.

(b) *Defining lack of capacity in terms of lack of decision-making ability*

3.38 In contrast to a causation-centred, diagnostic model, an effect-centred definition of incapacity would be formulated in terms of the individual being unable to make the relevant decision as opposed to focusing on the suggested cause of such incapacity. This approach implicitly acknowledges that the existence of a disability or illness does not lead automatically or inexorably to the conclusion that the individual does not have capacity. In some jurisdictions, the legislative formulation requires the person to understand the nature and to foresee the consequences of a decision. For example, section 6(1)(a) of New Zealand's *Protection of Personal and Property Rights Act 1988* requires the person concerned to "lack, wholly or partly, the capacity to understand the nature, and to foresee the consequences of decisions in respect of matters relating to his or her personal care and welfare." In other jurisdictions the focus is on the individual's ability to understand information relevant to the decision and to appreciate its reasonably foreseeable consequences.

(c) *Defining capacity in positive terms*

3.39 Capacity legislation may choose to include a definition of "capacity" rather than "incapacity". This approach is similar to an effect-based model of capacity as described in (b) above but with a focus on capacity rather than lack of capacity. In the Canadian province of Saskatchewan capacity is defined positively in terms of the ability to understand information relevant to making a decision and to appreciate the reasonably foreseeable consequences of making or not making a decision.⁵⁷

(d) *The Commission's view on defining capacity*

3.40 The Commission's preferred approach to defining capacity is one which views people as individuals and not on the basis of labels such as mental disorder. A positive definition of capacity is the preferred option. The Commission believes that a positive functional

⁵⁷ Section 2 of the *Adult Guardianship and Co-decision-making Act 2000*.

understanding of capacity which does not focus on any underlying causative factors is appropriate.⁵⁸

3.41 When should an adult be regarded as having capacity? Capacity essentially relates to decision-making ability. Capacity should then be understood primarily in terms of cognitive ability to understand and appreciate the nature and consequences of the decision and available choices. An adult is able to make a decision for themselves if they are able to understand information relevant to the decision and to make an informed decision based on that information. Cognitive ability entails the ability to arrive at a decision by weighing relevant information in the balance.

3.42 An adult should not to be regarded as unable to understand relevant information if he or she has the ability to understand an explanation of the information in broad terms and in simple language or through the use of pictorial or other visual aids.⁵⁹ The fact that a person can only retain relevant information for a short time should not automatically prevent them from being regarded as able to make a decision.⁶⁰

3.43 As discussed in Chapter 2, a legislative approach to capacity should reflect the functional approach to capacity which is capable of accommodating fluctuating capacity. Capacity legislation should specify that capacity is to be judged in relation to a particular decision to be made at the time it is to be made.⁶¹

3.44 *The Commission recommends that the proposed capacity legislation should contain a functional definition of capacity which focuses on an adult's cognitive ability to understand the nature and consequences of a decision in the context of available choices.*

3.45 If capacity legislation includes a functional definition of capacity couched in terms of cognitive ability, this raises a number of relevant points. First, while illnesses or disabilities may affect

⁵⁸ A person's cognitive ability involves the capacity to reason, remember, understand, solve problems and make decisions.

⁵⁹ See section 3(2) of the English *Mental Capacity Act 2005*.

⁶⁰ See section 3(3) of the English *Mental Capacity Act 2005*.

⁶¹ See paragraph 2.34 *ff* above.

cognition, this cannot be automatically presumed to be the case. Secondly, intrinsic to a functional approach to capacity is that a person may lack capacity in some domains but retain capacity in others. In addition, the Commission believes that it should be emphasised that adults are free to make what others regard as poor or eccentric decisions provided that they understand the nature of the decision they are making.⁶² The Commission considers that, in order to avoid any doubt on the matter, the proposed capacity legislation should state that an adult should not be regarded as unable to make a decision merely because he or she makes a decision which would ordinarily be regarded as imprudent as opposed to irrational. This reflects the trend in other jurisdictions such as the Canadian province of Saskatchewan,⁶³ England and Wales⁶⁴ and New Zealand⁶⁵ to include a statutory statement of principle to this effect.

3.46 *The Commission recommends that an adult should not be regarded as unable to make a decision merely because they make a decision which would ordinarily be regarded as imprudent.*

3.47 A further issue arises in connection with the formulation of a uniform understanding of capacity. Even if an adult has the requisite cognitive ability to make decisions, they may not be able to communicate their choices. This does not mean that a person must have the ability to communicate their choice verbally through fluent speech or in writing. It simply requires that there be some method by which they can communicate their decision if an action is required by someone else to carry that decision into effect, for example, by the use of a computer or by other bodily signals. In *Ryan v Ryan*⁶⁶ a testator who was paralysed except for his throat and various facial muscles communicated to a solicitor by a blinking system. The court

⁶² See *Masterman v Lister* [2003] 3 All ER 182, paragraph 26; paragraphs 2.25 and 2.36 above.

⁶³ Section 3(c) of the *Adult Guardianship and Co-decision-making Act 2000*.

⁶⁴ See Law Commission *Mental Incapacity* (Law Com No. 231) at paragraph 3.19; section 1(4) of the *Mental Capacity Act 2005*; Department for Constitutional Affairs *Mental Capacity Bill: Draft Code of Practice* (2004) at 21.

⁶⁵ Section 1(3) of the *Protection of Personal and Property Rights Act 1988*.

⁶⁶ (1904) 4 NIJR 164.

was satisfied that the solicitor had succeeded in ascertaining the testator's wishes and intentions.⁶⁷

3.48 The Commission is satisfied that a statutory definition of capacity must encompass an ability to communicate a decision. In summary, the preferred understanding of capacity which the Commission considers should be encapsulated in legislation is that of cognitive ability to make the decision in question at the time it is to be made and an ability to communicate effectively that decision in a manner which permits it to be carried into effect.

3.49 *The Commission recommends that a person will lack capacity if they are unable to communicate their choices by any means where communication to a third party is required to implement the decision.*

⁶⁷ See also *Re AK (Medical Treatment: Consent)* [2001] 1 FLR 129.

CHAPTER 4 REVIEW OF EXISTING LEGAL MECHANISMS TO ADDRESS LOSS OF CAPACITY

A Introduction

4.01 In order to formulate recommendations for legislative reform through the introduction of capacity legislation, it is necessary to examine the existing legal mechanisms which are designed to deal with the position of an adult who lacks legal capacity. The primary mechanisms under Irish law are wardship and enduring powers of attorney. Both regimes provide for the appointment of substitute decision-makers and were previously considered in some detail by the Commission in the *Consultation Paper on Law and the Elderly*.¹ This chapter does not duplicate the comprehensive treatment of the procedural aspects of both areas in the *Consultation Paper on Law and the Elderly*. Rather, the objective here is to highlight selected aspects of wardship and enduring powers of attorney which are worthy of attention in the present context of a review of the law on capacity. Part B of this chapter examines wardship and Part C examines enduring powers of attorney. Part D contains the Commission's conclusions in relation to each legal mechanism. In particular, this chapter examines how these regimes conceive of and define capacity, measured against the barometer of the predominantly functional model of capacity which the Commission recommended in Chapter 2.² The chapter also examines the need for procedural safeguards in connection with making determinations concerning a person's legal capacity.

¹ See Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at Chapter 3 (enduring powers of attorney) and Chapter 4 (wardship).

² See paragraph 2.40 above.

B Wardship

4.02 The Wards of Court system is a substitute decision making regime available for adults under Irish law.³ It owes its origins to the notion of the monarch as the *parens patriae* or guardian of the people and particularly of those unable to take care of themselves.⁴ The paternalistic concepts which are at the heart of the wardship system sit somewhat uncomfortably with the more recent social and human rights models of disability⁵ and the conception of capacity in functional terms.⁶ Furthermore, there are aspects of wardship procedure which may not reflect the emphasis on adequate procedural safeguards designed to protect human rights contained in the best practice recommendations of the Council of Europe⁷ and the European Convention on Human Rights (“ECHR”).

4.03 The responsibility for the operation of the Wards of Court system rests with the President of the High Court⁸ and is administered

³ For a detailed consideration of the operation of the wardship jurisdiction in Ireland see O’Neill *Wards of Court in Ireland* (First Law 2004); Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) (Chapter 4). See also Costello “Wards of Court – A general guideline of the procedure involved” (May 1993) *Law Society Gazette* 143; McLoughlin “Wardship: A Legal and Medical Perspective” (1998) *MLJI* 61; Ní Chúlacháin “Wardship: Time for Reform?” (2000) *Bar Review* 239.

⁴ The current basis of the jurisdiction is variously attributed to the *parens patriae* prerogative, Article 40.3.2° of the Constitution and the inherent jurisdiction of the High Court: see Tomkin and McAuley “Re a Ward of Court: Legal Analysis” (1995) 1 *MLJI* 45; Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at paragraph 4.04 *ff*; O’Neill *Wards of Court in Ireland* (First Law 2004) at paragraph 1.9-1.12.

⁵ See paragraph 1.19 *ff* above.

⁶ See Chapter 2 above.

⁷ See Council of Europe *Recommendation no. (99)4 of the Committee of Ministers to Member States on Principles concerning the Legal Protection of Incapable Adults* (adopted 23 February 1999) Principle 7; paragraph 1.37 *ff* above.

⁸ Section 9(2) of the *Courts (Supplemental Provisions) Act 1961* enables the President of the High Court to assign another High Court judge to exercise the jurisdiction.

by the Registrar and staff of the Office of Wards of Court.⁹ The criteria for wardship and the procedure for bringing a person into wardship are set out in the *Lunacy Regulation (Ireland) Act 1871* (“the 1871 Act”)¹⁰ and Order 67 of the *Rules of the Superior Courts 1986*¹¹ (“Order 67”). In 2003, 204 Orders were made by the High Court admitting adults to wardship.¹²

(1) Common Situations where Wardship Proceedings Instituted

4.04 Wardship proceedings are most commonly brought in respect of an adult where that person has substantially lost capacity through illness or injury and the person has a certain amount of money or property which needs to be protected and used for their maintenance.¹³ Other common scenarios where applications for admission to wardship are made include:

- where a person receives damages or a settlement in respect of personal injuries which had an adverse impact on their mental capacity;¹⁴

⁹ See generally Courts Service *Office of Wards of Court – An Information Booklet* (2003).

¹⁰ In the Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) (at paragraph 4.18, fn18), the Commission noted the inappropriateness in modern times of terms such as “lunacy”, “lunatic” and “idiot” which are used in the *Lunacy Regulation (Ireland) Act 1871*. In relation to the need for appropriate labelling see also Commission on the Status of People with Disabilities *A Strategy for Equality: Report of the Commission on the Status of People with Disabilities* at paragraph 2.1; paragraph 1.21 above.

¹¹ S.I. No. 15 of 1986 (as amended).

¹² Courts Service *Annual Report 2003* (2004) at 89.

¹³ It has been estimated by the staff of the Office of the Wards of Court that 75-80% of persons admitted to Wardship have senile dementia or some other mental infirmity associated with old age: Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at paragraph 4.03.

¹⁴ See *Re Keogh* High Court (Finnegan P) 15 October 2002; *Dolan v Registrar of Wards of Court* High Court (Kelly J) 19 March 2004 (*ex tempore*).

- where a person with a psychiatric illness or a learning disability receives or inherits property which they are unable to manage;¹⁵
- where the consent of a person with limited decision-making ability needs to be given to a particular transaction in relation to their property;¹⁶
- an individual requires to be protected from an identified risk of harm.¹⁷

(2) Procedure under Section 15 of the 1871 Act

4.05 In order to be taken into wardship, a person must be declared to be “of unsound mind and incapable of managing his person or property.”¹⁸

(I) Petition

4.06 Most commonly, wardship proceedings are taken by a family member¹⁹ in the High Court²⁰ under section 15 of the 1871 Act.²¹ This

¹⁵ In relation to wills and discretionary trusts to benefit an adult with an intellectual disability see: NAMHI *Making a Will – What you should know: A guide for parents and families of people with intellectual disabilities* (2003).

¹⁶ For example, in order to ensure that a purchaser receives a good, marketable title where the seller lacks the capacity to consent, making the individual a Ward of Court allows the Court to authorise the sale.

¹⁷ See, for example, *In re Application of Midland Health Board* [1988] ILRM 251 where a Health Board petitioned for a wardship inquiry in circumstances where there was a serious risk to the welfare of a 20 year old intellectually disabled woman in the family home.

¹⁸ Section 15 of the 1871 Act. See further paragraph 4.17 *ff* below.

¹⁹ The question of who may bring a petition is not addressed in the 1871 Act or the applicable rules. In practice, where a next of kin is not available or willing to act, a petition may be presented by a third party, medical practitioner, hospital authorities or solicitor: Courts Service *Office of Wards of Court – An Information Booklet* (2003) at 4.

²⁰ A request for Wardship may be made in the Circuit Court where the person’s property does not exceed €6,350 or the income from that property does not exceed €389 *per annum*: section 22(2) of the *Courts*

involves petitioning the Court to conduct an inquiry into whether to admit a person to wardship. The petition is accompanied by supporting affidavits from two medical practitioners²² attesting that the person is of unsound mind and unable to manage their affairs.²³

4.07 Neither the 1871 Act nor Order 67 specifies what information should be supplied in the medical affidavits. However, the Office of Wards of Court recommends that information supplied should include:

- (i) the date on which and place at which the examination took place (this should be no more than one month before the affidavit is sworn);
- (ii) a description of the person's response to the examination, including, where relevant, references to symptoms, demeanour and answers to mental tests;
- (iii) a diagnosis of the person's mental condition where applicable;
- (iv) any other observations relevant to the issue of the person's mental capacity or incapacity;
- (v) the opinion of the medical practitioner as to whether or not the person is of unsound mind and incapable of managing their affairs.²⁴

(Supplemental Provisions) Act 1961 (as amended). However, in practice wardship proceedings are rarely instituted in the Circuit Court.

²¹ For further detail on the procedure under section 15 of the *Lunacy Regulation (Ireland) Act 1871* and alternative procedural bases see O'Neill *Wards of Court in Ireland* (First Law 2004) at Chapter 2; Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at paragraph 4.19 ff.

²² This excludes psychologists and psychiatrists. However, on occasion an affidavit of a medical practitioner will make reference to the opinion of a consultant psychologist or to psychometric testing.

²³ In relation to the test for wardship see further paragraph 4.17 ff below.

²⁴ See O'Neill *Wards of Court in Ireland op cit* fn21 at paragraph 2.63.

(II) *Inquiry Order*

4.08 If the President of the High Court is satisfied with the medical evidence, an inquiry order is made and a Medical Visitor (a consultant psychiatrist) is sent to examine the person and report back to the Court. As a matter of practice, the Court will not issue an inquiry order unless the term “of unsound mind” appears on the medical affidavits.²⁵ The term “of unsound mind” therefore presents a dilemma for doctors and family members who are reluctant to attach such a stigmatising label. Indeed doctors would not normally use the term “of unsound mind” to describe a person with intellectual disability or a person who has experienced a decrease in cognitive ability.

(III) *Notice*

4.09 In order for a Wardship Inquiry to proceed, notice must be personally served on the person in respect of whom the wardship application is made (“the respondent”).²⁶ This will notify the person of the right to submit objections in writing to the Registrar.²⁷ The person is also informed of their entitlement to seek to have the inquiry heard before a jury. There are no guidelines as to who is the appropriate person to serve notice on the proposed Ward and what explanations should be given to them. Frequently notice of the wardship petition is served on the person by the family member who has made the application. The Commission notes the importance of fair procedures and the crucial importance of ensuring that a potentially vulnerable person is aware of what wardship involves and their legal right to object within 7 days.²⁸ If a notice of objection is lodged with the Registrar of Wards of Court, the Registrar will permit the respondent’s solicitor to forward a medical affidavit and may then

²⁵ See comments of Mr Noel Doherty, Registrar of Wards of Court *Wards of Court* Continuing Legal Education Lecture, Law Society (2003) at 42.

²⁶ Order 4, rule 8 of the *Rules of the Superior Courts 1986* (S.I. No. 15 of 1986).

²⁷ See *Re Keogh* High Court (Finnegan P) 15 October 2002, discussed at paragraph 4.18 below.

²⁸ See Rickard-Clarke “Elder Abuse – Legal Solutions” paper presented at Irish Women Lawyers’ Association, Seminar on Law and the Elderly, 2 January 2005 at 4.

allow the exchange of medical affidavits between the petitioner and the respondent. They may decide whether they wish to have their medical practitioners give oral evidence at the Wardship Inquiry.²⁹

4.10 While the respondent must be notified of the wardship application and the fact that medical affidavits have been submitted, there is no requirement to furnish them with details of or copies of the medical affidavits supporting the petition. In addition, it would appear that the Medical Visitor's report is not made available to the subject unless they make an objection to being made a Ward of Court and then make a request to be given a copy.³⁰

4.11 In *Eastern Health Board v MK*³¹ Denham J stated that "[w]ardship proceedings must be fair and in accordance with constitutional justice."³² Constitutional justice may not be complied with where a decision-maker relies on information outside the hearing which has not been disclosed to the subject of the decision.³³

4.12 Article 6(1) of the ECHR guarantees the right to a fair hearing including a legal determination of civil rights and obligations. In the seminal case of *Winterwerp v The Netherlands*,³⁴ a case concerning the involuntary psychiatric detention of a person which resulted in the automatic loss of their legal capacity to deal with their property, the

²⁹ See O'Neill *Wards of Court in Ireland* (First Law 2004) at 2.69.

³⁰ *Ibid* at 2.63.

³¹ [1999] 2 IR 99, 111.

³² See *Re Haughey* [1971] IR 217.

³³ See the comments of Blayney J. in *The State (Polymark Ltd) v ITGWU* [1987] ILRM 357 where the Labour Court obtained legal advice on an aspect of a submission from an employer concerning jurisdiction and carried on with the case without disclosing the advice obtained to the employer and giving the employer the opportunity to respond; Hogan and Morgan *Administrative Law in Ireland* (3rd ed Round Hall Sweet & Maxwell 1998) at 500 *ff*.

³⁴ (1979-80) 2 EHRR 387 at paragraph 73 (see paragraph 4.29 below); Jones *Mental Health Act Manual* (9th ed Sweet & Maxwell 2004) at 797 *ff*; Wachenfeld "The Human Rights of the Mentally Ill in Europe" (1991) 60 *Nordic Journal of International Law* 109, at 224.

European Court of Human Rights (“ECtHR”) stated:

“The capacity to deal with one’s property involves the exercise of private rights and hence affects ‘civil rights and obligations’ within the meaning of Article 6(1).”

It would appear that, by analogy, the guarantee of fair procedures in Article 6 applies to wardship procedures and the determination of a person’s legal capacity.³⁵ Arguably the practice of not automatically furnishing an adult who is the subject of wardship proceedings with the medical affidavits and the report of the Medical Visitor may also conflict with the guarantee of a fair hearing and equality of arms contained in Article 6(1) of the ECHR. The principle of equality of arms requires each party to be given a reasonable opportunity to present his case under conditions that do not place either party at a substantial disadvantage.³⁶ This may require the respondent to be given access to information such as medical affidavits and the report of the Medical Visitor in order to enable them or their representatives to assess effectively the evidence and where appropriate to oppose the wardship petition and to make an informed decision as to whether to opt for a jury trial. The concept of fair procedures under Article 6(1) includes the right of the parties to “have knowledge of and [to] comment on all evidence adduced or observations files with a view to influencing the court’s decision.”³⁷

4.13 The Commission notes that there is no provision for support, whether legal or advocacy services, to be made available to the respondent once they have been notified of the impending Wardship Inquiry in order to assist them to understand what wardship involves

³⁵ It would appear that Article 6(1) covers “not only ... the particular process of the making of the decision but extends more widely to the whole process which leads up to the final resolution”: *R (Alconbury Developments Ltd) v Secretary of State for the Environment, Transport and the Regions* [2001] 2 All ER 929, paragraph 152 *per* Lord Clyde.

³⁶ *Nideröst-Huber v Switzerland* 18990/91 European Court of Human Rights 18 February 1997.

³⁷ *MS v Finland* 46601/99 European Court of Human Rights 22 March 2005 at paragraph 32. See also *HAL v Finland* 38267/97 European Court of Human Rights 27 January 2004; *Rowe v United Kingdom* (2000) 30 EHRR 1; *Vermeulen v Belgium* 19075/91 European Court of Human Rights 20 February 1996.

and to formulate and lodge an objection within the required seven days. Indeed, the requirements of constitutional justice suggest that the courts should not make final orders where an interested party is not present or represented in cases affecting legal rights or interests.³⁸

4.14 The decision of the ECtHR in *Winterwerp* indicates that special procedural safeguards may be called for in order to protect the interests of persons who on account of a mental disability are not fully capable of acting for themselves.³⁹ In the later case of *Del Sol v France*⁴⁰ the ECtHR stated that the right of access to court guaranteed by Article 6 of the ECHR is “practical and effective” rather than “theoretical or illusory”. It has been suggested that a failure to provide a person with the assistance of a lawyer may breach Article 6(1) “where such assistance is indispensable for effective access to court”.⁴¹

(IV) *The Wardship Inquiry*

4.15 The inquiry would appear to be more inquisitorial than adversarial in nature and the rules of evidence are therefore relaxed⁴² unless the person has sought to have the inquiry heard before a jury. This has some significance in relation to the assessment of capacity because a clearly adversarial system would allow for cross-examination by the respondent in relation to medical evidence on capacity. It is possible that the guarantee of fair procedures in the context of the determination of civil rights and obligations contained in Article 6(1) of the ECHR could extend to a right to adversarial proceedings which would allow the petitioner’s medical evidence to be challenged by the respondent.

³⁸ See *The State (Rogers) v Galvin* [1983] IR 249, 253 where an *ex parte* order releasing the defendants from custody provided for in the Rules of the Superior Court resulted in Henchy J expressing reservations as to whether such a rule was *intra vires* the Superior Court Rules Committee.

³⁹ (1979-80) 2 EHRR 387, paragraph 60. See also *Multiplex v Croatia* 58112/00 European Court of Human Rights 10 July 2003.

⁴⁰ (2002) 35 EHRR 38 at paragraph 21.

⁴¹ *Jones Mental Health Manual* (9th ed Sweet & Maxwell 2004) at 798.

⁴² *Eastern Health Board v MK* [1999] 2 IR 99 (admission of hearsay evidence). See further Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at paragraph 4.18.

4.16 The standard of proof of legal incapacity is not specified in the *Lunacy Regulation (Ireland) Act 1871*. In the *Consultation Paper on Law and the Elderly*,⁴³ the Commission noted that in *Re a Ward of Court (No.2)*⁴⁴ there was “a considerable divergence of opinion on the standard of proof” in relation to an application by a Committee to the Court for a decision on medical treatment of a person who had been made a Ward of Court.⁴⁵

(3) Test for Wardship

4.17 In order to be taken into wardship, a person must be declared to be “of unsound mind and incapable of managing his person or property.”⁴⁶ A decision to bring a person into wardship is judicial rather than administrative in nature and must be exercised in accordance with the Constitution.⁴⁷ Even where the criteria for wardship are satisfied, the court has a discretion as to whether or not to make a Wardship Order.⁴⁸

4.18 *Re Keogh*⁴⁹ is authority for the proposition that the requirement that the person is “of unsound mind and incapable of managing his person or property” is to be construed conjunctively rather than disjunctively. Ms Keogh had been involved in a traffic accident which resulted in her sustaining a skull fracture and brain damage. As a result of the accident High Court proceedings were

⁴³ Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003).

⁴⁴ [1996] 2 IR 79.

⁴⁵ Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at paragraph 4.18. See also Tomkin and McAuley “Re A Ward of Court: Legal Analysis” (1995) 1 MLJI 45.

⁴⁶ Section 15 of the 1871 Act.

⁴⁷ *Eastern Health Board v MK* [1999] 2 IR 99; *Dolan v Registrar of Wards of Court* High Court (Kelly J) 19 March 2004 (*ex tempore*).

⁴⁸ *In re Application of Midland Health Board* [1988] ILRM 251, 259 per Finlay CJ; *Dolan v Registrar of Wards of Court* High Court (Kelly J) 19 March 2004 (*ex tempore*).

⁴⁹ High Court (Finnegan P) 15 October 2002.

instituted in the name of Ms Keogh suing by a next friend,⁵⁰ and these proceedings were settled. As a result a petition was presented to have Ms Keogh made a Ward of Court, supported by two medical affidavits, and the President of the High Court made an Order making her a Ward of Court. However, the President of the High Court was unaware that Ms Keogh had lodged a letter objecting to being made a Ward of Court.⁵¹ The matter was reviewed by the High Court and the jury considered (i) whether Ms Keogh was of unsound mind; and (ii) whether she was incapable of looking after her person and property. The jury found that Ms Keogh was not of unsound mind but she was incapable of looking after her person or property. Finnegan P held that since both matters had to be established, an order making Ms Keogh a Ward of Court could not be made.

4.19 As noted above, there has been concern that there is a stigma attached to the archaic labels used in the 1871 Act in relation to persons who are made a Ward of Court.⁵² The perceived stigma may make family members reluctant to make an application to have a relative made a Ward of Court. The recent High Court case of *Dolan v Registrar of Wards of Court*⁵³ illustrates such concerns. The case concerned a 21 year old with an intellectual disability to whom a settlement of IR£3 million was made in respect of a personal injury claim. The bulk of the money was placed with the Accountant General pending an application to the President of the High Court to make the man a Ward of Court. The parents did not initiate an application for wardship and resisted medical examination of their son by a Medical Visitor with a view to a wardship inquiry being initiated under section 12 of the 1871 Act.⁵⁴ In an application for an interlocutory injunction to prevent the inspection, the parents

⁵⁰ Where a person lacks capacity to litigate, a “next friend” can be appointed to sue on their behalf: Order 15, rule 17 of the *Rules of the Superior Courts 1986* (S.I. No. 15 of 1986).

⁵¹ See paragraph 4.09 above.

⁵² See paragraph 4.08 above.

⁵³ High Court (Kelly J) 19 March 2004 (*ex tempore*). See O’Neill *Wards of Court in Ireland* (First Law 2004) at 50-51.

⁵⁴ In relation to the procedure under section 12 see: Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at paragraph 4.28-4.29.

contended that they were concerned not to have their son labelled as an ‘idiot’, ‘lunatic’ or a ‘person of unsound mind’.

4.20 Kelly J held that an Order directing a Medical Visitor to carry out an examination was a necessary precondition to an application for wardship and could not be the subject of an injunction. He stated that the term “person of unsound mind” needed to be understood in the legal sense of a person who is incapable of managing his affairs. He held that the term “of unsound mind” connoted “no more than that the person is incapable of managing their affairs”. This was undoubtedly influenced by the facts of the case where the parents were seeking to avoid their son being made a Ward of Court on the basis that they were unhappy to have the stigmatising label “of unsound mind” applied to their son. However, while Kelly J’s approach in *Dolan* was pragmatic, it sits somewhat uneasily with the approach taken by Finnegan P in *Re Keogh*⁵⁵ where it was held that the issue of whether a person was “of unsound mind” was separate from the issue of whether a person is incapable of managing their affairs and that both conditions had to be met. Both cases illustrate the difficulties facing the judiciary in applying the 1871 Act in a contemporary setting.

(4) Impact of Wardship on Legal Capacity

4.21 The impact of being made a Ward of Court on a person’s decision-making and legal capacity is monumental.⁵⁶ O’Neill states that while “wardship may be accepted as a necessary and justifiable form of paternalism it is important to be aware that it involves a severe curtailment of individual liberties.”⁵⁷

4.22 When a wardship order is made by the High Court, the Court will appoint a Committee of the Estate and a Committee of the Person to take charge of the day to day affairs of the person under the supervision of the President of the High Court. The Court may order that all the funds of the person admitted to wardship be lodged in the Accountant’s Office for investment and management on their behalf.

⁵⁵ High Court (Finnegan P) 15 October 2002.

⁵⁶ See Courts Service *Office of Wards of Court – An Information Booklet* (2003) at 14-15; Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at paragraph 4.44 *ff*.

⁵⁷ O’Neill *Wards of Court in Ireland* (First Law 2004) at paragraph 7.1.

4.23 The legal effect of being made a Ward of Court is that the Court is vested with jurisdiction over all matters relating to their person and estate.⁵⁸ In other words, a person who has been made a Ward of Court loses the right to make any decisions about their person and property. Although the Court will have regard to the views of the committee and family members, the Court will make decisions based on the criterion of the ‘best interests’ of the Ward.⁵⁹ In *Re a Ward of Court (No.2)*⁶⁰ Lynch J’s approach of “the standpoint of a prudent and loving parent”⁶¹ was approved by Hamilton CJ in the Supreme Court.⁶² However, the fact that a person has been made a Ward of Court does not give them an entitlement to receive the services which will best serve the interests of their personal welfare. *CK v Northern Area Health Board*⁶³ concerned a Ward of Court whose funds were no longer sufficient to provide the 24 hour care that he needed. His sister sought a declaration that the Health Board’s failure to provide adequate care at home for the Ward was in breach of its statutory obligations. Although McGuinness J stated that “[i]t is abundantly clear that it is in the interests of the ward that he should be maintained in his own home”, the Supreme Court held that the *Health Act 1970* could not be interpreted as requiring the Health Board to provide an equivalent home care service to that which would be provided in hospital.

4.24 A person who has been made a Ward of Court cannot enter a binding contract,⁶⁴ cannot marry,⁶⁵ cannot independently institute or defend legal proceedings,⁶⁶ cannot buy or sell property or have a bank

⁵⁸ *Re a Ward of Court (No.2)* [1996] 2 IR 79, 106 *per* Hamilton CJ.

⁵⁹ *Re a Ward of Court (No.2)* [1996] 2 IR 79.

⁶⁰ [1996] 2 IR 79.

⁶¹ [1996] 2 IR 79, 99. This approach derives from Lord Goff’s opinion in *Airedale NHS Trust v Bland* [1993] AC 789.

⁶² See Donnelly “Decision-making for Mentally Incompetent People: The Empty Formula of Best Interests?” (2001) 20 Med. Law 405.

⁶³ *CK v Northern Area Health Board* [2003] 2 IR 544.

⁶⁴ See paragraph 5.19 below.

⁶⁵ See paragraph 6.48 below.

⁶⁶ Order 15, rule 17 of the *Rules of the Superior Courts 1986* provides for a person who has been admitted to wardship to institute and defend legal proceedings by his committee. Proceedings may only commenced by the

account. They may make a will if the High Court is satisfied that they have the required capacity to do this upon medical evidence of testamentary capacity being adduced. A person who has been made a Ward of Court does not have legal capacity to consent to medical treatment.⁶⁷ They cannot transfer residence from one nursing home to another without the consent of the High Court nor can they travel outside the country without the consent of the High Court.⁶⁸ O'Neill comments that in view of the potential deprivation of liberty involved, there should be a statutory requirement for the applicant to examine less restrictive alternatives to wardship before making a wardship application.⁶⁹

(5) Review of Capacity and Welfare of a Ward

(1) Periodic Review

4.25 A wardship order is of indefinite duration.⁷⁰ There is no systematic requirement that a person who has been made a Ward of Court be regularly visited or for periodic review of their welfare and general circumstances to be carried out. Section 56 of the *Lunacy Regulation (Ireland) Act 1871* provides that the President of the High Court may direct a Medical Visitor to visit a person after they have been made a Ward of Court. In addition, the Registrar has the power to require the Committee of the Person to provide details of the Ward's residence and physical and mental condition periodically.⁷¹

Committee with the approval of the Court and any settlement must be approved by the Court.

⁶⁷ *Re a Ward of Court (No.2)* [1996] 2 IR 79. Issues relating to consent to medical treatment in respect of adults who have been made a Ward of Court are discussed at paragraph 7.52 *ff* below.

⁶⁸ See Courts Service *Office of Wards of Court – An Information Booklet* (2003) at 8.

⁶⁹ O'Neill *Wards of Court in Ireland* (First Law 2004) at 2.91.

⁷⁰ A procedure for temporary wardship is available under section 103 of the *Lunacy Regulation (Ireland) Act 1871* but in practice this is rarely used. See further Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at paragraph 4.31-4.32.

⁷¹ Order 67, rule 59 of the *Rules of the Superior Courts 1986* (S.I. No. 15 of 1986).

4.26 In practice, the situation of an individual who has been made a Ward of Court is often likely to be examined only where a specific complaint has been received by the Office of Wards of Court.⁷² Where there is no periodic review of the capacity or welfare of a person who has been admitted to wardship, this gives rise to human rights concerns. Similar concerns led to the enactment of the *Mental Health Act 2001* which provides for the systematic review of involuntary psychiatric detention by Mental Health Tribunals.⁷³

(II) *Wardship and Order to Reside in a Psychiatric Unit or Long Stay Care Facility*

4.27 Frequently, where the person admitted to wardship resides in a long term care facility (nursing home) or psychiatric unit, an order is made that they should be detained there until further order. Section 57 of the 1871 Act dictates that where a person who has been made a Ward of Court is a private patient in a psychiatric hospital they must be visited at least four times a year by a Medical Visitor who will report on their mental and physical condition to the President of the High Court. In the case of a public patient in a psychiatric hospital, the statutory requirement is limited to at least one visit a year by a Medical Visitor.⁷⁴ This distinction between public and private patients which has its origins in the 1871 Act is difficult to justify. Furthermore, there is no comparable review requirement in respect of persons who are resident in a long stay care facility as opposed to a psychiatric hospital.

⁷² This may be open to legal question on the basis of the decision of the European Court of Human Rights in *HL v United Kingdom* 45508/99 European Court of Human Rights 5 October 2004. See Hewitt “Effective, unqualified control” (2004) 154 NLJ 1553; paragraph 4.30 below.

⁷³ See *Croke v Ireland* Application No 3326/96 concerning the application of Article 5(4) of the ECHR to a person’s involuntary psychiatric detention under section 172 of the *Mental Health Act 1945* and the lack of an automatic and independent review of that continuing detention (friendly settlement reached); *O’Reilly v Ireland* Application No. 24196/94 concerning the arbitrary deprivation of liberty under Article 5(1)(e) of the ECHR (friendly settlement reached). See Byrne and McCutcheon *The Irish Legal System* (4th ed Butterworths) at paragraph 17.54.

⁷⁴ See O’Neill *Wards of Court in Ireland* (First Law 2004) at 1.50.

4.28 A court order for a person's continuing detention which is consequent on the making of a wardship order falls outside the remit of the *Mental Health Act 2001* and the review mechanisms provided for in that legislation in respect of involuntary psychiatric detention. It is arguable that statutory provision for a person who has been made a Ward of Court to apply to the High Court to be discharged from wardship does not constitute an adequate review mechanism to address continuing detention in a long stay care facility or psychiatric residence having regard to case-law concerning Article 5 of the ECHR. Article 5(1)(e) of the ECHR guarantees that no-one shall be deprived of their liberty as "a person of unsound mind" except in accordance with a procedure prescribed by law. Article 5(4) of the ECHR provides:

"Everyone who is deprived of his liberty by arrest or warrant shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful."

4.29 The leading ECHR case in this area is *Winterwerp v The Netherlands*.⁷⁵ Mr Winterwerp was involuntarily detained in a psychiatric hospital as a "person of unsound mind". Under Dutch law this resulted in the automatic loss of his legal capacity to administer his property. He complained about not being given an adequate opportunity to challenge his detention contrary to Article 5(4) of the ECHR. In relation to Article 5(4) the ECtHR stated that:

"[t]he very nature of liberty under consideration [involuntary psychiatric detention] would appear to require a review of lawfulness to be available at reasonable intervals."

The ECtHR made it clear that detention which was initially lawful could become unlawful if a person was no longer of unsound mind.

Furthermore, the ECtHR stated that:

"it is essential that the person concerned should have access to a court and the opportunity to be heard either in person

⁷⁵ (1979-1980) 2 EHRR 387 at paragraph 55.

or, where necessary, through some form of representation....”⁷⁶

Therefore in this case, the court concluded that Mr Winterwerp had been the victim of a breach of Article 5(4) of the ECHR. A number of ECHR cases establish that Article 5(4) is a right not just to review, but to periodic review.⁷⁷

4.30 In *HL v United Kingdom*⁷⁸ a man with autism who was unable to speak and was described as having limited understanding was detained in a psychiatric unit after becoming agitated at a day centre and banging his head against a wall. The patient was admitted informally rather than being compulsorily detained and as such was not subject to the safeguards which applied to compulsory detention under the UK *Mental Health Act 1983*. A number of months later, acting through a next friend, the man made an application for judicial review of the hospital’s decision to admit him. When the case reached the House of Lords, it was held that the detention and treatment were justified under the common law doctrine of necessity. In the ECtHR the arguments on behalf of the applicant were that he had been deprived of his liberty contrary to Article 5(1) in a manner which was not “in accordance with a procedure prescribed by law” and was not lawful because he was not of unsound mind. It was argued that while it may have been an emergency at the time of his admission, the circumstances did not justify his continuing detention and that there was no adequate provision for review. While the Article 5(1) submission was found by the ECtHR to lack merit, the Court found that the lack of procedures governing detention and its review left “effective and unqualified control” in the hands of the relevant healthcare professionals and that the lack of procedural safeguards failed to protect against arbitrary deprivations of liberty particularly as there was no procedure for “continuing clinical assessment of the persistence of a disorder warranting detention.”⁷⁹ In relation to Article 5(4), the Court considered that the possibility of

⁷⁶ *Winterwerp v The Netherlands* (1979-1980) 2 EHRR 387 at paragraph 39.

⁷⁷ See, for example, *Megyeri v Germany* (1993) EHRR 584.

⁷⁸ European Court of Human Rights 5 October 2004.

⁷⁹ European Court of Human Rights 5 October 2004 at paragraph 120.

making an application for judicial review was an insufficient mechanism for reviewing the lawfulness of continuing detention.

(III) *Application for Discharge from Wardship*

4.31 An adult who has been made a Ward of Court can make an application to the President of the High Court to be discharged from wardship.⁸⁰ The Court may discharge a person from wardship on satisfactory medical evidence of the person's mental capacity being produced.⁸¹ If a discharge is granted this will restore the person's legal capacity and control of their person and property.

4.32 In *Matter v Slovakia*⁸² the guarantee of fair procedures in Article 6 of the ECHR was held by the ECtHR to apply to proceedings to determine whether or not legal capacity can be restored to the applicant to enable him to carry out certain legal acts. The judgment of the ECtHR in *Winterwerp v The Netherlands*⁸³ suggests that it should not be left to the initiative of a person who has been made a Ward of Court to seek to obtain legal representation to have their case reviewed by a Mental Health Review Tribunal. Recently similar concerns were expressed by the Court of Appeal in *R(MH) v The Health Secretary*,⁸⁴ a case concerning the review of involuntary detention of a woman with Down's syndrome who lacked the capacity to initiate a review application concerning her detention under section 2 of the UK *Mental Health Act 1983*. It was argued on her behalf that although a right to have her detention reviewed by a Mental Health Review Tribunal was provided for in the legislation, this was not sufficient to comply with Article 5(4) of the ECHR because the woman would not have the capacity to make such an application. The Court of Appeal granted a declaration of incompatibility with Article 5(4) in respect of the section's failure to

⁸⁰ Order 67, rule 93 of the *Rules of the Superior Courts 1986*. See O'Neill *Wards of Court in Ireland* (First Law 2004) at 180-183.

⁸¹ See O'Neill *Wards of Court in Ireland op cit* fn80 at 6.19 ff.

⁸² (2001) 31 EHRR 32, paragraph 51. See also *X v United Kingdom* (1981) 4 EHRR 188.

⁸³ (1979-1980) 2 EHRR 387. See paragraph 4.29 above.

⁸⁴ [2004] EWCA Civ 1609. See Hewitt "Incapacity and the Right to Liberty" (2005) NLJ 26.

make provision for circumstances in which a person is incapable of exercising the right to make an application to a Mental Health Review Tribunal on their own initiative.

4.33 Having regard to the case-law on Article 5(4) of the ECHR, the Commission considers that the lack of a system of automatic independent periodic review with appropriate safeguards to protect the interests of the person who has been made a Ward of Court gives rise to real concerns which need to be addressed.

(6) *Proposals for Reform*

4.34 In 1965 the Commission of Inquiry on Mental Handicap recommended, *inter alia*, that the law relating to Wards of Court be brought “into conformity with the modern terminology applied to the mentally handicapped”.⁸⁵ This recommendation was echoed in *In Re D*⁸⁶ by Finlay CJ where he stated:

“Having regard to the fact that in many instances mental retardation or mental handicap does not equate with unsoundness of mind, I would also consider it desirable that legislation should be enacted to provide for the protection of persons suffering from mental handicap where the law does not already do so. Valuable recommendations in this context were made in the report issued by the Commission of Inquiry into Mental Handicap in 1965.”

4.35 The Law Reform Commission’s *Consultation Paper on Law and the Elderly*,⁸⁷ identified a number of shortcomings associated with wardship. These related to jurisdictional and procedural issues and the substitute decision-making process once a person has been made a Ward of Court. In addition, the Commission identified issues which

⁸⁵ *Report of the Commission of Inquiry on Mental Handicap* (1965) (the Stationery Office) (Pr 8234) at paragraph 206 ff. See also Commission on the Status of People with Disabilities *A Strategy for Equality: Report of the Commission on the Status of People with Disabilities* (1996) at paragraph 2.2.

⁸⁶ [1987] IR 449, 457.

⁸⁷ Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003).

go the root of how capacity is conceived and assessed under the wardship regime and the effect in capacity terms of being made a Ward of Court:

“The Wards of Court system is cumbersome and outdated. The language and concepts used in the legislation are inappropriate to the current understanding of mental illness, mental impairment and legal capacity. The basis of the jurisdiction is not clear, the procedures involved are lengthy and too many decisions have to be referred to the President of the High Court. The powers and duties of the appointed Committee are not clear and the legislation does not deal with how decisions about the person of the Ward are to be made. The method of dealing with the Ward’s money is very cumbersome.”⁸⁸

4.36 The limitations of the operation of wardship led the Commission to propose a new substitute decision-making system for protecting vulnerable adults.⁸⁹ The Commission notes that the Courts Service’s Directorate of Reform and Development is currently conducting a review of the wardship jurisdiction.

C Enduring Powers of Attorney

4.37 An adult who has the required level of capacity can plan for possible future loss of capacity by executing an enduring power of attorney (“EPA”) under the *Powers of Attorney Act 1996*.⁹⁰ An EPA

⁸⁸ *Ibid* at paragraph 6.01.

⁸⁹ In the *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at 2, consideration of a new system was limited to the elderly but it was acknowledged that “the law in this area has created a common shelter under which many citizens may take refuge.” See further *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at paragraph 6.50 *ff*.

⁹⁰ This implemented the recommendations in Law Reform Commission *Report on Land Law and Conveyancing Law (2) Enduring Powers of Attorney* (LRC 21-1989). See also the *Enduring Powers of Attorney Regulations 1996* (S.I. No. 196 of 1996), the *Enduring Powers of Attorney (Personal Care Decisions) Regulations* (S.I. No. 287 of 1996) and Law Society of Ireland *Enduring Powers of Attorney – Guidelines for Solicitors* (2004). See further Gallagher *Powers of Attorney Act 1996* (Round Hall Sweet & Maxwell 1998); Law Reform Commission *Consultation Paper*

is designed to provide for the appointment of an individual⁹¹ or trust corporation as an attorney who can make certain decisions in the event of future loss of decision-making capacity. If a person has executed an EPA, this may avoid the possibility of them having to be made a Ward of Court if they lose capacity at a later stage. However, while the ability to nominate a trusted decision-maker to make important decisions in the event of a future loss of capacity is a welcome development, its utility is limited to situations where a person has both the foresight and the capacity to put the procedure in place. EPAs are not ideally suited to adults with intellectual disability who are less likely to have the requisite capacity to execute an EPA.

(1) Procedural Requirements

4.38 An EPA is an instrument which complies with the procedural requirements of the *Powers of Attorney Act 1996*. It must state that the donor intends the power to become effective during any “subsequent mental incapacity” of the donor which complies with the procedural requirements for its creation.⁹²

4.39 When an EPA is executed in the prescribed form⁹³ it has no legal effect until it is registered.⁹⁴ Section 9 of the *Powers of Attorney Act 1996* provides that an EPA can be registered when the donor of the EPA becomes or is becoming mentally incapacitated. The registration of an EPA and admission to wardship require an assessment of a person’s general capacity to manage their person and property. Section 9 requires attorneys to make an application for registration to the Registrar of Wards of Court “as soon as

on Law and the Elderly (LRC CP 23-2003) at Chapter 3, O’Neill *Wards of Court in Ireland* (First Law 2004) at Chapter 8.

⁹¹ Excluded individuals listed in section 5(4) of the *Powers of Attorney Act 1996* include a person who has been made bankrupt, a person who has been convicted of an offence involving fraud or dishonesty, and the owner of a nursing home where the donor resides.

⁹² Section 5(1) of the *Powers of Attorney Act 1996*.

⁹³ See the first and second schedules to the *Enduring Powers of Attorney Regulations 1996* (SI No 196 of 1996).

⁹⁴ Section 9 of the *Powers of Attorney Act 1996*.

practicable” if they have reason to believe that the donor is or is becoming mentally incapable.⁹⁵

(2) *Conception of Capacity*

4.40 Section 4(1) of the *Powers of Attorney Act 1996* defines “mental incapacity” as “incapacity by reason of a mental condition to manage his or her own property and affairs”. An EPA can only be executed by an individual with the requisite present capacity to do so.⁹⁶ One commentator makes the point that “[t]hese two conditions do not automatically coincide. People suffering from mental disorder may be quite capable of looking after their financial affairs, and those who are not mentally disordered may be completely hopeless in running their affairs.”⁹⁷

4.41 While there is no specific statutory test of capacity to execute an EPA in the 1996 Act,⁹⁸ the *Enduring Powers of Attorney Regulations 1996*⁹⁹ require the EPA to be in a particular format and to include:

- a statement by a medical practitioner that the donor, with the assistance of any explanations he or she gave to the donor, had the mental capacity to understand the effect of creating the power;¹⁰⁰

⁹⁵ 99 EPAs were registered in 2003: Courts Service *Annual Report 2003* (2004) at 89.

⁹⁶ An ordinary power of attorney automatically terminates when the donor of the power loses capacity to handle their affairs: *Yonge v Toynbee* [1910] 1 KB 215.

⁹⁷ Costello “The Enduring Problem of Powers of Attorney” (1998) CPLJ 35 at 42.

⁹⁸ See Pearce and O’Donnell “An Overview of the Law Relating to Powers of Attorney and an Analysis of the Practical Implications of the Powers of Attorney Act 1996 for Conveyancers” (1996) 1 CPLJ 41 at 42.

⁹⁹ S.I. No. 196 of 1996 (amended by the *Enduring Powers of Attorney (Personal Care Decisions) Regulations 1996* (S.I. No. 287 of 1996)).

¹⁰⁰ This accords with *In re K (Enduring Powers of Attorney)*, *In re F* [1988] Ch 310 where Hoffman J held that the test was not whether the donor would be able to exercise the powers herself but rather whether she understood the nature and effect of the powers being conferred under the

- a statement by the donor that the donor has read certain information as to the effect of creating an EPA; and
- a statement by the solicitor that, after interviewing the donor and making any necessary inquiries, the solicitor is satisfied that the donor understood the effect of creating the EPA and the solicitor has no reason to believe that the document is being executed by the donor as a result of fraud and undue pressure.

4.42 These requirements have the objective of ensuring that the person has sufficient understanding to have the requisite capacity to make an EPA and that they do so freely of their own volition. Clearly certain people will not have the requisite capacity and, in certain cases, particularly where dementia has begun to take its course, it will be a question of degree as to whether the person has the requisite capacity.¹⁰¹ On the other hand, if the standard of capacity required to execute an EPA is pitched too high then the possibility of appointing a substitute decision-maker will be reduced.

4.43 The English case of *In Re K (Enduring Powers of Attorney)*, *In re F*¹⁰² concerned the degree of capacity required to execute an EPA. In this case it was held that the test for capacity to execute a general power of attorney (which would continue despite the donor losing capacity) was whether the person understood that the attorney would be able to assume control over their affairs. Hoffman J stated that if the donor had the capacity to sign an enduring power of attorney but was incapable of managing their property, the attorney should register the power of attorney without delay.

(3) Impact of an EPA on Legal Capacity

4.44 The extent of loss of capacity which registration of an EPA entails will vary according to the terms of the particular EPA. It is open to the donor to provide for their attorney to be given power over

EPA. See Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at paragraph 1.11-1.12.

¹⁰¹ See Costello “The Enduring Problem of Powers of Attorney” (1998) 1 CPLJ 35.

¹⁰² [1988] Ch 310.

property, financial and business affairs and personal care decisions¹⁰³ or any of these should they lose capacity.¹⁰⁴ Once registered, the donee's powers become operative in accordance with the terms of the EPA.

4.45 Where personal care decisions are being made by an attorney, the attorney is required to act in the person's best interests and to take into account:¹⁰⁵

- The past and present wishes and feelings of the donor;
- Permitting and encouraging the person to participate as fully as possible in the decision;
- Consultation with anyone named by the donor to be consulted and anyone interested in the donor's welfare;
- The least restrictive method of achieving the purpose for the decision.¹⁰⁶

4.46 If an EPA does not give sufficient powers to the attorney, it may prove necessary to take wardship proceedings. An EPA is not automatically invalidated if the donor becomes a Ward of Court but section 5(9) of the *Powers of Attorney Act 1996* gives the Court power to invalidate an EPA in these circumstances.

¹⁰³ Under section 6(6) of the *Powers of Attorney Act 1996* personal care decisions are decisions relating to one or more of the following: where and with whom the donor should live, the persons the donor should see, training and rehabilitation, diet and dress, inspection of donor's personal papers, housing, social welfare and other benefits. The Commission recommended that the scope of welfare powers be widened to include authority to make decisions on medical treatment: Law Reform Commission *Consultation Paper on Law and the Elderly* (CP 23-2003) at paragraph 3.13 *ff*.

¹⁰⁴ Section 6 of the *Powers of Attorney Act 1996*.

¹⁰⁵ Section 6(7)(b) of the *Powers of Attorney Act 1996*.

¹⁰⁶ There is no requirement to take such factors into account in respect of financial decisions.

(4) Revocation of an EPA

4.47 In the *Consultation Paper on Law and the Elderly*,¹⁰⁷ the Commission recommended that solicitors should be obliged to inform clients of the right to revoke an EPA.¹⁰⁸ This recommendation was followed in the Law Society's subsequently adopted guidelines for solicitors in relation to enduring powers of attorney.¹⁰⁹ The *Powers of Attorney Act 1996* does not provide procedures for the revocation of an EPA prior to its registration. It may be revoked after registration if the revocation is confirmed by the Court.¹¹⁰

D Conclusions

4.48 In the *Consultation Paper on Law and the Elderly*,¹¹¹ the Commission made extensive recommendations for the replacement of the wardship system and to broaden the remit of EPAs. The central conclusion of the Consultation Paper was that a new system for the protection of vulnerable adults is needed.¹¹² The Consultation Paper went on to propose the creation of a new substitute or assisted decision-making system for vulnerable adults with limited decision-making ability. Under the proposed system, adults with a decision-making disability who lack legal capacity could have a Personal Guardian appointed to make decisions on their behalf.

4.49 The Commission reiterates the concerns expressed in the *Consultation Paper on Law and the Elderly* in relation to the outdated conception of capacity and the objectionable terminology which permeate the wardship regime.

¹⁰⁷ Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003).

¹⁰⁸ *Ibid* at paragraph 3.25.

¹⁰⁹ Law Society of Ireland *Enduring Powers of Attorney – Guidelines for Solicitors* (2004) at paragraph 1.10.

¹¹⁰ Sections 11(1)(a) and 12(3) of the *Powers of Attorney Act 1996*.

¹¹¹ Law Reform Commission *Consultation Paper on Law and the Elderly* *op cit* fn107.

¹¹² *Ibid* at paragraph 6.01.

(1) *Wardship*

4.50 Undoubtedly the language used in the 1871 Act in relation to capacity is objectionable. Labels such as “idiot”, “lunatic”, “lunacy” and “person of unsound mind”¹¹³ are unnecessarily stigmatising and reflect a paternalistic approach which was prevalent at the time of the legislation’s enactment. They do not reflect the social model of disability’s emphasis on ability.¹¹⁴ Nor do they reflect the evolution and development of human rights¹¹⁵ and constitutional rights emphasising the values of autonomy and self-determination. The importance of choosing appropriate and clear tests of capacity formulated in sympathetic language is illustrated by *Re Keogh*¹¹⁶ and *Dolan v Registrar of Wards of Court*.¹¹⁷

4.51 *The Commission regards the use of phrases such as ‘idiot’, ‘lunatic’ and ‘person of unsound mind’ in the Lunacy Regulation (Ireland) Act 1871 as out of step with the contemporary understanding of disability and recommends that they should not form part of any reforming legislation.*

4.52 At a more fundamental level, the test for wardship presents capacity as an all-or-nothing status¹¹⁸ which does not take account of contextual variation in decision-making ability. Thus a person’s general legal capacity is seen in black and white terms as either present or absent rather than viewing capacity in functional, issue-specific terms. This may not present a difficulty where a person’s senile dementia is so far advanced that they have minimal cognitive or decision-making ability. However, a status approach to capacity

¹¹³ The label “of unsound mind” which features in the *Mental Treatment Act 1945* was not used in the *Mental Health Act 2001*.

¹¹⁴ See paragraph 1.20 *ff* above.

¹¹⁵ See *Winterwerp v The Netherlands* (1980) EHRR 387; *HM v Switzerland* (2004) 38 EHRR 17; *HL v United Kingdom* 45508/99 European Court of Human Rights 5 October 2004.

¹¹⁶ High Court (Finnegan P) 15 October 2002.

¹¹⁷ High Court (Kelly J) 19 March 2004 (*ex tempore*).

¹¹⁸ While temporary wardship is possible under section 103 of the 1871 Act, this is rarely used. See Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at paragraph 4.31– 4.32.

does not allow for the existence of a middle ground to deal with, for example, an adult who can make many decisions independently but is not good at handling money. Indeed, the current arrangements for wardship are out of step with the Council of Europe *Recommendation on the Legal Protection of Vulnerable Adults*,¹¹⁹ Principle 3(2) of which states that a measure of protection for vulnerable adults

“should not automatically deprive the person concerned of the right ... to consent to any intervention in the health field, or to make decisions of a personal character at any time when his capacity permits him or her to do so.”

4.53 These concerns are addressed by the recommendations in the *Consultation Paper on Law and the Elderly*¹²⁰ to replace wardship with a new system of substitute decision-making which embraces a functional understanding of capacity.

4.54 In this chapter, in the context of a review of the wardship regime, the Commission raised the importance of procedural safeguards when adjudicating on a person’s capacity. This requirement of procedural fairness arises both as a matter of constitutional justice and also in connection with the application of Articles 5 and 6 of the ECHR. The Commission’s conclusion is that the design of a new system for adjudicating on legal capacity issues will necessitate accompanying safeguards to be built in to ensure that a person whose capacity is called into question has access to appropriate information about the process in terms they will understand. It would be important to provide advocacy and legal representation in order to assist such adults to understand the implications of the process and to make submissions in relation to their legal status. Furthermore, in accordance with this Consultation Paper’s espousal of a functional understanding of capacity, and the requirements of human rights law, capacity legislation should provide for automatic periodic review of a decision on capacity which has ongoing implications.

¹¹⁹ *Recommendation no. R(99)4 of the Committee of Ministers to Member States on Principles Concerning the Legal Protection of Vulnerable Adults* (adopted 23 February 1999). See further paragraphs 1.37-1.39 above.

¹²⁰ *Law Reform Consultation Paper on Law and the Elderly* (LRC CP 23-2003).

4.55 *The Commission recommends that capacity legislation should ensure that a determination of a person's legal capacity complies with procedural fairness by ensuring that the person has appropriate assistance in terms of information, access to representation and other reasonable assistance which will enable them to understand the implications of the process and to make submissions in relation to their capacity.*

4.56 *The Commission recommends that where it has been determined that a person lacks capacity in a particular area which has an ongoing impact on their decision-making ability, the proposed capacity legislation should make provision for a system of automatic periodic review of that determination, with appropriate procedural safeguards to protect the rights of the person concerned.*

(2) *Enduring Powers of Attorney*

4.57 In the *Consultation Paper on Law and the Elderly*¹²¹ the Law Reform Commission concluded that the EPA system “has the potential to be a very useful mechanism as it facilitates the retention of as much autonomy as possible for vulnerable adults.”¹²² EPAs are, however, limited to those who have the capacity to execute them in the first place.

4.58 The EPA system is open to criticism for operating a status approach to capacity rather than a functional view of capacity which measures decision-making ability relative to the time and nature of the decision to be made. Registration of an EPA occurs when the donor becomes mentally incapable. The statutory definition of incapacity in the *Powers of Attorney Act 1996*, which is based on a person being incapable by reason of a mental condition to manage their property or affairs, constitutes an all-or-nothing approach to capacity which does not pay attention to the type of decision to be made at the time it is to be made.¹²³ Indeed, in England and Wales the

¹²¹ Law Reform *Consultation Paper on Law and the Elderly* (LRC CP 23-2003).

¹²² *Ibid* at paragraph 6.01.

¹²³ In New Zealand, under the *Protection of Personal and Property Rights Act 1988*, a separate enduring power of attorney may be created in respect of property and personal care and welfare decisions.

UK government was opposed to registration of proposed lasting powers of attorney at a notional point of incapacity because “[i]t would be wrong to rely on blanket labels of incapacity to avoid the complexities of assessing capacity in relation to the particular decision at the particular time.”¹²⁴

4.59 The Commission’s conclusion is that EPAs operate under the *Powers of Attorney Act 1996* in a rather unsubtle manner because the legislation is based on an underlying view of capacity as either present or absent. This perspective would need to be reviewed in the context of the recommendation in this Consultation Paper that capacity should be understood in predominantly functional terms¹²⁵ and the recommended legislative understanding of capacity set out in Chapter 3 above.

4.60 *The Commission recommends that the approach to capacity in the Powers of Attorney Act 1996 be reviewed in the light of the definition of capacity recommended in this Consultation Paper.*

¹²⁴ Department for Constitutional Affairs *Government Response to the Scrutiny Committee’s Report on the Draft Mental Incapacity Bill* (2004), Recommendation 48.

¹²⁵ See paragraph 2.40 above.

PART B

SPECIFIC AREAS OF DECISION-MAKING

CHAPTER 5 CAPACITY TO CONTRACT

A Introduction

5.01 This chapter discusses the capacity of an adult with limited decision-making ability¹ to enter into an enforceable contract.² In an everyday context common contracts include those relating to the purchase of goods and services, the rental and purchase of accommodation, insurance contracts, loans and credit transactions, and employment contracts. There is a tension in the law in this area between the need to protect vulnerable adults and the counterbalancing need to protect the good faith supplier who is unaware that a person may lack the requisite capacity to enter the contract. Modern disability policy would suggest a further policy goal of facilitating persons with a mental disability to live their lives as independently as possible.³ Part B of this Chapter considers the policy considerations which underlie the law on contractual capacity. Part C considers the circumstances in which a contract entered into by an adult with limited decision-making capacity may be avoided by them. Part D considers the impact of loss of capacity on agency

¹ See Chapter 1 above at Part B.

² See generally Clark *Contract Law in Ireland* (5th ed Round Hall Thomson 2004) at Chapter 16; Friel *The Law of Contract* (2nd ed Round Hall Sweet & Maxwell 2000) at Chapter 5; Mc Dermott *Contract Law* (Butterworths (Ireland) Ltd 2001) at Chapter 17; Furmston *Cheshire, Fifoot & Furmston's Law of Contract* (14th ed Butterworths Lexis Nexis 2001) at Chapter 13; British Medical Association and The Law Society *Assessment of Mental Capacity: Guidance for Doctors and Lawyers* (1st ed 1995) at Chapter 7; Law Commission *Mentally Incapacitated Adults and Decision-Making: An Overview* (Consultation Paper No 119 1991) at paragraph 2.16; Law Commission *Report on Mental Incapacity* (Law Com No 231 1995) at paragraph 4.8 *ff*.

³ See, for example, Quinn and Degener *Human Rights and Disability* (United Nations HR/PUB/02/01 2002) at 10-11.

relationships and the effect which appointing a substitute decision-maker may have on a person's contractual capacity. Part E discusses the discrete obligation on persons lacking contractual capacity to pay a reasonable price to suppliers for "necessaries". Part F considers the implications of the *Equal Status Acts 2000 to 2004* on the behaviour of suppliers in relation to contracts with persons who have limited decision-making ability. The recommendations of the Commission in this area are contained at the end of this chapter in Part G.

B Policy Considerations

5.02 Generally a contract is the outcome of a process of offer and acceptance by two or more parties of a bargain which involves the passing of consideration⁴ (money or other form of value) from one party to the other in return for goods or services supplied. In *Tansey v The College of Occupational Therapists*,⁵ Murphy J described the contractual process in the following terms:

"Contractual obligations derive from agreement made between two or more parties under which one promises or undertakes with the other the performance of some action. Ordinarily, the existence of an agreement presupposes an offer by one party to perform the action on certain terms and the acceptance of that offer by the other."⁶

5.03 Therefore, if by reason of a lack of mental capacity one party fails to appreciate the nature and effect of the putative contract, it might be supposed that there is no real mutual intent to contract and that there should be no contract. The difficulty is that however equitably the rules are formulated, losses may occur which have to be borne by someone.⁷ Therefore the case-law has built up principles

⁴ The law relating to capacity to make a gift is considered in the Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at paragraph 1.07.

⁵ [1995] 2 ILRM 601.

⁶ [1995] 2 ILRM 601, 615.

⁷ See the comments of the Australian Law Reform Commission in its report on *Guardianship and Management of Property* (Report No 52 1989) at paragraph 4.71.

which endeavour to find an appropriate balance as between the parties. The law of contract has sought to balance two countervailing considerations: first, the duty to protect those who through lack of mental capacity are unable to protect their own interests, and, secondly, the desirability of upholding contracts in the interests of certainty where there has been no underhand dealing, in order to ensure that contracting parties are not prejudiced by the actions of a person whose lack of capacity is not apparent.⁸

5.04 The law's desire to uphold bargains where possible is evident in the general rule that a person will be bound by a contract unless they can show (i) that by reason of their mental condition at the time they did not understand what they were doing and the effect it would have on their interests, and (ii) that the other contracting party was aware of this lack of capacity.⁹ The law on capacity to contract has therefore operated differently from capacity in other contexts in that a proof of lack of understanding is not in itself sufficient to vitiate a contract. Consequently, a presumption of capacity¹⁰ to contract has not been expressly articulated by the courts since proof of lack of understanding is not alone sufficient to cast off contractual liability.¹¹ As the Law Commission of England and Wales stated "[i]t is arguable, therefore, that the contractual position is in truth a rule of unconscionability rather than a rule of capacity."¹²

C The Rules on Contractual Capacity

5.05 Before going on to consider the rules governing contractual capacity in greater depth, it should be observed that there has been comparatively little consideration of the distinct area of capacity to contract in the common law world. Rather, case law has tended to concentrate on the application of the allied equitable doctrines of

⁸ See Green, "Public Policies Underlying the Law of Mental Incompetency" (1940) 38(8) Mich L.R. 1189.

⁹ See paragraph 5.09 - 5.12 below.

¹⁰ See paragraph 2.27 above.

¹¹ See Part C below.

¹² Law Commission *Mentally Incapacitated Adults and Decision-Making: An Overview* (Consultation Paper No. 119 1991) at paragraph 2.16.

undue influence and unconscionable bargain.¹³ There is a considerable body of consumer protection measures in place, many of them EU-driven, which offer protection to consumers in a wide range of areas such as doorstep selling, the provision of credit and unfair terms in consumer contracts.¹⁴ The formulation of consumer policy is actively under consideration by the Consumer Strategy Group¹⁵ and the Irish Financial Services Regulatory Authority.¹⁶ While such protective measures are designed to protect the consumer from being

¹³ See Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at paragraph 5.28 ff; *O' Siodhachain v O'Mahony* High Court (Kearns J) 31 October 2002.

¹⁴ A non-exhaustive list of relevant Irish consumer protection legislation includes the *Sale of Goods Act 1893*; the *Consumer Information Act 1978*; the *Sale of Goods and Supply of Services Act 1980*; the *European Communities (Misleading Advertising) Regulations 1988* (SI No 134 of 1988); the *European Communities (Cancellation of Contracts Negotiated away from Business Premises) Regulations 1989* (SI No 224 of 1989); the *Liability for Defective Products Act 1991* (and associated regulations); the *European Communities (Unfair Terms in Consumer Contracts) Regulations 1995* (SI No 27 of 1995); the *Consumer Credit Act 1995* (and associated regulations); the *European Communities (Unfair Terms in Consumer Contracts) (Amendment) Regulations 2000* (SI No 307 of 2000); the *European Communities (Protection of Consumers in Respect of Contracts Made by Means of Distance Communications) Regulations 2001* (SI No 207 of 2001); the *European Communities (Certain Aspects of the Sale of Consumer Goods and Associated Guarantees) Regulations 2003* (SI No 11 of 2003); the *European Communities Directive 2000/31 EC Regulations 2003* (SI No 68 of 2003); the *European Communities (Distance Marketing of Consumer Financial Services) Regulations 2004* (SI No 853 of 2004); and the *European Communities (Protection of Consumers in Respect of Contracts Made by Means of Distance Communication (Amendment) Regulations 2005* (SI No 71 of 2005). On 18 June 2003 the European Commission adopted a proposal for a Directive on unfair business-to-consumer practices which makes specific reference to vulnerable consumers:

http://europa.eu.int/comm/consumers/cons_int/safe_shop/fair_bus_pract/directive_prop_en.pdf.

¹⁵ See Consumer Strategy Group *Report on Consumer Policy* (Government Publications 2005).

¹⁶ IFSRA is developing codes of conduct for providers of financial services which will ensure a standard of protection for consumers: Irish Financial Services Regulatory Authority *Consumer Protection Code* (Consultation Paper CP10 February 2005).

taken advantage of, on the other side of the coin, the *Equal Status Acts 2000 to 2004* require that where a person has capacity to contract this should be respected.¹⁷

(1) Level of Understanding Required

5.06 A person must be capable of understanding the nature and effect of the specific contract into which they are entering.¹⁸ In establishing this, differing considerations apply to adults whose cognitive capacity is permanently impaired in comparison to those who experience periods of temporary cognitive impairment through the impact of mental or degenerative illness.

5.07 The degree of understanding required will vary according to the complexity of transaction.¹⁹ Thus a person may be regarded as having capacity to purchase a cinema ticket but not the capacity to enter into a finance agreement in respect of a car. Where a person is suffering from delusions this is not conclusive as to their ability or inability to understand the contract even where the delusions are connected with the subject matter of the contract.²⁰ If the person had capacity when the contract was entered into, evidence of a subsequent lack of mental capacity is immaterial.²¹

5.08 Where a person has a mental illness it may be that the underlying motivation to act is of greater significance than cognitive ability to understand the nature and effect of the transaction. For example, during the manic phase of bipolar affective disorder (sometimes referred to as ‘manic depression’) a person with an elevated mood may engage in an extravagant shopping spree spending vast amounts of money on expensive items they would not normally consider buying. In such circumstances it may be said that the person has a compulsion to act in a manner which they would not

¹⁷ See paragraph 5.30 below.

¹⁸ *Boughton v Knight* (1873) LR 3 PD 64 at 72. However, the absence of capacity is not in itself sufficient to prevent a contract being enforceable: see paragraph 5.09 *ff* below.

¹⁹ *Re Beaney* [1978] 2 All ER 595.

²⁰ *Jenkins v Morris* (1880) 14 Ch D 674.

²¹ *Hall v Warren* (1804) 9 Ves. Jun. 605.

normally. The American courts have recognised that a person does not have capacity to contract when they enter it “under the compulsion of a mental disease or disorder but for which the contract would not have been made.”²² If a person is so affected by mental illness as not to have any idea what he is signing, he may seek to repudiate the obligations created by the document by pleading *non est factum* (‘this is not my deed’).²³ A successful plea of *non est factum* renders a contract void *ab initio* whereas lack of capacity to understand renders it voidable.²⁴

(2) *Criteria for Voidability*

5.09 Under the *Rule in Beverley’s Case*,²⁵ a person could not plead their own incapacity as a defence to an action for breach of contract. That rule was relaxed by the courts in the mid-19th century with the result that what was termed ‘unsoundness of mind’ would be a good defence to an action for breach of contract if it could be shown that the other party was aware of it.²⁶

5.10 The decision of the Court of Appeal in *Imperial Loan Co v Stone* developed the modern rules on capacity to contract.²⁷ In that case the defendant argued that at the time he signed a promissory note as surety he was so insane that he could not understand the

²² *Faber v Sweet Style Manufacturing Corp.* 40 Misc 2d 212, 216 (1969). This case concerned extravagant contracts entered into by a man during the manic phase of bipolar affective disorder. See also Note “Manic-Depressive Held Incompetent to Contract Despite Apparent Ability to Understand Transaction” (1964) 39 NYUL Rev. 356.

²³ See *Saunders v Anglia Building Society* [1971] AC 1004, 1025 *per* Lord Wilberforce.

²⁴ See New South Wales case of *PT Ltd v Maradona Pty Ltd* (1992) 25 NSWLR 643 at 673-675.

²⁵ *Beverley’s Case* (1603) Cro. Eliz. 398.

²⁶ *Molton v Camroux* (1848) 2 Exch 487; affirmed (1849) 4 Exch 17. In Scotland, the law followed the Roman law approach of looking at whether the person at the time the contract was entered into had capacity to understand and transact the business in question. If so, the contract was binding. If not, the contract was null and void and the loss lay where it fell: *Loudin & Co v Hunter* [1923] Ll. L. Rep. 500.

²⁷ [1892] 1 QB 599.

transaction. Lord Esher MR stated that even where this was established, “the contract is binding on him in every respect, whether it is executory or executed, unless he can prove further that the person with whom he contracted knew him to be so insane as not to be capable of understanding what he was about.”²⁸

5.11 The circumstances may be such that any reasonable person would be aware of the person’s lack of capacity. In the Irish case of *Hassard v Smith*²⁹ it was held that to vitiate a contract the circumstances of which the other party had knowledge must lead to the reasonable conclusion that the person lacked capacity. In this case a lack of capacity to enter a lease would appear to have been pleaded in order to break the lease but it was held that a lack of capacity would not have been apparent to the other party.³⁰ In *Collins v May*,³¹ the Supreme Court of Western Australia held that it is not necessary to establish that the other party had precise knowledge of the existence of the relevant medical condition and lack of mental capacity - in appropriate circumstances constructive knowledge of the lack of capacity could be ascribed to the other party. In that case a woman who made a voluntary disposition of her house suffered from senile dementia and the defendant was aware of a number of relevant factors which would give rise to an apprehension that she might not have sufficient capacity. Accordingly, the voluntary disposition of the property was set aside.

5.12 If it is proven that the other party knew of the person’s lack of capacity, the contract is voidable at the option of the person who lacked the capacity and, as a general rule, title will pass unless the transaction is avoided. It would appear that a person may be bound by a contract which would otherwise be voidable if their behaviour during a lucid interval or on recovery amounts to a ratification of the contract.³²

²⁸ [1892] 1 QB 599, 601.

²⁹ (1872) Ir. 6 Eq 429.

³⁰ See also *York Glass Co v Jubb* (1925) 134 LT 36.

³¹ [2000] WASC 29.

³² *Matthew v Baxter* (1873) LR 8 Ex. 132.

(a) *Executory and Executed Contracts*

5.13 The English courts have declined to distinguish between executory contracts³³ and executed contracts³⁴ in relation to their enforceability where one party's contractual capacity is affected by mental incapacity.³⁵ Clearly, avoiding an executory contract is less likely to cause prejudice than endeavouring to undo a contract which has been executed. Indeed, in certain circumstances effecting *restitutio in integrum* (placing the parties back in their original position before the contract was entered into) may be difficult or impossible in relation to an executed contract.

5.14 A restitutionary solution is provided in section 15 of the American Law Institute's *Restatement (Second) of Contracts*³⁶ which provides that a contract may be avoided by a person if by reason of mental illness or defect he is unable to act in a reasonable manner in relation to the transaction and the other party has reason to know of his condition. Where the contract is made on fair terms and the other party is without knowledge of the mental illness or defect, the power of avoidance cannot be exercised to the extent that the contract has been performed or where the circumstances have so changed that

³³ An executory contract refers to a contract where the obligations under it have not been carried out.

³⁴ An executed contract refers to a contract where the obligations under it have been carried out.

³⁵ *Imperial Loan Co v Stone* [1892] 1 QB 599 discussed at paragraph 5.10 *ff* above.

³⁶ American Law Institute *Restatement of the Law Second Contract 2d* Volume 1 (1981). The American Law Institute is an association of academic lawyers, legal practitioners and members of the judiciary. The aim of its *Restatement (Second) of Contracts* is to set out a coherent and accessible statement of principles based on a review and, where required, a re-working of existing law. The Restatement does not carry the force of law but would be referred to in the courts as persuasive authority. By contrast, the Commission of European Contract Law's *Principles of European Contract Law* (2000), which sets out general rules in the area of contract law akin to the American Restatement of the Law of Contract, did not cover capacity on the basis that rules on capacity were considered to be more a matter of the law of persons than of contract proper (at 227).

avoidance would be unjust. In such a case, the Restatement gives the court a broad discretion to grant such relief as justice requires.³⁷

5.15 The Law Reform Commission's *Report on Minors' Contracts*³⁸ considered the necessities rule which applies to minors under section 2 of the *Sale of Goods Act 1893*. In that Report, the Commission favoured reform in the guise of a statutory based restitutionary approach. This would mean that a contract made by a minor with an adult party would be enforceable by the minor against the adult but unenforceable by the adult against the minor. The adult would, however, be entitled to apply to the court for compensation based on restitutionary rather than contractual principles.³⁹ The Commission went on to recommend that in making any such order the Court should have regard to a variety of factors such as the type of contract, the value of any property involved, the mental capacity and experience of the minor, the respective economic circumstances of the parties, the value of any benefit obtained by each party as a result of entering the contract and the expenses and losses sustained or likely to be sustained by each party in making and discharging the contract.⁴⁰

5.16 The Commission is aware that different considerations apply to adults who may lack contractual capacity from those applicable to minors. In particular, the lack of capacity which the law imposes on minors is based on age alone rather than individual decision-making capacity. Nevertheless, for present purposes it should be noted that the development of some form of restitutionary solution in relation to contracts entered into by persons lacking capacity may allow for the development of an even-handed equitable approach tailored to take account of all the circumstances.

³⁷ Section 15(2) of the American Law Institute *Restatement of the Law Second 2d* Volume 1 (1981).

³⁸ Law Reform Commission *Report on Minors' Contracts* (LRC 15-1985). The recommendations made in this Report have not been implemented to date.

³⁹ Law Reform Commission *Report on Minors' Contracts* (LRC 15-1985) at 108. The restitutionary principle was expressed to apply to both concluded transactions and to those which had not yet been concluded: *ibid* at 113.

⁴⁰ Law Reform Commission *Report on Minors' Contracts* (LRC 15-1985) at 109 – 110.

(b) *Contractual Unfairness*

5.17 *Hart v O'Connor*⁴¹ is authority for the proposition that mere contractual imbalance or unfairness in a contract with a person who lacks mental capacity will not be sufficient to vitiate it. In this case, an 83 year old man, entered into an agreement to sell land to a purchaser who was unaware of his lack of mental capacity. The Court of Appeal in New Zealand held that although the purchaser did not know of the vendor's contractual incapacity, the agreement was unenforceable because the terms were unfair. On appeal, the Privy Council confirmed the test in *Imperial Loan Co v Stone*⁴² to the effect that where the lack of mental capacity is not known to the other party, the contract will be binding.⁴³ Where unfairness is raised, it may be dealt with by the law relating to unconscionable bargains. It is likely that a similar approach would be taken by the Irish courts who have recognised that in appropriate cases the equitable doctrines of unconscionable bargains and undue influence may be invoked in relation to unfair contracts.⁴⁴

D Appointment of Agents and Substitute Decision-Makers

5.18 Where a person's lack of capacity renders them incapable of acting on their own behalf, they will not have the legal capacity to appoint an agent.⁴⁵ Furthermore, if a principal becomes mentally incapable, the agency relationship will terminate.⁴⁶ The *Powers of*

⁴¹ [1985] 2 All ER 880. See also *Irvani v Irvani* [2000] 1 Lloyd's Rep 412.

⁴² [1892] 1 QB 599 discussed at paragraph 5.10 *ff* above.

⁴³ The Privy Council in *Hart v O'Connor* [1985] 2 All ER 880 overturned the decision in the New Zealand case of *Archer v Cutler* [1980] 1 NZLR 386 to the effect that where a contract is substantively unfair, a lack of capacity could be successfully invoked against a party who was not aware of it.

⁴⁴ See Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at paragraph 5.28 *ff*.

⁴⁵ *Elliot v Ince* (1857) 7 De G M & G 475.

⁴⁶ *Drew v Nunn* (1879) 4 QBD 661, 666, *per* Brett LJ. *Yonge v Toynbee* [1910] 1 KB 215. However, there may be an agency by estoppel or holding out where a third party deals with the agent without the knowledge of the principal's loss of capacity: *Drew v Nunn* (1879) 4 QBD, 661, 667-

Attorney Act 1996 provides an exception to this principle in the form of an enduring power of attorney which is specifically designed to take effect following any subsequent loss of capacity by the donor.⁴⁷

5.19 When a person who is incapable of managing their affairs has been made a Ward of Court their affairs are managed by a committee of the estate and a committee of the person.⁴⁸ It would appear that any purported attempt by a Ward of Court to enter into a contract will be void irrespective of the other party's knowledge of his or her status as a Ward of Court because any dealing by the Ward with his or her property is considered inconsistent with the passing of control over the Ward's property to the committee of the estate.⁴⁹

5.20 In the *Consultation Paper on Law and the Elderly*⁵⁰ the Commission recommended the establishment of a new system of appointing substitute decision-makers for adults who lack capacity including the ability to enter into contracts on their behalf. Other jurisdictions have sought to address the issues of a person in respect of whom a substitute decision-maker has been appointed entering into contracts in a manner which is inconsistent with such an appointment.

5.21 Section 53 of New Zealand's *Protection of Personal and Property Rights Act 1988* largely removes the contractual liability of persons subject to a management order other than in relation to necessities. However, special authorisation may be obtained in respect of a particular transaction. A transaction entered into by a person lacking capacity is not automatically void – the other party may write to the manager and give him or her 28 days to decide whether to avoid the contract. If the transaction is avoided the Family

669. See *Halsbury's Laws of England* (Fourth Ed Reissue) Volume 30 at paragraph 1395.

⁴⁷ See generally Chapter 4 above; Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003), Chapter 3.

⁴⁸ See generally Chapter 4 above; Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at Chapter 4.

⁴⁹ *Re Walker* [1905] 1 Ch 160. See also the Australian case of *Re Barnes* [1983] 1 VR 605.

⁵⁰ Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at Chapter 6.

Court of New Zealand is given wide powers to adjust the parties rights to produce a fair outcome.

5.22 Section 71(1) of the Australian Capital Territories' *Guardianship and Management of Property Act 1991* (consolidated) provides that where a manager has been appointed over the personal property of a person, the transaction is not void on the ground that the person was not legally competent to enter into the transaction. However, under section 71(2) a guardian, manager or any person concerned in the transaction may make an application to the tribunal, the Supreme Court or the Magistrates Court to either confirm the transaction, declare the transaction void or adjust the rights of the parties to the transaction.

E Necessaries

5.23 An exception to the general principles governing contract law, discussed in Part C above, applies in relation to contracts for necessary items. At common law a person who sells and delivers "necessaries" to an adult without mental capacity to contract is entitled to recover a reasonable price for such necessaries. Section 2 of the *Sale of Goods Act 1893* encapsulated the position at common law in respect of the sale of goods. Section 2 states:

"... where necessaries are sold and delivered to an infant, minor, or to a person who by reason of mental incapacity or drunkenness is not competent to contract, he must pay a reasonable price therefor. Necessaries in this section means goods suitable to the condition in life of such infant or minor or other person, and to his actual requirements at the time of the sale and delivery."⁵¹

The necessaries rule performs a useful function in allowing people who lack capacity to obtain independently foodstuffs and other items required for their day to day living while ensuring that the supplier will be reasonably recompensed but not permitted to exploit by charging exorbitant prices.

⁵¹ It would appear that this is the position irrespective of whether the supplier was aware of the person's incapacity at the time of the putative contract.

(1) *The Concept of Necessaries*

5.24 “Necessaries” is to be understood as goods and, at common law, services⁵² suitable to the condition in life of the person. Thus the concept of necessaries may vary considerably according to the circumstances of the particular individual. Goods such as food and drink⁵³ and clothing,⁵⁴ and services such as transport,⁵⁵ nursing home care, accommodation⁵⁶ and medical aid⁵⁷ have been regarded as necessaries in certain circumstances.⁵⁸ Necessaries do not extend, however, to luxury items.⁵⁹ Nevertheless, it must be said that the ambit of the category of necessaries is imprecise.⁶⁰ Existing case-law is of limited utility in determining the issue as judicial discussion of what constitutes necessaries has largely arisen in the context of the parallel provision in Section 2 of the *Sale of Goods Act 1893* for contracts for necessaries entered into by minors rather than adults. Furthermore the relevant case-law is concerned with lifestyles in the 17th to early 20th century which have little parallel in today’s world.⁶¹

⁵² Although the quasi-contractual liability in relation to the supply of necessaries contained in section 2 of the *Sale of Goods Act 1893* is only expressed to cover the sale of goods, the same principles apply at common law in relation to the supply of essential services.

⁵³ See, for example, *Pickering v Gunn* Palm 528, 82 ER 96 (1928).

⁵⁴ *Nash v Inman* [1908] 2 KB 1.

⁵⁵ *Clyde Cycle Co v Hargreaves* 78 LT 296 (1898).

⁵⁶ *Re Rhodes* (1890) 44 Ch D 94.

⁵⁷ *Dale v Copping* 1 Bulst 39, 80 ER 743 (1610), *Huggins v Wiseman* Carth. 110, 90 ER 699 (1690).

⁵⁸ For a discussion of the case-law see Law Reform Commission *Report on Minors’ Contracts* (LRC 15-1985) at Chapter 2.

⁵⁹ “Articles of mere luxury are always excluded, though luxurious articles of utility are in some cases allowed.” *Cowern v Nield* [1912] 2 KB 419, 422.

⁶⁰ Law Reform Commission *Report on Minors’ Contracts* (LRC 15-1985) at 116.

⁶¹ See the comments of Craig J of the Supreme Court of British Columbia in *First Charter Financial Corp. Ltd. v Musclow* 49 DLR (3d) (1974) 138, 142-143.

(2) Sale

5.25 Where there is no “sale” in relation to goods, for example, where they are provided on hire purchase or barter, the statutory provision on necessities has no application and the general principles discussed above⁶² will apply - the contract will be voidable if the other party knew or must have known that the person lacked capacity.

(3) Liability to Pay a Reasonable Price

5.26 The liability imposed by the necessities rule in section 2 of the *Sale of Goods Act 1893* is to pay a reasonable price for goods sold and delivered rather than the price agreed. The liability is quasi-contractual or restitutionary in nature.⁶³ This has led commentators to suggest that a person without capacity to contract may not be bound by a contract for necessary goods which is purely executory in that the goods contracted for have not been delivered.⁶⁴

(4) Burden and Onus of Proof

5.27 It is for the supplier to overcome the double-hurdle of proving (a) that the goods were necessities in the context of the circumstances of the person lacking capacity; and (b) that the person was not already supplied with goods or services of a similar kind.⁶⁵ It is immaterial that the seller was unaware of the buyer’s situation: the fact that the buyer was already adequately provided with goods of the relevant type is sufficient for them not to be necessities in law.⁶⁶ The Scottish Law Commission criticised the notion that there should be an onus on a trader to enquire whether the person with a mental disability already has similar goods on the basis that these enquiries would be time-

⁶² See paragraph 5.17 above.

⁶³ *Re Rhodes* (1890) 44 Ch D 94.

⁶⁴ See Goff and Jones *The Law of Restitution* (6th ed London Sweet & Maxwell 2002) at 629.

⁶⁵ *Nash v Inman* [1908] 2 KB 1. Furthermore, it would appear that the goods must be necessities both at the time the contract is made *and* at the time of delivery.

⁶⁶ *Barnes & Co v Toye* (1884) 13 QBD 410; *Johnstone v Marks* (1887) 19 QBD 509; *Nash v Inman* [1908] 2 KB 1.

consuming and could be seen as impertinent.⁶⁷ As a result the Scottish Law Commission recommended that suppliers of goods should be entitled to receive a reasonable price for necessities sold and delivered to a mentally incapable person whether or not they are actually required by him or her at the time of sale and delivery unless the supplier knew that they were not required.⁶⁸

(5) Reform in England and Wales

5.28 The Law Commission of England and Wales in its *Report on Mental Incapacity*⁶⁹ recommended a statutory provision applying the necessities rule to both goods and services so that when necessary goods and services are supplied to a person without capacity, they must pay a reasonable price for them.⁷⁰ This recommendation has been taken up in Section 7 of the *Mental Capacity Act 2005* which states:

“(1) If necessary goods or services are supplied to a person who lacks capacity to contract for the supply, he must pay a reasonable price for them.

(2) ‘Necessary’ means suitable to a person’s condition in life and to his actual requirements at the time when the goods or services are supplied.”

5.29 The Explanatory Notes prepared by the Department of Constitutional Affairs for the English *Mental Capacity Bill* describe the effect of the provision as follows:

“... if the milkman carries on delivering milk to the house of someone who has progressive dementia, they can expect to be paid. If, however, a roofer puts a completely unnecessary new roof on to that person’s house, when all

⁶⁷ Scottish Law Commission *Mentally Disabled Adults: Legal Arrangements for Managing their Welfare and Finances* (Discussion Paper No 94 1991) at paragraph 7.17.

⁶⁸ *Ibid* at paragraph 7.17. This issue was not addressed in the *Adults with Incapacity (Scotland) Act 2000*.

⁶⁹ Law Commission *Mental Incapacity* (Law Com No 231) (1995).

⁷⁰ *Ibid* at paragraph 4.9.

that is required was a minor repair, then the rule [on necessities] will not apply.”⁷¹

F The Equal Status Acts 2000 to 2004

5.30 The *Equal Status Act 2000*, as amended by Part 3 of the *Equality Act 2004* (“the *Equal Status Acts*”), gives protection against discrimination in the provision of goods and services. Services are defined broadly to include access to public places, banking and insurance services, entertainment, facilities for refreshment and transport. The legislation prohibits discrimination on a number of grounds, including disability. However, section 16(2)(b) of the *Equal Status Act 2000* states that treating a person differently does not constitute discrimination outlawed by the Act “if the person is incapable of entering into an enforceable contract and for that reason the treatment is reasonable in the particular case”. It would appear from the wording of section 16(2)(b) that incapacity will be judged as a question of fact rather than on the basis of the subjective judgment of the supplier. It is permissible to refuse to do business with an adult who does not have the capacity to understand the nature and impact of the transaction. However, it may not be considered reasonable to refuse to enter into a contract for necessities⁷² because the supplier would be entitled to recover a reasonable price for the goods despite the person’s lack of capacity.

5.31 Cases involving discrimination prohibited under the *Equal Status Acts* may be referred to the Equality Tribunal. Notably, section 53 of the *Equality Act 2004* amended the definition of “complainant” in section 20 of the *Equal Status Act 2000* to allow a parent or guardian or other person acting in place of a parent to take a complaint on behalf of a person who is “unable by reason of an intellectual or psychological difficulty” to pursue effectively a claim for redress. The complaint may be resolved by way of mediation led by an equality mediation officer. If dealt with by the Equality Tribunal, the complainant can be awarded compensation of up to the maximum amount that can be awarded by the District Court in civil

⁷¹ Department of Constitutional Affairs *Explanatory Notes to Mental Capacity Bill* (17 June 2004) at paragraph 37.

⁷² See Part E above.

cases in contract⁷³ (currently €6,250). Alternatively, the Equality Tribunal may make an order requiring a person to take a particular course of action to remedy matters.⁷⁴ A decision of the Equality Tribunal can be appealed to the Circuit Court where the Court can substitute its discretion for that of the Equality Tribunal.⁷⁵

5.32 In *Dexter v NPower Plc*,⁷⁶ a case taken under the UK's *Disability Discrimination Act 1995*, an agent of a gas company refused to accept the signature of a woman on a contract for the supply of gas and electricity without the countersignature of a neighbour. The woman had a neurological condition which caused her to shake but was of full mental capacity. The company's policy that all contracts with older people and disabled people were to be countersigned was found to be discriminatory and unlawful under Part III of the UK's *Disability Discrimination Act 1995*. It is likely that a similar view would be taken were such a case referred to the Equality Tribunal under the *Equal Status Acts*.

G Conclusions

(1) A Presumption of Capacity to Contract

5.33 The rationale behind the current law on capacity to contract is a desire to balance the potential hardship which may arise for a person with limited ability in agreeing to transactions the implications of which they do not fully understand against the potential hardship to another person who agrees to provide goods or services to them. In the introduction to this chapter,⁷⁷ the Commission alluded to a further policy goal of ensuring that persons with limited decision-making ability maximise their capacity to live as independently as possible, a goal which is reinforced by the provisions of the *Equal Status Acts 2000 to 2004*.

⁷³ Section 27 of the *Equal Status Act 2000*.

⁷⁴ Section 27 of the *Equal Status Act 2000*.

⁷⁵ Section 28 of the *Equal Status Act 2000*. This section also provides for an appeal on point of law to the High Court.

⁷⁶ 28 January 2003 (Swindon County Court).

⁷⁷ See paragraph 5.01 above.

5.34 The Commission believes that, rather than relying on the existing judicial test in *Hart v O'Connor*⁷⁸ of whether the other party had reason to suspect that the person may lack capacity, the law relating to capacity to contract should be governed by a rebuttable legal presumption of capacity to contract. A presumption of capacity to contract is in line both with the general presumption of capacity and the functional approach to capacity which the Commission has embraced in this Consultation Paper.⁷⁹ Approaching capacity to contract in this manner allows for a consistent approach to capacity issues.

5.35 The effect would be that where a person rebutted the presumption of capacity to contract, the contract would be void rather than voidable. This would mean no longer deciding that a contract is voidable based on a test of whether a lack of capacity would have been reasonably apparent to the other party from the circumstances. The Commission considers that any potential hardship to good faith suppliers who had no reason to suspect a lack of capacity would be considerably tempered by the addition of a revised ‘necessaries rule’ requiring persons lacking contractual capacity to pay a reasonable sum for goods and services supplied to them for daily living.⁸⁰ Therefore it would generally only be where goods or services contracted for are out of the ordinary that the issue of capacity would need to receive real consideration. Furthermore, while not strictly concerned with capacity, the equitable doctrines concerning unconscionable bargains and undue influence may be of assistance in relation to contracts with vulnerable adults where the other party has abused a position of superior bargaining power.⁸¹

⁷⁸ [1985] 2 All ER 880. See paragraph 5.17 above.

⁷⁹ See Chapters 2 and 3 above.

⁸⁰ See paragraph 5.41 *ff* below.

⁸¹ The law on unconscionable bargain and undue influence received some consideration in the Law Reform Commission’s *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at paragraph 5.28*ff* and may receive further consideration in the Law Reform Commission’s final report on *Vulnerable Adults and the Law* (as to which see the Introduction to this Consultation Paper).

5.36 The Commission envisages that a presumption of capacity to contract would be subsumed within the general statutory presumption of capacity which the Commission recommended in Chapter 3.

5.37 *The Commission recommends that a presumption of capacity to contract should form part of a statutory presumption of capacity.*

5.38 The onus would be on the party disputing contractual capacity to rebut the presumption of contractual capacity on the balance of probabilities. In the *Consultation Paper on Law and the Elderly*⁸² the Law Reform Commission recommended that the system of wardship be replaced by the appointment of a personal guardian or the making of one-off provision by means of an intervention or services order.⁸³ A functional approach to capacity would mean that while the existence of a guardianship order, services order or intervention order could be adduced as supporting evidence of incapacity to contract, the making of such an order would not in itself be decisive of the issue.

(2) *Adjudicating on Contractual Capacity*

5.39 Building on the guardianship framework set out in the *Consultation Paper on Law and the Elderly*,⁸⁴ the proposed capacity legislation could provide that any party to the contract, a personal guardian or other person connected with a party in respect of whom a lack of understanding is alleged⁸⁵ could refer a contract to the Office of the Public Guardian. Where both sides agree a mediator could be appointed by the Public Guardian. If the matter is not resolved by mediation, the Public Guardian could be given power to examine the case and

(a) declare that the transaction is binding on both parties; or

⁸² Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003).

⁸³ *Ibid* at Chapter 6.

⁸⁴ *Ibid* at Chapter 6.

⁸⁵ This is designed to prevent an argument that an individual does not have the capacity to make the complaint. See the similarly broad definition of “complainant” under section 20 of the *Equal Status Act 2000* (as amended by section 53 of the *Equality Act 2004*). See paragraph 5.31 above.

(b) declare the transaction void and make any adjustment to the rights of the parties which it considers just having regard to the circumstances of the case.⁸⁶

The decision of the Public Guardian would be subject to an appeal to the Circuit Court involving a full re-hearing of the case. Giving the proposed Public Guardian this adjudicative function in relation to contractual capacity would be in line both with the accepted role of quasi-judicial bodies in Ireland, (such as the Equality Tribunal, the Employment Appeals Tribunal and the Private Residential Tenancies Board), and current trends in favour of alternative dispute resolution generally.⁸⁷ Furthermore, in cases where a lack of contractual capacity is determined, empowering the Public Guardian with a broad discretion to impose a just solution would enable the difficult question of deciding how the loss should fall to be determined in as just a manner as possible in the particular circumstances of the case.

5.40 *The Commission recommends that the proposed capacity legislation should provide that a contract purportedly entered into by an adult whom it is alleged lacked contractual capacity may be referred to the Public Guardian by a party to the contract, a personal guardian or other person connected with a person in respect of whom it is alleged there was a lack of contractual capacity. The Commission further recommends that on such a contract being referred to it, the Public Guardian could, with the consent of the parties, refer the matter to mediation, or the Public Guardian could examine the matter. The Public Guardian should be given power to declare the contract binding on both parties or to declare the contract void for lack of capacity and to make any adjustment to the rights of the parties considered just in the circumstances. A decision of the Public Guardian could be appealed to the Circuit Court and such an appeal would involve a full rehearing of the matter.*

⁸⁶ This approach echoes section 15 of the American Law Institute's *Restatement (Second) of Contracts* (see paragraph 5.14 above) and some aspects of the recommendations of the Law Reform Commission in relation to minors' contracts (see paragraph 5.15-5.16 above).

⁸⁷ See, for example, sections 15 and 16 of the *Civil Liability and Courts Act 2004*.

(3) *The Necessaries Rule*

5.41 The Commission is in favour of the retention of the necessities rule as a mechanism for fairly dividing rights and duties between suppliers and consumers who lack full decision-making capacity in relation to the purchase of everyday goods and services. Nevertheless we are conscious that the application of the necessities rule is, in some respects, not free from doubt. We are therefore of opinion that a reformulated provision should be incorporated in the capacity legislation proposed by this Consultation Paper. This would accord with the Council of Europe's recommendation that "[w]henever possible adults should be enabled to enter into legally effective transactions of an everyday nature."⁸⁸

5.42 First, such provision should be expressed to apply to both goods and services. Secondly, in order to avoid any doubt in relation to executory contracts, we submit that the provision should be expressed to apply where goods or services have been supplied (it is envisaged that this would also cover partly executed contracts - where part delivery of goods or services has occurred). Thirdly, a statutory clarification of the application of the necessities rule to adults without the capacity to enter into such contracts would also afford a useful opportunity to formulate such a rule in modern terminology which is more easily understood. "Necessaries" could be defined in terms of goods and services supplied which are suitable to the person's reasonable living requirements but excluding goods and services which could be classed as luxury in nature.

5.43 *The Commission recommends that the proposed capacity legislation should provide that an adult who lacks the capacity to enter into a particular contract is nonetheless obliged to pay the supplier a reasonable amount for necessities supplied.*

5.44 *"Necessaries" should be statutorily defined as goods and services supplied which are suitable to the person's reasonable living*

⁸⁸ Council of Europe *Committee of Ministers Recommendation No. R99(4) on Principles Concerning the Legal Protection of Vulnerable Adults* (23 February 1999), Principle 3(4). See further paragraphs 1.37-1.39 above.

requirements but excluding goods and services which could be classed as luxury in nature.

CHAPTER 6 PERSONAL RELATIONSHIPS

A Introduction

6.01 Entering into personal relationships, marrying and having children are fundamental aspects of adult life. However, where a person has limited decision-making ability, the law treads a difficult line in attempting to strike a balance between the primary need to protect vulnerable individuals from exploitation and the need to respect an individual's autonomy and capacity to engage in voluntary and freely chosen relationships. To achieve such a balance is undoubtedly a complex task. The Commission acknowledges that the law should be responsive to changes in society and social perspectives. Historically, the law has approached the personal relationships of persons with limited decision-making ability with a form of benign paternalism based on the concept of what is considered to be in their best interests. However, while modern disability dialogue has sought to move away from paternalism in favour of a social rather than a medical view of disability,¹ the issue of personal relationships for persons with limited decision-making ability has yet to be widely debated in this country.

6.02 Part B of this chapter considers applicable constitutional and human rights considerations; Part C examines the law on capacity to consent to sexual relationships; Part D examines the law on capacity to marry; and Part E considers non-consensual sterilisation.

¹ See paragraph 1.04 above.

B Constitutional and Human Rights Considerations

(1) Constitutional Rights

6.03 Article 40.1 of the Constitution, which deals with equality before the law, prohibits invidious or unjustifiable discrimination by the State between different classes or persons but expressly permits the State in its enactments to have due regard to differences of capacity.² Furthermore, it has been recognised by the Supreme Court in *Re a Ward of Court (withholding medical treatment) (No.2)*³ that a loss of mental capacity does not result in any diminution of a person's personal rights under Article 40.3.1° and Article 40.3.2° of the Constitution. The courts have recognised that these personal rights include the right to privacy,⁴ including self-determination⁵ and the right to marry and found a family.⁶

6.04 The right to privacy was described by Hamilton P in *Kennedy v Ireland*⁷ as "one of the fundamental personal rights of the citizen which flow from the Christian and democratic nature of the State".⁸ However, the courts have concluded that the right to privacy is not unqualified⁹ and may be restricted by the constitutional rights of others, by the requirements of the common good, and by public morality.¹⁰

² See paragraph 1.32 *ff* above.

³ [1996] 2 IR 73, 126 *per* Hamilton CJ.

⁴ *McGee v Attorney General* [1974] IR 284; *Kennedy v Ireland* [1987] IR 587; *Hanahoe v Hussey* [1998] 3 IR 69.

⁵ *Re a Ward of Court (No.2)* [1995] 2 ILRM 401.

⁶ *Ryan v Attorney General* [1965] IR 294; *Murray v Ireland* [1985] IR 532 [1991] ILRM 465.

⁷ [1987] IR 587.

⁸ [1987] IR 587, 592.

⁹ *Norris v Attorney General* [1984] IR 36; *Kennedy v Ireland* [1987] IR 587; *Foy v an t-Ard Chláraitheoir* High Court (McKechnie J) 9 July 2002; *Bailey v Flood* Supreme Court 14 April 2000.

¹⁰ *Kennedy v Ireland* [1987] IR 587, 592, *per* Hamilton P.

6.05 Nor has the right to marry been interpreted by the courts as absolute or unqualified in nature.¹¹ The right to procreate or to beget children was considered in *Murray v Ireland*¹² where Costello J considered it to be an unenumerated right under Article 40.3. As with all personal rights, it is not an absolute right, and has only received judicial consideration in the context of married partners.

(2) *The European Convention on Human Rights*

6.06 The *European Convention on Human Rights Act 2003* requires courts to take into account relevant jurisprudence on the *European Convention for the Protection of Human Rights and Fundamental Freedoms* ('ECHR').¹³ In dealing with matters involving intimate aspects of private life, the jurisprudence of the European Commission on Human Rights¹⁴ and European Court of Human Rights has given a narrow margin of appreciation¹⁵ to national authorities.¹⁶ Article 8 and Article 12 of the ECHR are particularly relevant in the current context.

(a) *Article 8 of the ECHR*

6.07 Article 8 states:

- “1. Everyone has the right to respect for his private and family life, his home and correspondence.¹⁷
2. There shall be no interference by a public authority with the exercise of this right except such as is in

¹¹ *Foy v An t-Ard Chláraitheoir* High Court (McKechnie J) 9 July 2002.

¹² [1985] IR 532. See also the Supreme Court [1991] ILRM 465.

¹³ See paragraph 1.34 *ff* above.

¹⁴ The Commission ceased to exist on the coming into effect of Protocol No.11 to the ECHR in 1998.

¹⁵ This describes the amount of latitude given to national authorities in the application of the European Convention on Human Rights. See Lavender “The Problem of the Margin of Appreciation” [1997] EHRLR 380.

¹⁶ See *Dudgeon v United Kingdom* (1982) 4 EHRR 149; *Norris v Ireland* (1989) EHRR 186; *Sutherland v UK* [1998] EHRLR 117.

¹⁷ See also Article 7 of the *Charter of Fundamental Rights for the European Union* OJ NO. 364/1 (2000). See paragraph 1.45 above.

accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the protection of the rights and freedom of others.”

In *Bruggemann and Scheuten v Germany*¹⁸ the European Commission on Human Rights stated:

“The right to respect for private life is of such a scope as to secure the individual a sphere within which he can freely pursue the development and fulfilment of his personality. To this effect, he must also have the possibility of establishing relationships of various kinds, including sexual, with the other person. In principle whenever the state sets up rules for the behaviour of the individual within this sphere, it interferes with respect for private life and such interference must be justified in the light of Article 8(2).”¹⁹

(b) *Article 12 of the ECHR*

6.08 Article 12 of the ECHR provides: “Men and women of marriageable age have the right to marry and found a family, according to the national laws governing the exercise of this right.”²⁰ This right is expressly subject to national law governing the exercise of this right which must not substantially interfere with the right to marry. In *Hamer v UK*,²¹ a case concerning the refusal of the UK authorities to allow a convicted prisoner to marry in prison or to grant him temporary release in order to marry, the European Commission of Human Rights indicated that national law may not deprive “a person or category of persons of full legal capacity of the right to marry”.²² Therefore the prisoner’s rights under Article 12 were found to have been violated.

¹⁸ (1977) EHRR 244.

¹⁹ (1977) 3 EHRR 244 at paragraph 55.

²⁰ See also Article 9 of the *Charter of Fundamental Rights for the European Union* OJ NO. 364/1 (2000). See paragraph 1.45 above.

²¹ (1982) 4 EHRR 139.

²² (1982) 4 EHRR 139 at paragraphs 60 – 62. See further McDermott *Prison Law* (Round Hall Sweet & Maxwell 2000) at 10.04.

C Capacity to Consent to Sexual Relationships

6.09 This Consultation Paper is concerned with law on capacity as it impacts on decision-making capacity in a civil law context. However, when considering personal relationship issues, capacity to enter into a sexual relationship is a matter which is ruled by the criminal law. Therefore of necessity a consideration of capacity issues in relation to sexual relationships necessitates a discussion of criminal law and the appropriate function of the criminal law in this area. The criminal law requires that to enter into a sexual relationship, each of the parties (a) is of age, and (b) consents to the act. In relation to persons of age with limited decision-making ability, consent, and more particularly, capacity to consent to a sexual relationship is a key issue.²³ The development and reform of the law in this area is discussed below.

(1) Sexual Assault Offences

6.10 When one person touches another person in a sexual manner without the other person's consent, a sexual assault²⁴ or aggravated sexual assault²⁵ may be committed. Where a person has penetrative sexual relations with a person over the age of consent who lacks the mental capacity to consent, this may amount to rape where the person knows or is reckless as to whether the other person consents.²⁶

²³ See McAuley and McCutcheon *Criminal Liability* (Round Hall Sweet & Maxwell Dublin 2000) at 513 ff.

²⁴ See section 2 of the *Criminal Law (Rape) (Amendment) Act, 1990*. The maximum penalty is imprisonment for 10 years.

²⁵ See section 3 of the *Criminal Law (Rape) (Amendment) Act, 1990*. The maximum penalty is imprisonment for life.

²⁶ Rape carries a maximum sentence of life imprisonment. For the ingredients of rape offences see section 2 of the *Criminal Law (Rape) (Amendment) Act 1981* (as amended) and section 4 of the *Criminal Law (Rape) (Amendment) Act 1990*; O'Malley *Sexual Offences: Law, Policy and Punishment* (Round Hall Sweet & Maxwell 1996) at Chapter 2; Charleton, McDermott and Bolger *Criminal Law* (Butterworths 1999) at Chapter 8.

6.11 “Consent” is not defined in legislation dealing with rape or sexual assault but its existence is to be objectively determined.²⁷ However, section 9 of the *Criminal Law (Rape) (Amendment) Act 1990* states that failure or omission to offer resistance does not of itself constitute consent to the act. This means that submission without resistance will not in itself amount to evidence of consent in relation to a sexual assault offence. A person will not have the capacity to consent if they do not understand the nature and consequences of the act. In *R v Flattery*²⁸ a man who had sexual intercourse with the victim under the pretence that he was performing a surgical operation for her benefit was convicted of rape.²⁹

(2) Sexual Acts with Adults with Limited Decision-Making Ability

(a) Section 4 of the Criminal Law Amendment Act 1935

6.12 Prior to relatively recent times, the archaic terminology of section 4 of the *Criminal Law Amendment Act 1935*³⁰ (the “1935 Act”) provided that a person who had sexual intercourse with a woman or girl with knowledge at the time that she was “an idiot, or an imbecile or is feeble-minded”³¹ could be sentenced to up to two years in prison. Section 254 of the *Mental Treatment Act 1945* increased the maximum penalty to five years’ penal servitude where the offender under section 4 of the *Criminal Law Amendment Act 1935* was a carer or was in the management or employment of the mental institution where the victim was a patient.³²

²⁷ The common law test is that expounded by the Supreme Court of Victoria in *R v Morgan* [1970] VR 337. See further Charleton, McDermott and Bolger *Criminal Law* (Butterworths 1999) at paragraph 8.23.

²⁸ (1877) 2 QBD 410.

²⁹ On fraud as to purpose see generally McAuley and McCutcheon *Criminal Liability* (Round Hall Sweet & Maxwell 2000) at 523 – 526.

³⁰ This section was repealed by section 14 of the *Criminal Law (Sexual Offences) Act 1993* with effect from 7 July 1993. See paragraph 6.16 ff below.

³¹ These offensive terms were statutorily defined in the *Mental Deficiency Act 1913*.

³² Section 254 of the *Mental Treatment Act 1945* was to be repealed by section 7 of the *Health (Mental Services) Act 1981* (the “1981 Act”).

(b) *The Law Reform Commission Report on Sexual Offences Against the Mentally Handicapped*

6.13 The need for modernisation of the law in this area was addressed in the Commission's 1990 *Report on Sexual Offences Against the Mentally Handicapped*³³ which followed on from previous recommendations in the Commission's *Consultation Paper on Rape*³⁴ and *Report on Rape and Allied Offences*.³⁵ In the Commission's *Consultation Paper on Rape*, section 4 of the 1935 Act was regarded by the Commission as "expressed in the language of a former age"³⁶ and the Commission's subsequent *Report on Rape and Allied Offences* recommended that the offensive wording in section 4 of the 1935 Act³⁷ should be replaced with words such as "mental incapacity" or "mental handicap".³⁸ The Commission notes that contemporary disability terminology would now favour the use of the term 'intellectual disability' in preference to 'mental handicap'.³⁹

6.14 The subject matter was revisited in greater depth in the Commission's *Report on Sexual Offences Against the Mentally*

However, the 1981 Act was not commenced and is to be repealed in its entirety by section 6 of the *Mental Health Act 2001* (when commenced). In any event section 254 of the 1945 Act has been rendered nugatory since the repeal of section 4 of the *Criminal Law Amendment Act 1935* by the *Criminal Law (Sexual Offences) Act 1993*. Section 254 will be repealed by section 6 of the *Mental Health Act 2001* on the commencement of that section.

³³ Law Reform Commission *Report on Sexual Offences Against the Mentally Handicapped* (LRC 33-1990).

³⁴ Law Reform Commission *Consultation Paper on Rape* (1987).

³⁵ Law Reform Commission *Report on Rape and Allied Offences* (LRC 24-1988).

³⁶ *Consultation Paper on Rape* at 23, paragraph 39, at 81, paragraph 126. In relation to the deficiencies of section 4 of the *Criminal Law Amendment Act 1935* see further Charleton, McDermott and Bolger *Criminal Law* (Butterworths 1999) at paragraph 8.24.

³⁷ See paragraph 6.12 above.

³⁸ Law Reform Commission *Report on Rape and Allied Offences* (LRC 24-1988) at paragraph 51. See also Law Reform Commission *Consultation Paper on Rape* (1987) at 82, paragraph 126.

³⁹ See paragraph 1.06 above.

*Handicapped*⁴⁰ which laid emphasis on two distinct principles in relation to the law's function regarding sexual behaviour and persons with an intellectual disability:

- (i) The law should respect the right of such persons to sexual fulfilment;
- (ii) The law should, so far as practicable, protect such persons against sexual exploitation.⁴¹

6.15 The Commission regarded the language of section 4 of the 1945 Act as "both offensive and out of date" such as would justify the repeal of the section and its replacement with a more appropriately worded section.⁴² In so doing the Commission went further than its previous recommendation that the section should be reformulated with more acceptable terminology. The Commission acknowledged however that the categorisation of persons who should be protected was "a question of considerable difficulty".⁴³ Ultimately, the Commission recommended that section 4 of the 1935 Act be repealed and replaced with an indictable offence of sexual intercourse with "a person with mental handicap, or suffering from mental illness which is of such a nature or degree that the person is incapable of guarding himself against exploitation".⁴⁴ A parallel offence in respect of anal penetration and other acts of sexual exploitation was also recommended.⁴⁵ The Commission entered a caveat to the effect that a sexual relationship between persons suffering from mental handicap or mental illness should not *in itself* constitute an offence:

"It is possible that a sexual relationship between two people suffering from mental handicap or mental illness could

⁴⁰ Law Reform Commission *Report on Sexual Offences Against the Mentally Handicapped* (LRC 33-1990).

⁴¹ *Ibid* at paragraph 27.

⁴² *Ibid* at paragraph 18.

⁴³ *Ibid* at paragraph 18.

⁴⁴ *Ibid* at paragraph 32.

⁴⁵ Law Reform Commission *Report on Sexual Offences Against the Mentally Handicapped* (LRC 33-1990) at paragraph 33. The question of how such acts should be described was not addressed in the Report.

result in the conviction of either or both This would clearly be contrary to the underlying principles which, in our view, should inform the proposed legislation.

We accordingly recommend that no act of vaginal sexual intercourse, or anal penetration or other proscribed sexual activity should constitute an offence where both participants are suffering from mental handicap or mental illness as defined, unless the acts in question constitute a criminal offence by virtue of some other provision of the law.”⁴⁶

(3) Section 5 of the Criminal Law (Sexual Offences) Act 1993

6.16 Following the Commission’s *Report on Sexual Offences Against the Mentally Handicapped*, section 5 of the *Criminal Law (Sexual Offences) Act 1993* (the “1993 Act”) reformed the law in this area. As recommended by the Law Reform Commission in the *Report on Sexual Offences Against the Mentally Handicapped*,⁴⁷ the 1993 Act repealed section 4 of the 1935 Act.⁴⁸ Section 5 of the 1993 Act introduced a new offence which applies where a person has or attempts to have sex⁴⁹ with a person who is “mentally impaired” unless they are married to each other.⁵⁰ It is also an offence for a male

⁴⁶ Law Reform Commission *Report on Sexual Offences Against the Mentally Handicapped* (LRC 33-1990) at paragraph 35. A similar perspective is evident in Australia’s Model Criminal Code Officers Committee of Attorneys-General *Report on Sexual Offences Against the Person* (1999) at 177.

⁴⁷ (LRC 33-1990).

⁴⁸ See paragraph 6.12 above.

⁴⁹ Sexual intercourse or buggery. Other acts of a sexual nature are not covered by this offence: see Department of Justice, Equality and Law Reform *The Law on Sexual Offences* (Discussion Paper 1998) (The Stationery Office) at paragraph 9.3.3.

⁵⁰ Section 5 of the *Criminal Law (Sexual Offences) Act 1993*. The maximum penalty for sexual intercourse or buggery within section 5 of the 1993 Act is 10 years’ imprisonment. Attempted intercourse or buggery attract a maximum penalty of 3 years’ imprisonment for a first offence and 5 years’ imprisonment for subsequent offences. See further O’Malley *Sexual Offences: Law, Policy and Punishment* (Round Hall Sweet & Maxwell 1996), Chapter 6.

person to commit or attempt to commit an act of gross indecency with another male.⁵¹

6.17 A defence is available to a person who did not know and had no reason to suspect that the person was “mentally impaired”.⁵² “Mentally impaired” is statutorily defined as :

“suffering from a disorder of the mind, whether through mental handicap or mental illness, which is of such a nature or degree as to render a person incapable of living an independent life or⁵³ of guarding against serious exploitation.”⁵⁴

6.18 Prosecutions for an offence under section 5 of the 1993 Act are at the discretion of the Director of Public Prosecutions.⁵⁵ The Department of Justice in its Discussion Paper on sexual offences⁵⁶ noted that prosecutorial discretion would prevent inappropriate prosecutions.⁵⁷ The English Court of Criminal Appeal judgment in *R v Hall*⁵⁸ suggests that, in the event of a prosecution, the question of

⁵¹ Section 5(2) of the *Criminal Law (Sexual Offences) Act 1993*.

⁵² Section 5(3) of the *Criminal Law (Sexual Offences) Act 1993*. The definition of mental impairment is based on a similar definition in section 96 of the *Mental Health (Scotland) Act 1960*. See further Law Reform Commission *Report on Sexual Offences Against the Mentally Handicapped* (LRC 33-1990) at paragraphs 24 and 31.

⁵³ It would appear that the tests contained in this definition are disjunctive or alternative - the person must be incapable of leading an independent life *or* incapable of guarding against serious exploitation: Department of Justice, Equality and Law Reform *The Law on Sexual Offences* (Discussion Paper The Stationery Office 1998) at 9.3.2.

⁵⁴ Section 5(5) of the *Criminal Law (Sexual Offences) Act 1993*. Part IV of the *Sex Offenders Act 2001* utilises the definition of “mentally impaired” in section 5 of the *Criminal Law (Sexual Offences) Act 1993*.

⁵⁵ Section 5(4) of the *Criminal Law (Sexual Offences) Act 1993*. See further Director of Public Prosecutions *Statement of General Guidelines for Prosecutors* (2001) at 9-16.

⁵⁶ Department of Justice, Equality and Law Reform *The Law on Sexual Offences* (Discussion Paper) (The Stationery Office 1998).

⁵⁷ *Ibid* at paragraph 9.4.1.

⁵⁸ (1988) 86 Cr App R 159.

whether a person was “mentally impaired” would be a matter for the jury to decide.

6.19 The Commission regards section 5 of the 1993 Act and the use of the term “mentally impaired” as an advance on the outmoded language and scope of the pre-existing section 4 of the *Criminal Law Amendment Act 1935*. Nevertheless, viewed from current perspectives on disability, it is submitted that both the concept and definition of “mental impairment” in section 5 of the 1993 Act are unsatisfactory. In relation to the definition of “mentally impaired” (a term which may in itself be considered objectionable),⁵⁹ the Commission reiterates its view expressed in the *Report on Sexual Offences Against the Mentally Handicapped*⁶⁰ that the test of ability to guard against serious exploitation (the second test in section 5(5) of the 1993 Act) constitutes a better yardstick of capacity to consent than ability to lead an independent life (the first test in section 5(5) of the 1993 Act) because some degree of dependence would not necessarily preclude an ability to consent.⁶¹

6.20 The Commission notes that a regrettable effect of section 5 of the 1993 Act is that outside a marriage context a sexual relationship between two “mentally impaired” persons may constitute a criminal offence because there is no provision for consent as a defence in respect of a relationship between adults who were both capable of giving a real consent to sexual intercourse.⁶² The operation of section 5 of the 1993 Act as a potential bar to a mutually consensual sexual relationship with another person with a limited decision-making ability runs contrary to the Commission’s recommendation in the *Report in Sexual Offences Against the Mentally Handicapped* that a relationship between persons with a decision-making disability should not in itself be prohibited.⁶³ Fear of facilitating the commission of a

⁵⁹ See paragraphs 1.22 and 3.16 *ff* above.

⁶⁰ See Law Reform Commission *Report on Sexual Offences Against the Mentally Handicapped* (LRC 33-1990).

⁶¹ *Ibid* at paragraph 32. This view is approved in the NAMHI publication *Who Decides and How? People with Intellectual Disabilities – Legal Capacity and Decision Making* (2003) at 65.

⁶² See McAuley and McCutcheon *Criminal Liability* (Round Hall Sweet & Maxwell Dublin 2000) at 515.

⁶³ See paragraph 6.15 above.

criminal offence on the part of parents and carers may prevent relationships between two adults with intellectual disability developing even where they have capacity to consent and there is no element of exploitation.

6.21 O'Malley, commenting on the need for the criminal law to achieve the appropriate balance between paternalism and autonomy, stated that:

“it may swing the balance too far in the direction of depriving mentally ill or disabled persons of the right to a sexual life compatible with their physical, mental and emotional capacities. The policy adopted in s.5 of the Act of 1993 may be faulted on this ground. Even allowing for the tacit assumption that prosecutorial discretion will diminish the incidence of ‘hard cases’, the section fails to reflect the right of persons who are mentally impaired (to use its own language) to have a sexual life.”⁶⁴

In the Commission's *Report on Sexual Offences against the Mentally Handicapped*⁶⁵ the following comments of MJ Gunn were quoted in the context of the requirements of Article 8 of the European Convention on Human Rights:

“If sexual development and reproduction are to be possible, it must be legally acceptable for people with a mental handicap to enter into sexual relationships. Wholly unreasonable restrictions on such relationships would appear to fall foul of article 8, ECHR, where the right to private life, including sexual life, can only be restricted if the conditions in article 8(2) are fulfilled. It, therefore, needs to be considered whether the restrictions which are imposed by English criminal law are ‘... for the protection of health or morals, or for the protection of the rights and freedom of others’.

⁶⁴ O'Malley *Sexual Offences: Law Policy and Punishment* (Round Hall Sweet & Maxwell 1996) at 133.

⁶⁵ (LRC 33-1990).

English criminal law may hinder and perhaps prevent sexual relationships of people with mental handicap through the offences created by the Sexual Offences Acts 1956-76.⁶⁶

6.22 The Commission is of the view that if the matter arose for consideration, section 5 of the 1993 Act may be considered to breach Article 8 of the ECHR by disproportionately interfering with a person's right to respect for his private life under Article 8 of the ECHR⁶⁷ and not to fall within the State's narrow "margin of appreciation" in matters of this kind. In particular, the Commission notes that in previous ECHR cases concerning the criminalisation of consensual homosexual acts in breach of Article 8, a practice of non-enforcement by the national authorities was deemed irrelevant by the European Court of Human Rights.⁶⁸

6.23 In Australia, it was considered that a blanket ban on all sexual contact would not properly allow for the sexual rights of persons with impaired mental functioning.⁶⁹ This thinking is also evident in recent reforming legislation in the UK. The *Sexual Offences Act 2003* contains a number of specific offences relating to sexual activity with a person with a mental disorder (which includes a learning disability) who "lacks the capacity to choose whether to agree to the touching (whether because he lacks sufficient understanding of the nature or reasonably foreseeable consequences of what is being done or for any other reason)" or is unable to communicate such a choice.⁷⁰ Capacity to consent is therefore articulated in terms of functional capacity to understand the nature and consequences of the act. The offence requires the perpetrator to know or be reasonably expected to have

⁶⁶ Gunn *Medical Law* (1986) 255 at 257. Quoted in Law Reform Commission *Report on Sexual Offences Against the Mentally Handicapped* (LRC 33-1990) at paragraph 12.

⁶⁷ See paragraph 6.07 above.

⁶⁸ See *Dudgeon v UK* (1981) 4 EHRR 149; *Norris v Ireland* (1991) 13 EHRR 186; *Modinos v Cyprus* (1993) 16 EHRR 485. In Ireland, the blanket prohibition on buggery was removed by section 2 of the *Criminal Law (Sexual Offences) Act 1993*.

⁶⁹ The Model Criminal Code Officers Committee of the Standing Committee of Attorneys-General *Report on Sexual Offences Against the Person* (May 1999) at 177.

⁷⁰ Section 30 of the UK *Sexual Offences Act 2003*.

known that because of a mental disorder the other person was unlikely to be able to refuse.

(4) Conclusions

6.24 The law's incursion on the sexual behaviour of adults with limited decision-making ability requires a careful balancing exercise in order to protect vulnerable adults from abuse while also respecting sexual autonomy where real consent is present. While the Commission commends the protective aim of Section 5 of the *Criminal Law (Sexual Offences) Act 1993*⁷¹ in relation to adults who are vulnerable to sexual exploitation, we are nevertheless concerned that a blanket prohibition on relationships between the "mentally impaired" ignores the circumstances in which such relationships can consensually occur, where no exploitation has taken place. Furthermore, as currently configured, section 5 may breach Article 8 of the ECHR.

6.25 The first potential option for reform in this area would be to amend section 5 of the *Criminal Law (Sexual Offences) Act 1993* to replace the concept of "mental impairment" with more acceptable language by re-working the definition of the protected class in line with modern disability language.⁷² This would conform with the recommendation of the Commission on the Status of People with Disabilities that legal definitions of disability should be reviewed and offensive language replaced with "language which reflects the right of people with disabilities to be treated as full citizens and to be included in all aspects of society."⁷³

6.26 A more fundamental option for reform would be to amend section 5 of the *Criminal Law (Sexual Offences) Act 1993* in order to

⁷¹ This protective function is buttressed by Part 4 of the *Sex Offenders Act 2001* which requires anyone who applies to do work involving unsupervised access to "mentally impaired" persons (as defined in section 3 of the *Criminal Law (Sexual Offences) Act 1993*) to inform the employer of any previous conviction for a sexual offence.

⁷² See paragraph 6.16 ff above.

⁷³ Commission on the Status of People with Disabilities *A Strategy for Equality: Report of the Commission on the Status of People with Disabilities* (1996) at paragraph 2.2.

ensure that relationships between adults with limited decision-making ability would be lawful where there is real informed consent. The UK *Sexual Offences Act 2003*⁷⁴ contains a specific functional concept of lack of capacity to consent in relation to persons with limited decision-making ability articulated as an absence of sufficient understanding of the nature or reasonably foreseeable consequences of the act or an inability to communicate choice.⁷⁵ Such a reform would be designed to continue the protective function of the criminal law in this area for adults who do not have the capacity to consent while ensuring that persons with limited decision-making ability are not unfairly precluded from relationships of a sexual nature where they have the requisite understanding of what a sexual relationship entails. Undoubtedly the promotion of capacity to consent to sexual relationships is closely linked to the provision of sex education to young adults with limited decision-making ability which is pitched at an appropriate level to their capacity.

6.27 It is clear that this is a complex area where law and society's views are not settled. The Commission therefore finds it appropriate to invite views on reform in this area.

6.28 *The Commission invites views in relation to the reform of section 5 of the Criminal Law (Sexual Offences) Act 1993. In particular, views are invited as to whether the offence should be remodelled so that it would be an offence to have or attempt to have sexual intercourse or buggery with a person who lacked capacity to consent to the relevant act at the time because they did not understand the nature or reasonably foreseeable consequences of the act or could not communicate their consent or lack of consent.*

⁷⁴ See paragraph 6.23 above.

⁷⁵ The Department of Justice, Equality and Law Reform's Discussion Paper *The Law on Sexual Offences* (The Stationery Office 1998) raised the issue as to whether the perpetrator of a sexual assault offence by a carer in an institution should attract a higher maximum penalty (at paragraph 9.5.2). This was a recommendation of the Commission in the *Report on Sexual Offences Against the Mentally Handicapped* (LRC 33-1990) at paragraph 36.

D Capacity to Marry

6.29 The classic common law statement of the nature of the contract of marriage is that of Lord Penzance in *Hyde v Hyde*⁷⁶ where he described it as “the voluntary and permanent union of one man and one woman to the exclusion of all others for life.”⁷⁷ Legally, marriage is a civil contract which creates reciprocal rights and duties between the parties and which establishes a status which is constitutionally protected by Article 41.3.1° of the Constitution.⁷⁸ Once solemnised, a marriage is presumed valid until the contrary is established.⁷⁹ In Ireland, a right to marry has been recognised as one of the unenumerated personal rights under Article 40.3.1° of the Constitution⁸⁰ though not, however, an absolute right.⁸¹

6.30 In Ireland, the formalities (including the required age) in relation to marriage are set out in statute while the issue of capacity to marry⁸² remains a matter of common law. Section 31(a) of the *Family Law Act 1995* allows persons over 18 to marry.⁸³

(1) *Understanding the Nature of Marriage*

6.31 Apart from observing the necessary formalities required to effect a valid marriage, the free consent of both parties is a

⁷⁶ (1866) L.R. 1 P&D 130.

⁷⁷ (1866) L.R. 1 P&D 130, 133. The permanency characteristic has been watered down as a result of the divorce referendum which led to the amendment of Article 41.3.2 and provision for divorce pursuant to in the *Family Law (Divorce) Act 1996*.

⁷⁸ See generally Shannon (ed) *Family Law Practitioner* (Round Hall Sweet & Maxwell loose-leaf) at Division A.

⁷⁹ *N (or se K) v K* [1986] ILRM 75, 89 per Griffin J.

⁸⁰ *Ryan v Attorney General* [1965] IR 294. See also *Donovan v Minister for Justice* (1951) 85 ILTR 134.

⁸¹ *Foy v An t-Ard Chláraitheoir* High Court (McKechnie J) 9 July 2002.

⁸² This Part is concerned only with issues relating to capacity to marry which arise from the existence of a decision-making disability on the part of one or more of the parties.

⁸³ An exemption to the age requirement may be granted on application to the Circuit Family Court pursuant to section 33 of the *Family Law Act 1995*.

prerequisite to a valid marriage. As well as requiring an exercise of independent will, ‘informed consent’ means that each party must have an understanding of the nature and responsibilities of marriage at the time of marriage otherwise the marriage is void. In certain circumstances an adult with limited decision-making ability may not be in a position to give informed consent to marriage. The onus of proving that a person did not understand or was incapable of understanding the nature and consequences of the marriage ceremony rests on the person asserting this.⁸⁴ There is no presumption that a person with an intellectual disability or mental disorder does not have capacity to marry.⁸⁵ However, a person who is a Ward of Court may not marry.⁸⁶

6.32 It is clear that traditionally the courts have not pitched the required understanding of the nature of marriage at a high level. As Hannen P observed in *Durham v Durham*:⁸⁷

“the contract of marriage is a very simple one, which does not require a high degree of intelligence to comprehend. It is an engagement between a man and woman to live together, and love one another as husband and wife, to the exclusion of all others.”

The low level of understanding required for capacity to consent to marriage is illustrated by *Re Park*⁸⁸ where a man who was deemed unfit to execute a detailed will was found to have the capacity to marry.⁸⁹

⁸⁴ *Sheffield City Council v E* [2004] EWHC 2808 (Fam).

⁸⁵ See Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at paragraph 6.60.

⁸⁶ See paragraph 6.48 below.

⁸⁷ (1885) 10 P.D. 80 at 82. See also *Sheffield City Council v E* [2005] All ER (D) 192 (Jan) at paragraph 132.

⁸⁸ [1953] 2 All ER 1411.

⁸⁹ See also the decision of the Ontario Supreme Court in *Re McElroy* (1978) 93 D.L.R. (3d) 522 at 525.

6.33 *Sheffield City Council v E*⁹⁰ concerned a 21 year old woman who was assessed as functioning at the level of 13 year old who wanted to marry a 37 year old man with a history of sexually violent crimes. The local authority brought proceedings in order to prevent them from marrying on the basis that she lacked the capacity to marry. A preliminary issue arose as to the correct test to be employed in assessing capacity to marry.

6.34 The authorities on capacity to marry were summarised by the Court in four propositions:

- (i) It is not enough that someone appreciates that he or she is taking part in a marriage ceremony or understands its words.
- (ii) He or she must understand the nature of the marriage contract.
- (iii) This means that he or she must be mentally capable of understanding the duties and responsibilities that normally attach to marriage.
- (iv) That said, the contract of marriage is in essence a simple one, which does not require a high degree of intelligence to comprehend.⁹¹

6.35 Munby J stated that the essence of a contract of marriage is:

“an agreement between husband and wife to live together, and to love one another as husband and wife, to the exclusion of all others. It creates a relationship of mutual and reciprocal obligations, typically involving the sharing of a common home and a common domestic life and the right to enjoy each other’s society, comfort and assistance.”⁹²

⁹⁰ [2004] EWHC 2808 (Fam).

⁹¹ [2004] EWHC 2808 (Fam) at paragraph 67.

⁹² [2004] EWHC 2808 (Fam) at paragraph 132.

In terms of policy, Munby J stated:

“There are many people in our society who may be of limited or borderline capacity but whose lives are immensely enriched by marriage. We must be careful not to set the test of capacity to marry too high, lest it operate as an unfair, unnecessary and indeed discriminatory bar against the mentally disabled.”⁹³

6.36 The Court therefore rejected a submission that capacity should be assessed in relation to the particular marriage proposal in question. Rather, in assessing a person’s capacity to marry, the Court held that it is not concerned with the wisdom of their marrying in general nor with the wisdom of marrying the particular person contemplated:

“The implications for A of choosing to marry B rather than C may be immense. B may be a loving pauper and C a wife-beating millionaire. But this has nothing to do with the nature of the contract of marriage into which A has chosen to enter. Whether A marries B or marries C, the contract is the same, its nature is the same, and its legal consequences are the same. The emotional, social, financial and other implications for A may be very different but the nature of the contract is precisely the same in both cases.”⁹⁴

6.37 Lack of informed consent also encompasses the concept of one party failing to disclose a material fact to the other prior to the marriage. The test for ‘informed consent’ is a subjective one. In *O’M(M) v O’C(B)*⁹⁵ the Supreme Court granted the petitioner a nullity decree because she had not been informed before the marriage that her husband had attended a psychiatrist for 6 years and she stated that she would not have married him had she known of this.

⁹³ [2004] EWHC 2808 (Fam) at paragraph 144.

⁹⁴ [2004] EWHC 2808 (Fam) at paragraph 85.

⁹⁵ [1996] 1 IR 208.

(2) ***Entering a Caveat Concerning a Person's Capacity to Marry***

6.38 If there is a concern as to a person's capacity to marry, a caveat may be entered with a Registrar of Marriages before the marriage takes place to prevent a certificate or licence being granted. In practice, capacity is more likely to be called into question after the event in subsequent nullity proceedings.

6.39 Under section 23 of the *Marriages (Ireland) Act 1844*⁹⁶ any person, on payment of a nominal fee, may enter a written caveat with the Registrar against the granting of a certificate or licence in respect of a person named in it. The caveat must state the ground of objection which, it is contended, constitutes an impediment to marriage. Where a caveat is lodged, the Registrar cannot issue a certificate or licence to the person named in the caveat unless the Registrar is satisfied that the objection is unfounded or the caveat is withdrawn by the person who lodged it.⁹⁷ If the Registrar refuses to grant a marriage certificate or licence, the person applying for it can appeal to an t-Ard Chláraitheoir. If a caveat comes to an t-Ard Chláraitheoir for consideration which is premised on the contention that a party does not have the capacity to consent to marriage, an t-Ard Chláraitheoir may seek the advice of a psychiatrist or psychologist in relation to a person's capacity to marry.

6.40 The *Civil Registration Act 2004* represents the first major reform of civil registration law and involves the repeal of the *Marriages (Ireland) Act 1844*. Section 58 of the *Civil Registration Act 2004*,⁹⁸ replaces section 23 of the *Marriages (Ireland) Act 1844* with a similar procedure for entering a caveat by which a person may lodge an "objection" in writing with a Registrar at any time before the

⁹⁶ 7 & 8 Vic., C.81. See Shannon (ed) *Family Law Practitioner* (Round Hall Sweet & Maxwell 2000) at paragraph A-106.

⁹⁷ If there is any doubt in relation to the matter, the Registrar can refer the matter to an t-Ard Chláraitheoir for determination: section 23 of the *Marriages (Ireland) Act 1844*.

⁹⁸ Section 58 of the *Civil Registration Act 2004* has not been commenced at the time of writing.

solemnisation of a marriage.⁹⁹ A non-technical objection will be referred on to an t-Ard Chláraitheoir for investigation as to whether there is an impediment to the intended marriage. If there is an objection, steps are to be taken to prevent the solemnisation of the marriage and its registration. An appeal against a decision by an t-Ard Chláraitheoir may be taken to the Circuit Family Court by a party to the proposed marriage.

(3) *The Law of Nullity*

6.41 The law of nullity lays down the conditions under which a marriage contract may not be valid and binding at the date of the marriage.¹⁰⁰ Either party to a putative marriage may commence nullity proceedings in the Circuit Court or High Court seeking a declaration of nullity.¹⁰¹ The right to marital privacy cannot be invoked to prevent an inquiry into the validity of a marriage.¹⁰² A declaration of nullity has the effect that a marriage that is null and void is deemed never to have existed.¹⁰³ Nullity proceedings are adversarial rather than inquisitorial in nature.¹⁰⁴ The onus of establishing lack of consent lies on the petitioner who must establish his or her case on the balance of probabilities.¹⁰⁵ A person may obtain

⁹⁹ See paragraph 6.48 below in relation to the procedure where an objection is based on the *Marriage of Lunatics Act 1811*.

¹⁰⁰ The jurisdiction was transferred from the ecclesiastical courts of the Church of Ireland to the civil courts by the *Matrimonial Causes and Marriage Law (Ireland) Amendment Act 1870*. See Law Reform Commission *Report on the Nullity of Marriage* (LRC 9-1984) at 3.

¹⁰¹ Alternatively, under the *Family Law (Divorce) Act 1996* divorce is available on a “no fault basis” where the parties having been living apart for four out of the previous five years.

¹⁰² *JS v CS* [1997] 2 IR 506.

¹⁰³ This also means that any children will be non-marital children and ancillary reliefs in relation to property and maintenance will not be available as they would be in the case of a decree of judicial separation or divorce.

¹⁰⁴ *McG v F* [2001] 2 ILRM 326.

¹⁰⁵ *S.C. v P.D.* High Court (McCracken J) 14 March 1996. Earlier cases had suggested that a more onerous burden of proof might apply. In *O’R v B* [1995] 2 ILRM 57, 75 Kinlen J stated that in cases where a nullity application is not contested “[i]t would be eminently desirable at public

a decree of nullity on the basis of their own lack of capacity to consent. In *DC (Orse DW) v DW*¹⁰⁶ a decree was granted to a person with schizophrenia.

6.42 In *JS v CS*¹⁰⁷ Budd J described the court's role in relation to this ground of nullity as follows:¹⁰⁸

“The court may have to explore not only the capacity of the party to enter into the appropriate marital relationship but also the party's capacity to sustain this relationship. Indeed, it may well be that a party who was incapable at the time of the marriage of forming a meaningful marital relationship, may, with medical help, stand a realistic prospect of being cured so that the capacity to form the required relationship may be restored or acquired. On the other hand, the affliction may have brought about such an irretrievable breakdown of relationship that even if the party's condition is ameliorated, nevertheless the marital relationship is irredeemably destroyed ... In view of the strong public interest which the State has in the preservation of existing marital unions, it may be that in an appropriate case, much consideration will have to be given to the prospect of curative treatment. There is also the peculiar anomaly that a party may be able to obtain a decree of nullity because of the existence of an incapacitating antecedent illness, but will be denied relief if the illness causing the inability came after the marriage.”

(a) *Medical Evidence*

6.43 Where capacity is at issue in nullity proceedings, one or two medical inspectors who may be psychiatrists or psychologists may be appointed to carry out a psychiatric examination of the relevant party

expense to have a *'legitimus contradictor'*, an *'amicus curiae'* or *'devil's advocate'* to argue in favour of the existence of the marriage.”

¹⁰⁶ [1987] ILRM 58.

¹⁰⁷ [1997] 2 IR 506.

¹⁰⁸ [1997] 2 IR 506, 509.

or parties and to report in writing to the court.¹⁰⁹ A medical inspector is entitled to have access to relevant medical and psychiatric records.¹¹⁰ While the medical evidence is important, the determination of capacity to marry in nullity cases is a judicial function. In *McG v F*¹¹¹ the Supreme Court held that it was not open to a medical inspector to interview third parties such as friends and relatives as a matter of course as this would amount to a preliminary hearing. However, Denham J stated *obiter* that in appropriate circumstances a court could give additional authority to a medical inspector to interview third parties with the consent of both parties to the proceedings.¹¹²

(b) *The Effect of Mental Illness at Time of Marriage*

6.44 If a person was suffering from mental illness at the time of the marriage and was incapable of understanding the nature of the contract into which they were entering, a decree of nullity can be obtained. In *ME v AE*¹¹³ the respondent was suffering from paranoid schizophrenia which prevented him from giving full, free and informed consent. In *JS v JM*¹¹⁴ Lavan J granted a decree of nullity to a petitioner whose wife had been suffering from depression and schizo-affective illness at the time of her marriage.

(c) *Ability to Enter and Sustain a Normal Marital Relationship*

6.45 A person's capacity to appreciate the nature of the contract of marriage can be distinguished from their capacity to undertake the obligations of marriage, that is, their ability to enter into and sustain a normal marital relationship. In *RSJ v JS*¹¹⁵ Barrington J stated that it was "impossible to imagine any form of meaningful marriage where one of the parties lacks the capacity of entering into a caring, or even

¹⁰⁹ Order 70, r.32(2), 32(3) of the *Rules of the Superior Courts 1986* (S.I. No. 15 of 1986).

¹¹⁰ *FP v SP (Medical Examiner: Discovery)* [2002] 4 IR 280.

¹¹¹ [2001] 2 ILRM 326.

¹¹² [2001] 2 ILRM 326, 334.

¹¹³ [1987] IR 147.

¹¹⁴ High Court (Lavan J) 10 December 1997.

¹¹⁵ [1982] ILRM 263.

a considerate relationship with the other.”¹¹⁶ Therefore if it could be shown that at the date of the marriage, one party, through illness, lacked the capacity to form a considerate or caring relationship with their spouse, this would be a ground on which a decree of nullity might be granted. This reasoning was approved by Costello J in *D v C*¹¹⁷ where he observed that “the lifelong union which the law enjoins requires for its maintenance the creation of an emotional and psychological relationship between the spouses.”¹¹⁸ Where a party to a marriage lacks the capacity to enter into and sustain a normal marital relationship, the marriage will be voidable.¹¹⁹ Thus where a party has a psychiatric illness (or, in certain instances, extreme emotional immaturity) which is of such severity as to prevent them from entering into and sustaining a normal caring marriage relationship, this may be sufficient to obtain a declaration of nullity.¹²⁰

6.46 The length of the putative marriage is immaterial unless the court is of the view that the petitioner approbated the marriage after realising that it may be voidable. Where a mental illness such as bipolar disorder is latent at the time of the marriage but later manifests itself, it would appear that this cannot be regarded as affecting the person’s ability to enter into a marriage and although it may later affect their ability to sustain the marriage this would not justify a declaration of nullity.¹²¹ Indeed where it is clear that a mental illness can be controlled with medication this may render a party capable of sustaining a marriage which would not be the case in the absence of treatment.¹²²

¹¹⁶ [1982] ILRM 263, 264.

¹¹⁷ [1984] ILRM 173.

¹¹⁸ [1984] ILRM 173, 189. This reasoning was expressly approved by the Supreme Court in *F v C* [1991] 2 IR 352.

¹¹⁹ Where a marriage is voidable it may be subject to approbation by the other party if they act in a manner which accepts the validity of the marriage: *M O’D v C O’D* High Court (O’Hanlon J) 5 August 1992.

¹²⁰ *UF v JC* [1991] ILRM 65 (Supreme Court endorsing previous High Court decisions).

¹²¹ *SC v PD* High Court (McCracken J) 14 March 1996.

¹²² *SC v PD* High Court (McCracken J) 14 March 1996.

6.47 In *D v C*¹²³ Costello J held that the husband's manic depression (bipolar disorder) before, during and after the marriage severely impaired his capacity to form and sustain a normal marriage. The marriage was ruled to be voidable rather than void. However, temperamental incapacity alone has not been regarded as sufficient.¹²⁴ In certain cases, the absence of a recognised psychiatric illness has resulted in a declaration of nullity being refused.¹²⁵ The decision of the Supreme Court in *UF v JC*¹²⁶ established that it was not necessary that the grounds of relief "should be confined to advances and knowledge which can be placed before the court, as strictly coming within the definition of psychiatric medicine."¹²⁷ It was sufficient to show that the relevant incapacity "arose from some other inherent quality or characteristic which could not be said to be voluntary or self-induced."¹²⁸ This opened the door to applications based on emotional immaturity. In *PC v VC*¹²⁹ it was held that the parties had a mutual incapacity relative to each other. This case has been described as a high watermark in the law of nullity.¹³⁰ Evidence that this ground of nullity may have receded from its high watermark is evident in *JWH v GW*¹³¹ where emotional immaturity alone was held by the High Court to be insufficient to preclude the formation of a valid marriage.

(4) *The Marriage of Lunatics Act 1811*

6.48 The *Marriage of Lunatics Act 1811* was passed "to prevent the marriage of lunatics". Its effect is to render void a marriage contracted by a person found to be a "lunatic" by inquisition. The

¹²³ [1984] ILRM 173.

¹²⁴ *PC v VC* [1990] 2 IR 91.

¹²⁵ *EP v MC* [1985] ILRM 34; *PC v DO'B* High Court (Carroll J) 2 October 1985.

¹²⁶ [1991] ILRM 65.

¹²⁷ [1991] ILRM 65, 93.

¹²⁸ [1991] ILRM 65, 92.

¹²⁹ [1990] 2 IR 91.

¹³⁰ Shannon (ed) *Family Law Practitioner* (Round Hall Sweet & Maxwell 2000) at paragraph A-241.

¹³¹ High Court (O'Higgins J) 25 February 1998.

Act remains on the statute book¹³² and in modern times its effect is to render void a marriage by a person who has been made a Ward of Court¹³³ unless they have been discharged from wardship. This ignores the fact that an individual who has been made a Ward of Court may be able to understand the nature of the marriage contract.¹³⁴ The continued applicability in Ireland of the 1811 Act was confirmed in the *Civil Registration Act 2004*. Under section 58(11) of the *Civil Registration Act 2004*,¹³⁵ an objection on the ground that a marriage would be void by virtue of the *Marriage of Lunatics Act 1811* must be accompanied by a certificate of a registered medical practitioner supporting the objection. This does not resolve the difficulty that a reading of the *Marriage of Lunatics Act 1811* suggests that any marriage by a Ward of Court will be void even if conducted during a lucid interval.¹³⁶

(5) Conclusions

6.49 The Commission recognises that there is a well-established jurisprudence in the area of nullity law which sets out the capacity requirements for marriage in terms of an ability to understand the nature of marriage and the ability to sustain a normal, caring marital relationship. It is not proposed to interfere with this.

6.50 Given the safeguards provided by the law of nullity to protect those suffering from mental illness or impairment, the Commission regards the *Marriage of Lunatics Act 1811* as anachronistic and out of step with modern views of mental disability and a functional approach to capacity issues. The 1811 Act may breach the right to marry under Article 12 of the ECHR¹³⁷ and its repeal would also be consistent with the functional, issue-specific approach to capacity put

¹³² It was repealed in the UK by the *Mental Health Act 1959*.

¹³³ See McLoughlin “Wardship: A Legal and Medical Perspective” (1998) MLJI 61.

¹³⁴ See McLoughlin “Wardship: A Legal and Medical Perspective” (1998) MLJI 61 at 62.

¹³⁵ At the time of writing section 58 of the *Civil Registration Act 2004* has not been commenced.

¹³⁶ *Turner v Myers* (1808) 1 Hag. Con. 414.

¹³⁷ See *Hamer v UK* (1982) 4 EHRR 139; paragraph 6.08 above.

forward in this Consultation Paper. The Commission is of the view that the *Marriage of Lunatics Act 1811* serves no useful purpose and on balance we consider that it should be repealed.

6.51 *The Commission recommends that the Marriage of Lunatics Act 1811 be repealed.*

E Sterilisation

6.52 Sterilisation is a surgical method of rendering a male or female incapable of reproduction.¹³⁸ It is in most instances an irreversible procedure. It would appear that there is no precise information available as to the incidence of sterilisation of people with limited decision-making ability in Ireland.¹³⁹ The Commission on the Status of People with Disabilities stated in its 1996 report:

“It is assumed that the sterilisations which do take place are authorised on the basis of medical and psychological opinion and with parental agreement. It is not known to what extent people with disabilities are consulted about such decisions.

This is a profoundly complex question with ethical, social, economic and legal implications. It is a question to be faced

¹³⁸ An alternative course of action in long term care facilities may be the administering of sex-drive suppressants and contraceptives to adults with an intellectual disability without their knowledge or consent: Report of the Commission on the Status of People with Disabilities *A Strategy for Equality: Report of the Commission on the Status of People with Disabilities* (1996) at paragraph 18.29; paragraph 7.77 below.

¹³⁹ See Commission on the Status of People with Disabilities *A Strategy for Equality: Report of the Commission on the Status of People with Disabilities* (1996) at paragraph 18.27 ff. See Cooney “Sterilisation and the Mentally Handicapped” (1989) 11 DULJ 56; Donnelly, “Non-consensual sterilisation of mentally disabled people: the law in Ireland” (1997) 32 Irish Jur 297; Freeman “Sterilising the Mentally Handicapped” in Freeman *Medicine, Ethics and the Law* at 55-84. In relation to consent to medical treatment generally see Chapter 7 below.

in the future, given the developing emphasis on people's rights and changing attitudes."¹⁴⁰

6.53 Sterilisation is an issue which could potentially be ruled on as part of the *parens patriae* jurisdiction for the protection of vulnerable persons including adults with a mental disability.¹⁴¹ However, it would appear that to date the issue of non-consensual sterilisation has not come before the courts in this country.

6.54 In other jurisdictions such as Canada and the United States, systematic non-consensual sterilisation of disabled persons originated in eugenics theory which is unacceptable today.¹⁴² A distinction has been drawn in the literature and case law between therapeutic and non-therapeutic sterilisation. Essentially therapeutic sterilisation is required for the person's mental or physical health while non-therapeutic sterilisation is used for contraceptive purposes.¹⁴³

(1) Comparative Overview

6.55 In the seminal Canadian case on sterilisation, *Re Eve*,¹⁴⁴ the Canadian Supreme Court was asked to consent to a mother's application for a sterilisation operation for her daughter who had a mild to moderate intellectual disability. The reason the operation was sought was to prevent pregnancy rather than any medical necessity.

¹⁴⁰ Commission on the Status of People with Disabilities *A Strategy for Equality: Report of the Commission on the Status People with Disabilities* (1996) at paragraph 18.27.

¹⁴¹ See generally Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at paragraph 4.04 ff.

¹⁴² Article 3 of the *Charter of Fundamental Rights for the European Union* OJ 18.12.2000 C 364/1 (see paragraph 1.45 above) specifically prohibits "eugenic practices".

¹⁴³ See Macklin and Gaylin (eds) *Mental Retardation and Sterilization: A Problem of Complacency and Paternalism* (New York Plenum Press 1981); Ogbourne and Ward "Sterilization, the Mentally Incompetent and the Courts" (1989) *Anglo-Am L Rev* 230; Park and Radford "From the Case Files: reconstructing a history of involuntary sterilisation" 1998 *Disability & Society* Vol. 13, No. 3, 317; Manitoba Law Reform Commission *Report on Sterilization and Legal Incompetence* (1992).

¹⁴⁴ (1986) 31 DLR (4th)1.

La Forest J, delivering the decision of the Canadian Supreme Court said:¹⁴⁵

“The grave intrusion on a person’s right and the certain physical damage that ensues from non-therapeutic sterilisation without consent, when compared to the highly questionable advantages that can result from it, have persuaded me that it can never safely be determined that such a procedure is for the benefit of that person. Accordingly, the procedure should never be authorized for non-therapeutic purposes under the *parens patriae* jurisdiction.”

Accordingly the application for consent to sterilisation was refused.

6.56 In contrast to the approach in *Re Eve*,¹⁴⁶ in England and Wales non-consensual sterilisation has been carried out on the basis of a best interests test and there has not been a requirement of therapeutic intent. Sterilisation of an adult who is not competent to consent requires the prior sanction of a High Court judge where there are disputes or difficulties in relation to the person’s capacity or best interests¹⁴⁷ and the position in relation to sterilisation has been clarified by a Practice Note summarising the effect of decisions in this area.¹⁴⁸ If a sterilisation procedure is necessary for therapeutic purposes (as opposed to contraceptive purposes) there is generally no need to bring an application to court.¹⁴⁹ If an application is brought,

¹⁴⁵ (1986) 31 DLR (4th)1, 32.

¹⁴⁶ (1986) 31 DLR (4th)1.

¹⁴⁷ *Re B (A Minor) (Wardship: Sterilisation)* [1987] 2 All ER 206; *Re F (Mental Patient: Sterilisation)* [1989] 2 All ER 545. The test for capacity to consent to medical treatment is set out in *Re MB (An Adult) (Medical Treatment)* [1997] 2 FCR 541. See *Re A (Medical Treatment)* [1997] 2 FCR 541.

¹⁴⁸ Official Solicitor *Practice Note* [2001] 2 FCR 569. This Practice Note concerns making medical and welfare decisions for adults lacking capacity. See further paragraph 7.65 *ff* below.

¹⁴⁹ *Re GF (A Patient)* [1991] FCR 786. This was echoed by the Law Commission of England and Wales in its Report *Mental Incapacity* (Law Com No. 231 1995) at paragraph 6.4. However, if there is a doubt as to whether the procedure is therapeutic, it should be referred to the court: *Re SL (Adult Patient) (Medical Treatment)* [2000] 2 FCR 452.

the court must be satisfied that the operation will promote the best interests of the person without capacity rather than the interests or convenience of parents or carers. Three particular factors for consideration are:

- (i) Whether there is an identifiable risk of pregnancy;¹⁵⁰
- (ii) Evidence of likely physical or psychological damage deriving from conception;¹⁵¹
- (iii) The person's likely ability to care for and/or have a fulfilling relationship with a child.

6.57 In *Pembrey v The General Medical Council*¹⁵² the Privy Council upheld the decision of the General Medical Council to strike a medical practitioner off the medical register based on a finding of professional misconduct in relation to cases where non-therapeutic sterilisation procedures were carried out on a number of adult women with a learning disability. The Privy Council affirmed the decision of the General Medical Council based on a finding that there had not been adequate (or, in some cases, any) consideration given to alternative options to sterilisation nor had appropriate consideration being given, in consultation with other professionals, to an assessment of the women's capacity to consent or to their best interests.

6.58 In Scotland, sterilisation in circumstances where there is no serious malfunction or disease of the reproductive organs is subject to the approval of the Court of Session under the *Adults with Incapacity (Scotland) Act 2000*.¹⁵³ This is also the case in relation to the surgical implantation of hormones for the purposes of reducing sex drive.¹⁵⁴

¹⁵⁰ *Re LC (Medical Treatment) (Sterilisation)* [1997] 2 FLR 258; *Re S (Adult: Sterilisation)* [1999] 1 FCR 277.

¹⁵¹ In the case of a male, different considerations will apply; *Re A (Medical Treatment: Male Sterilisation)* [2000] 1 FCR 193, at 202-203.

¹⁵² [2003] UKPC 60, 97 of 2002.

¹⁵³ *The Adults with Incapacity (Specified Medical Treatments) (Scotland) Regulations 2002* (No. 275), Schedule 1, Part I.

¹⁵⁴ Drug treatment of an adult without capacity for the purpose of reducing sex drive (other than surgical implantation of hormones) requires a certificate from a practitioner appointed by the Mental Welfare Commission certifying that the adult is incapable in relation to the decision

These forms of medical treatment can only be carried out in relation to an adult who is incapable in relation to a decision about that treatment if the court is satisfied, on application to it by the medical practitioner primarily responsible for the medical treatment, that the treatment will safeguard or promote the physical or mental health of the adult and that the adult does not oppose the treatment or resist it being carried out. The Court of Session is obliged to afford an opportunity to any person having an interest in the personal welfare of the adult to make representations to it.¹⁵⁵

(2) *The Irish Context*

6.59 In the Commission's 1990 *Report on Sexual Offences against the Mentally Handicapped*¹⁵⁶ the Commission commented that it seems probable that if the issue of non-consensual sterilisation came up for judicial consideration in Ireland, the approach in *Re Eve*¹⁵⁷ would be preferred, namely, that non-consensual sterilisation would only be sanctioned for therapeutic purposes.¹⁵⁸ It has since been argued that a consideration of whether sterilisation is in the best interests of an individual would not be sufficient given the existence of the mentally disabled person's underlying constitutional rights.¹⁵⁹ In Ireland the right to have children has been recognised in a marital context as one of the unenumerated rights guaranteed by Article 40 as being essential to the human condition and personal dignity.¹⁶⁰ A

and that the treatment is likely to safeguard or promote the adult's physical or mental health: Regulation 4 of *The Adults with Incapacity (Specified Medical Treatments) (Scotland) Regulations 2002* (No. 275).

¹⁵⁵ See further paragraph 7.77 below.

¹⁵⁶ LRC 33-1990.

¹⁵⁷ (1986) 31 DLR (4th)1. See paragraph 6.55 above. See the discussion of *Re Eve* and the US Supreme Court decision on sterilisation *Buck v Bell* (1927), 274 US 200 in *North Western Health Board v HW* Supreme Court 8 November 2001.

¹⁵⁸ Law Reform Commission *Report on Sexual Offences Against the Mentally Handicapped* (LRC 33-1990) at paragraph 41.

¹⁵⁹ Donnelly "Non-Consensual Sterilisation of Mentally Disabled People: The Law in Ireland" (1997) 32 Ir Jur 297, 310.

¹⁶⁰ *Murray v Ireland* [1991] ILRM 465, 471, 476. A wider formulation of this right was put forward in *In re F (Mental Patient: Sterilisation)* [1989] 2

person who has the capacity to marry¹⁶¹ and retains that capacity may have the capacity to consent or refuse sterilisation. A wider right to reproduce has not yet been judicially recognised in Irish constitutional law. In any case, the constitutional right to bodily integrity¹⁶² and Article 8 of the ECHR are relevant in this context.¹⁶³ Furthermore, in certain circumstances non-consensual sterilisation may constitute a trespass against the person in civil law and a criminal assault offence under the *Non-Fatal Offences Against the Persons Act 1997*.¹⁶⁴

6.60 In 1996, the Commission on the Status of People with Disabilities recommended that there should be a legal prohibition on sterilisation on the basis of disability alone *i.e.* non-therapeutic sterilisation.¹⁶⁵ Furthermore, in any case where sterilisation was being considered, it was recommended that every effort should be made to ensure that informed and free consent exists. Where informed consent is not possible, it recommended that a court should determine that there is just and necessary cause, that other methods of contraception are unworkable, that fair procedures are observed including medical and psychological assessment of the person's welfare and rights, full consultation with parents and carers and that independent advocacy should be available to the person.¹⁶⁶

6.61 The Commission notes that the Department of Justice, Equality and Law Reform acknowledged in its progress report on the implementation of the recommendations of the Commission in the Status of People with Disabilities¹⁶⁷ that this is a profoundly complex

WLR 1025, 1068 where Lord Brandon regarded the right to bear children as “one of the fundamental rights of a woman.”

¹⁶¹ See paragraph 6.29 *ff* above.

¹⁶² See paragraph 7.09 below.

¹⁶³ See paragraph 7.10 below.

¹⁶⁴ See paragraphs 7.13-7.14 below.

¹⁶⁵ Commission on the Status of People with Disabilities *A Strategy for Equality: Report of the Commission on the Status of People with Disabilities* (1996) at paragraph 18.27 *ff*.

¹⁶⁶ *Ibid* at paragraph 18.31.

¹⁶⁷ Department of Justice, Equality and Law Reform *Towards Equal Citizenship: Progress Report on the Implementation of the*

area and stated that it would examine the implications of the recommendations in consultation with other relevant Departments and interested parties.¹⁶⁸ Although such a consultation would be desirable, it has not occurred to date. Given that non-consensual sterilisation raises important constitutional and human rights issues for persons with limited decision-making ability, and may amount to a criminal offence, the Commission believes that it is appropriate to affirm the recommendation of the Commission on the Status of People with Disabilities that any proposed non-consensual sterilisation on grounds of disability alone should be referred to the courts.¹⁶⁹

6.62 *The Commission recommends that the proposed capacity legislation should provide that any proposed non-consensual sterilisation of a person with limited decision-making ability where there is no serious malfunction or disease of the reproductive organs would require an application to court.*

Recommendations of the Commission on the Status of People with Disabilities (Stationery Office 2000).

¹⁶⁸ *Ibid* at 226.

¹⁶⁹ See paragraph 7.98 below. The Commission has examined the broader area of consent to medical treatment in Chapter 7 below.

CHAPTER 7 CAPACITY TO MAKE HEALTHCARE DECISIONS

A Introduction

7.01 From time to time most adults will visit the doctor or the dentist. A visit to a general practitioner may result in medication being prescribed. Further referral to a consultant may result in a recommendation that a surgical procedure be carried out. A visit to the dentist may result in an assessment that orthodontic work is required. In each case there may be several options for treatment, each with its own benefits and risks. As a general principle, the patient must agree or consent to any treatment being proposed by a medical practitioner¹ before it is carried out.

7.02 This chapter discusses issues relating to the capacity of adults to make healthcare decisions.² While a requirement of “informed consent” to medical treatment is enshrined in law and ethics, there is an absence of corresponding clear and comprehensive guidance for medical practitioners in relation to issues surrounding capacity to make healthcare decisions.³ Part B of this Chapter sets out applicable legal principles in relation to consent to treatment. Part C considers

¹ The term “medical practitioner” is generally used in this chapter as an umbrella term to cover clinicians of all kinds including general practitioners, hospital consultants, surgeons and dentists.

² In this chapter healthcare decisions can generally be taken to refer to decisions concerning any surgical, medical, nursing, optical or dental treatment, procedure or examination. Clinical trials and research are examined as a discrete area in paragraph 7.61 *ff* below. Involuntary psychiatric admissions under the *Mental Health Act 2001* are outside the scope of this Consultation Paper.

³ See also Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at paragraphs 1.08-1.10; 3.13-3.15; 4.47-4.51; 6.62-6.72.

issues relating to the assessment of capacity to make a healthcare decision. Part D examines the law relating to making a healthcare decision where an adult lacks the required capacity. Part E contains an overview of recent reforms in the United Kingdom. Part F contains the Commission's conclusions in this area.

B Legal Principles concerning Consent to Medical Treatment

(1) *The Requirement of Informed Consent*

7.03 It is well-established in law that, as a general principle, in order to carry out medical treatment, whether of a routine or extraordinary nature, the consent of the patient is required.⁴ It is immaterial whether the medical treatment is of an ordinary or an extraordinary nature. This can be written, oral or non-verbal (implied).⁵ In the past 'simple consent' was sufficient – this was satisfied by assent manifested by a verbal indication of consent or the signature of a patient on a consent form supplied by a hospital. Simple consent accepts a verbal affirmation or signature agreeing to treatment at face value as evidence of consent without the need for further inquiry. However, medical ethics and law have moved on from a requirement of 'simple consent' to one of 'informed consent' to medical treatment.⁶ The requirement of informed consent means

⁴ The law in this area can be traced back as far as *Slater v Baker & Stapleton* 95 Eng. 860, 2 Wils KB 359 (1767). See Mazur "Influence of the law on risk and informed consent" 2003 BMJ 327: 731-734. See generally Madden *Medicine, Ethics and the Law* (Butterworths 2002) at Chapter 9; Mills *Clinical Practice and the Law* (Butterworths 2002) at Chapter 4; Tomkin and Hanafin *Irish Medical Law* (Round Hall Press 1995) at Chapter 3.

⁵ See Mills *Clinical Practice and the Law* (Butterworths 2002) at paragraph 4.06–4.09; Irish Medical Council *A Guide to Ethical Conduct and Behaviour* (6th ed 2004) at paragraph 17.1.

⁶ The term 'informed consent' appears to have been coined in the Californian case of *Salgo v Leland Stanford Junior University Board of Trustees* 154 Cal. App.2d 560, 317 P.2d 170 (1957). See generally Faden and Beauchamp *A History and Theory of Informed Consent* (Oxford University Press 1986); Donnelly *Consent: Bridging the Gap between Doctor and Patient* (Cork University Press 2002); *Walsh v Family Planning Services Ltd* [1992] 1 IR 496; *Bolton v Blackrock Clinic*

that a signature on a consent form does not in itself prove the consent is valid. Thus it is often said that consent is a process not a form.⁷ Patients need sufficient information about the reason they need treatment, the benefits and risks of the treatment proposed, and alternative treatments. If the patient is not offered as much information as they reasonably need to make their decision in a form they can understand, their consent may not be valid.⁸

7.04 There is no general statutory embodiment of the common law requirement of informed consent to medical treatment.⁹ However, section 56 of the *Mental Health Act 2001* sets out a statutory definition of what constitutes consent to treatment for a ‘mental disorder’:

“... ‘consent’, in relation to a patient, means consent obtained freely without threats or inducement, where –

(a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and

(b) the consultant psychiatrist has given the patient adequate information, in a form and language that the patient can

Supreme Court 23 January 1997; *Geoghegan v Harris* [2000] 3 IR 536; *Quinn v South Eastern Health Board* High Court (Ó’Caoimh J) 22 March 2002; *Philip v Ryan* High Court (Peart J) 11 March 2004.

⁷ “Ethically valid consent is a process of shared decision-making based upon mutual respect and participation, not a ritual to be equated with reciting the contents of a form that details the risks of particular treatments.”: President’s Commission for the Study of Ethical Problems in Medicine and Biomedical Healthcare Research *Making Healthcare Decisions – A Report on the Ethical and Legal Implications of Informed Consent in the Patient – Practitioner Relationship* Volume One (New York 1982) at 2.

⁸ The requirement of free and informed consent is recognised in Article 3 of the *Charter of Fundamental Rights of the European Union* OJ No. 364/1 (2000). See paragraph 1.45 above. See also the Council of Europe *Convention on Human Rights and Biomedicine* (ETS 164 and additional Protocol ETS 168) to which Ireland is not yet a party. See further paragraphs 7.11-7.12 below.

⁹ See Donnelly *Consent: Bridging the Gap between Doctor and Patient* (Cork University Press 2002) at 50.

understand, on the nature, purpose and likely effects of the proposed treatment.”

7.05 In general terms, we can conclude that informed consent essentially requires that the following elements be satisfied:¹⁰

- (i) prior disclosure of sufficient relevant information by the medical practitioner to the patient to enable an informed decision to be made about the treatment proposed;
- (ii) the patient has the necessary capacity at the time to decide whether or not to consent to the proposed treatment;
- (iii) the context allows the patient to voluntarily make a decision as to whether to consent to or to decline the proposed treatment.¹¹

7.06 It is the responsibility of the medical practitioner to ensure that a person has the capacity to make the healthcare decision. Indeed the doctrine of informed consent is part of a medical practitioner’s duty of care under the tort of negligence and has been judicially recognised as an aspect of the constitutional right of privacy which ensures the dignity and freedom of the individual.¹²

7.07 The Medical Council was established by the *Medical Practitioners Act 1978*. One of its functions is to provide guidance to the medical profession on professional standards and ethical conduct.¹³ The Medical Council publishes ethical guidelines for the

¹⁰ See generally Grisso and Applebaum *Assessing Competence to Consent to Treatment* (Oxford University Press 1998) at 6; Irish Medical Council *A Guide to Ethical Conduct and Behaviour* (6th ed 2004) at paragraph 17.1; fn 6 above.

¹¹ See *Re T (Adult: Refusal of Medical Treatment)* [1992] 4 All ER 649; *JM v St Vincent’s Hospital* [2003] 1 IR 321.

¹² *Re a Ward of Court (No.2)* [1996] 2 IR 79, 163 *per* Denham J. See further paragraph 7.08 *ff* below.

¹³ Section 69(2) of the *Medical Practitioners Act 1978*.

profession and these are periodically revised.¹⁴ On the issue of informed consent, the Medical Council's ethical guidelines state:

“ ... Informed consent can only be obtained by a doctor who has sufficient training and experience to be able to explain the intervention, the risks and benefits and the alternatives. In obtaining this consent the doctor must satisfy himself/herself that the patient understands what is involved by explaining in appropriate terminology....”¹⁵

(2) Treatment without Consent

7.08 The right to determine what may be done with one's own body is a fundamental one. As Robins JA of the Court of Appeal of Ontario stated in *Malette v Shulman*:¹⁶ “[t]he concepts inherent in this right are the bedrock upon which the principles of self-determination and individual autonomy are based.” If medical treatment or a medical examination is carried out without consent, this has implications under the Constitution, human rights law, the law of torts and criminal law.¹⁷

(a) Constitutional Rights

7.09 The requirement of consent to medical treatment and medical examinations is an aspect of the constitutional right to bodily integrity, an unenumerated personal right under Article 40.3 of the Constitution.¹⁸ The right to bodily integrity as a personal right must

¹⁴ The Medical Council's ethical guidelines are currently updated every five years. However, the Medical Council recently indicated that it intends to publish amendments on a more regular basis on a web site: Ganly, “Changes sought on ‘vulnerable’ patients” *Irish Medical Times* Vol. 39 No.15, 15 April 2005 at 6.

¹⁵ Irish Medical Council *A Guide to Ethical Conduct and Behaviour* (6th ed 2004) at paragraph 17.1.

¹⁶ (1990) 72 OR (2d) 417, 432.

¹⁷ In some situations, the common law doctrine of necessity may provide a legal justification: see paragraph 7.29 *ff* below.

¹⁸ *Ryan v Attorney General* [1965] IR 294, 313 *per* Kenny J.

be vindicated by the State “as far as practicable”.¹⁹ If medical treatment is given without consent this may constitute a breach of the individual’s right to bodily integrity.²⁰ In *Re A Ward of Court (No.2)*²¹ Denham J viewed the requirements of consent to medical treatment and to be treated with dignity as aspects of the unenumerated right to privacy under Article 40.3.²²

(b) *Human Rights Law*

7.10 The guarantee of protection for private life in Article 8(1)²³ of the European Convention on Human Rights (“ECHR”)²⁴ has been interpreted by the European Court of Human Rights to include protection for the physical integrity of the person.²⁵ ECHR jurisprudence suggests that a compulsory medical intervention or psychological examination may interfere with Article 8 rights²⁶ and that medical treatment of an adult without their consent would interfere with a person’s physical integrity in a manner capable of infringing Article 8(1).²⁷

7.11 The Council of Europe in *Convention on Human Rights and Biomedicine*²⁸ (the ‘Biomedicine Convention’) has at its core the

¹⁹ Article 40.3.2°; *Hanrahan v Merck, Sharpe and Dohme Ltd* [1988] ILRM 629; *AD v Ireland* [1994] 1 IR 369. It would appear that in certain instances the right to bodily integrity must also be recognised by private individuals: *The People (DPP) v T* (1988) 3 Frewen 141, 158 .

²⁰ *Re a Ward of Court (No.2)* [1996] 2 IR 79, 124-125.

²¹ [1996] 2 IR 79.

²² See further paragraph 1.31 above.

²³ Article 8 of the ECHR is quoted at paragraph 6.07 above.

²⁴ See paragraph 1.34-1.36 above.

²⁵ *X and Y v The Netherlands* (1986) 8 EHRR 235 at paragraph 22.

²⁶ *YF v Turkey* (2004) 39 EHRR 34 (forced gynaecological examination); *Glass v The United Kingdom* (2004) 39 EHRR 15. See also the Commission decisions in *Acmane v Belgium* (1984) 40 DR 254, *X v Austria* (1980) 18 DR 154.

²⁷ *Pretty v United Kingdom* (2002) 35 EHRR 1, paragraph 63.

²⁸ Council of Europe *Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and*

protection of the dignity and integrity of human beings in the area of biology and medicine. In the present context there are four important principles set out in the Biomedicine Convention. First, an intervention should only be carried out on a person who does not have the capacity to consent for his or her direct benefit.²⁹ Second, the intervention must be authorised by the person's "representative or an authority or a person or body provided for by law".³⁰ Thirdly, the previously expressed wishes by a patient who is not in a position at the time of the intervention to express them are required to be taken into account.³¹ Fourthly, a necessity principle³² is broadly recognised in Article 8 which states:

"When because of an emergency situation the appropriate consent cannot be obtained, any medically necessary intervention may be carried out immediately for the benefit of the individual involved."

7.12 Parties to the Biomedicine Convention are required to provide for appropriate sanctions to be applied in the event of infringement of these provisions.

(c) *The Law of Torts*

7.13 Treatment without consent may give rise to a claim for trespass to the person and/or professional negligence in civil law.³³ In *Appleton v Garrett*³⁴ aggravated damages for trespass to the person

Medicine Oviedo, 4. IV.1997. Although a member of the Council of Europe, Ireland is not yet a signatory to the Convention.

²⁹ Article 6(1) of the Biomedicine Convention.

³⁰ On the question of making legal provision for the appointment of substitute decision-makers see Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at Chapter 6.

³¹ Article 9 of the Biomedicine Convention.

³² See further paragraph 7.38 *ff* below.

³³ See McMahon and Binchy *Law of Torts* (3rd ed Butterworths 2000) at paragraph 14.76; *Walsh v Family Planning Services Ltd* [1992] 1 IR 496, 531.

³⁴ [1997] 8 Med L.R. 75.

were awarded against a dentist who carried out unnecessary dental work on patients without their informed consent.

(d) *Criminal Law*

7.14 Treatment without informed consent may constitute an assault offence under sections 2 to 4 of the *Non-Fatal Offences Against the Person Act 1997*.³⁵

(3) *Age and Capacity Thresholds*

7.15 If a person is under the age of 16, a parent or guardian may consent to or refuse treatment on their behalf. Generally speaking, by virtue of section 23 of the *Non-Fatal Offences against the Person Act 1997* a person aged 16 or above may consent to surgical, medical or dental treatment. The general position is that a person aged 18 or above, having reached the age of majority,³⁶ may consent or refuse all forms of healthcare. However, where an adult lacks the requisite capacity to make a decision on healthcare, as a general rule no-one else has the legal right to make a decision on their behalf since the guardianship of their parents or guardians ceases at 18 irrespective of the adult's decision-making capacity.

7.16 The law on capacity generally favours a functional approach to capacity³⁷ and a presumption of capacity operates in law.³⁸ In the medical context, an adult is presumed to have the capacity to make a healthcare decision unless the contrary is established.³⁹ A person may

³⁵ See Charleton, McDermott and Bolger *Criminal Law* (Butterworths 1999) at paragraph 9.77 *ff*. Cases on the common law offence of battery (which was codified in the *Non-Fatal Offences Against the Person Act 1997*) suggest that it makes no difference if the touching is by hand (see, for example, *Latter v Braddell* (1881) L.J.Q.B. 166, 448) or with some instrument controlled by the doctor (see, for example, *S v McC*; *W v W* [1972] AC 24, 57).

³⁶ Under section 2(1) of the *Age of Majority Act 1985*.

³⁷ See paragraph 2.23 *ff* above.

³⁸ See paragraph 2.28 *ff* above.

³⁹ *Re MB (An Adult) (Medical Treatment)* [1997] 2 FCR 541.

temporarily lack capacity through unconsciousness,⁴⁰ the effect of hallucinations, shock, severe fatigue, phobia⁴¹ or some impairment or disturbance of mental functioning.⁴² These circumstances may result in the person being unable to comprehend and retain material information as to the likely consequences of having or not having the treatment, or being unable to use the information and weigh it in the balance in order to arrive at a decision.⁴³

(4) Right of Adult with Capacity to Refuse Treatment

7.17 Allied with the requirement of informed consent is the concomitant right of a person with capacity to make a decision on their medical treatment to decline recommended treatment.⁴⁴ This affords autonomous decision-making to persons judged to have the capacity to make the relevant decision on their healthcare. Denham J summarised the autonomy of a person with capacity in relation to healthcare decisions in *Re a Ward of Court (No.2)* as follows:

“The consent which is given by an adult of full capacity is a matter of choice. It is not necessarily a decision based on medical considerations. Thus medical treatment may be refused for other than medical reasons, or reasons most citizens would regard as rational, but the person of full age and capacity may make the decision for their own reasons.”⁴⁵

⁴⁰ *Re a Ward of Court (No.2)* [1996] 2 IR 76; *J.M. v St Vincent’s Hospital* [2003] 1 IR 321.

⁴¹ *Re MB (An Adult) (Medical Treatment)* [1997] 2 FCR 541.

⁴² See, for example, *Re C (Refusal of Medical Treatment)* [1994] 1 All ER 819; *Norfolk and Norwich Healthcare (NHS) Trust v W* [1996] 2 FLR 613; *Tameside and Glossop Acute Services Trust v CH* [1996] 1 FLR 762.

⁴³ Assessment of capacity is discussed at Part C below.

⁴⁴ See section 4 of the *Health Act 1953*; Irish Medical Council *A Guide to Ethical Conduct and Behaviour* (6th ed 2004) at paragraph 17.1; *Sidaway v Board of Governors of the Bethlem Royal Hospital and Maudsley Hospital* [1985] AC 871; *Re MB (Medical Treatment)* [1997] 2 FCR 541.

⁴⁵ *Re a Ward of Court (No.2)* [1996] 2 IR 79, 156.

C Assessment of Capacity to Make Healthcare Decisions

7.18 Two important principles can be derived from the case law in relation to the assessment of capacity to make healthcare decisions. The first serves to give weight to the gravity of the circumstances in assessing the level of capacity required. The second principle exerts a counterbalance by directing that an assessor should not be unduly swayed by the consequences of the healthcare decision, including the refusal to follow the advice of the medical practitioner, as opposed to focusing on the underlying functional capacity of the adult.

(1) Capacity is commensurate with the gravity of the decision

7.19 The courts have viewed the level of capacity required as being related to the gravity of the consequences of the healthcare decision. In *Re T (Adult: Refusal of Treatment)*, Butler-Sloss LJ stated:

“Doctors faced with a refusal of consent have to give very careful and detailed consideration to the patient’s capacity to decide at the time when the decision was made. It may be the more difficult case of a temporarily reduced capacity at the time when his decision was made. What matters is that the doctors should consider whether at that time he had a capacity which was commensurate with the gravity of the decision which he purported to make. The more serious the decision, the greater the capacity required. If the patient had the requisite capacity, they are bound by his decision.”⁴⁶

(2) Consequences of choice not determinative of capacity

7.20 The rise in importance of autonomy and self-determination is difficult to reconcile with the paternalism which has traditionally guided medical practitioners. In certain circumstances the ethical principles of autonomy and beneficence may conflict. While medical practitioners will have a natural interest in ensuring a person’s wellbeing from the point of view of best medical practice, case law in this area emphasises that a person should not be found to lack

⁴⁶ [1992] 4 All ER 649, 661. See also *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871, 904; *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] 1 AC 112, 169 and 186.

competence simply because they do not want to take their doctor's advice or because their choice appears objectively irrational.

7.21 In *Re C (Adult: Refusal of Medical Treatment)*⁴⁷ a person suffering from paranoid schizophrenia was found to have the capacity to refuse to consent to the amputation of his leg in circumstances where he might die if the gangrene were to spread. Although C's general capacity to make a decision had been impaired by schizophrenia, the English High Court held that the evidence failed to establish that he lacked sufficient understanding of the nature, purpose and effects of the proposed treatment, but instead showed that he had understood and retained the relevant treatment information, believed it and had arrived at a clear choice. It followed that the presumption of capacity had not been displaced and Thorpe J held that he was entitled to refuse to consent to the amputation.

7.22 A difference in values should not in itself lead to a finding of lack of capacity. In *Re B*⁴⁸ a tetraplegic patient was being kept alive by a ventilator and wished to have the ventilator turned off.⁴⁹ The court held that the woman had mental competence commensurate with the gravity of the decision she wished to make. Butler-Sloss P stated:

“If there are difficulties in deciding whether the patient has sufficient mental capacity, particularly if the refusal may have grave consequences for the patient, it is most important that those considering the issue should not confuse the question of mental capacity with the nature of the decision made by the patient, however grave the consequences. The view of the patient may reflect a difference in values rather than an absence of competence and the assessment of capacity should be approached firmly with this in mind. The doctors must not allow their emotional reaction to or strong disagreement with the decision of the patient to cloud their judgment in answering

⁴⁷ [1994] 1 All ER 819. See further paragraph 2.13 above.

⁴⁸ [2002] 2 All ER 449.

⁴⁹ In *Re a Ward of Court (No.2)* [1996] 2 IR 79,124 Hamilton CJ stated that the right to life under Article 40.3 of the Constitution “necessarily implies the right to have nature take its course and to die a natural death”.

the primary question whether the patient has the mental capacity to make the decision.”⁵⁰

7.23 However, in some situations, the reasoning behind a decision may be inherently flawed by irrationality so as to lead to the conclusion that the individual lacks the required capacity to make the decision. *NHS Trust v T*⁵¹ concerned a woman diagnosed with a borderline personality disorder who had completed an advance care directive refusing blood transfusions on the basis that her blood was “carrying evil”. It was held by the English High Court that, having regard to this irrational reason, she lacked the capacity to refuse a blood transfusion.

(3) *Guidelines on the Assessment of Capacity*

7.24 The area of assessment of capacity to make a healthcare decision is fraught with uncertainty. While medical practitioners have to make such assessments on a daily basis, there is little guidance or common understanding among medical practitioners concerning how capacity assessments should be approached.⁵² This reflects a lack of consensus in the medical profession globally on how capacity should be assessed.⁵³ There is no universally accepted methodology for assessing capacity to consent to medical treatment.⁵⁴

⁵⁰ [2002] 2 All ER 449, 474.

⁵¹ [2005] 1 All ER 387.

⁵² See further paragraph 3.26 above. Research indicates that if the decision-making task is broken down into manageable, simpler steps capacity may improve: see Wong *et al* “The capacity of people with a ‘mental disability’ to make a healthcare decision” (2000) 30 *Psychological Medicine* 295 at 302.

⁵³ See Wong *et al* “The capacity of people with a ‘mental disability’ to make a health care decision” (2000) 30 *Psychological Medicine* 295; Applebaum and Grisso “Assessing patients’ capacities to consent to treatment” (1988) 319 *New England Journal of Medicine* 1635; Arscott *et al* “Assessing the capacity of people with learning disabilities to make decisions about treatment” (1999) 29 *Psychological Medicine* 1367; Kapp and Mossman “Measuring Decisional Capacity: Cautions on the Construction of a ‘Capacimeter’ (1996) 2 *Psychology, Public Policy, and Law* 73.

⁵⁴ See Glass “Redefining definitions and devising instruments: two decades of assessing mental competence” (1997) 20 *International Journal of Law and Psychiatry* 5.

Tests such as the Mini-Mental State Examination (MMSE)⁵⁵ and the Wechsler Adult Intelligence Scale⁵⁶ are useful indicators or diagnostic tools but should not be regarded as determinative of capacity to make healthcare decisions.⁵⁷ Ideally an assessment of capacity requires an exercise of clinical judgement guided by professional guidelines and legal requirements.⁵⁸

7.25 The Medical Council's ethical guidelines for the medical profession⁵⁹ contain some guidance (albeit of a very general nature) on capacity issues.⁶⁰ The guidelines require an assessment of competence to be carried out by a medical practitioner "in conjunction with a senior colleague".⁶¹ The ethical guidelines do not, however, give guidance on the appropriate methodology for assessing competence.

7.26 In some jurisdictions detailed guidelines of a general nature assist healthcare professionals assessing capacity to make healthcare

⁵⁵ The MMSE is designed to assess orientation, attention, calculation and language. See Folstein "Mini-mental state: a practical method for the grading the cognitive state of patients for clinician" (1975) Vol.12 *Journal of Psychiatric Research* 189.

⁵⁶ Wechsler *Wechsler Adult Intelligence Scale* (3rd ed London The Psychological Corporation).

⁵⁷ See Murphy and Clare "Adults' Capacity to Make Legal Decisions" in (eds Carson and Bell) *Handbook of Psychology in Legal Contexts* (2nd ed Wiley & Sons 2003) at 35.

⁵⁸ See generally British Medical Association and the Law Society *Assessment of Mental Capacity: Guidance for Doctors and Lawyers* (2nd ed 2004).

⁵⁹ Irish Medical Council *A Guide to Ethical Conduct and Behaviour* (6th ed 2004).

⁶⁰ Some hospitals have adopted their own detailed guidelines on consent issues. For example, the Adelaide and Meath Hospital incorporating the National Children's Hospital has its own *Guidelines in Relation to Obtaining Consent* (2005) which are periodically revised.

⁶¹ Irish Medical Council *A Guide to Ethical Conduct and Behaviour* *op cit* fn 59 at paragraph 17.1. In *Re B (Adult: Refusal of Medical Treatment)* [2002] 2 All ER 449 Butler-Sloss P stated that where there is a disagreement about capacity "it is of the utmost importance that the patient is fully informed of the steps being taken [to resolve the issue] and made a part of the process." (at paragraph 100).

decisions. The British Medical Association has published a “Consent Tool Kit” to assist healthcare professionals in dealing with consent issues.⁶² The Tool Kit lists factors to be taken into account in assessing competence to consent to treatment:

“To demonstrate capacity individuals should be able to:

- Understand in simple language what the medical treatment is, its purpose and nature and why it is being proposed;
- Understand its principal benefits, risks and alternatives;
- Understand in broad terms what will be the consequences of not receiving the proposed treatment;
- Retain the information for long enough to use it and weigh it in the balance in order to arrive at a decision.”

Furthermore, the Tool Kit states that the patient should be able to make a choice which is freely made.

7.27 Section 13 of Scotland’s *Adults with Incapacity (Scotland) Act 2000* requires the Scottish Executive to have a code of practice on medical treatment approved and provides for its review from time to time. The resulting Code of Practice is of assistance to medical practitioners seeking to assess capacity.⁶³ Although compliance with the Code of Practice is not legally binding, it would constitute evidence of best practice and can be referred to in evidence in an action for negligence.⁶⁴ Under the Code of Practice, medical practitioners assess an adult’s capacity to make a healthcare decision on the basis of consideration of a range of factors including whether the person:

- Is capable of making and communicating their choice;

⁶² British Medical Association *Consent Tool Kit* (2nd ed 2003) available at <http://www.bma.org.uk/ap.nsf/Content2/consenttk2>.

⁶³ *Adults with Incapacity (Scotland) Act 2000 Code of Practice for Persons Authorised to Carry Out Medical Treatment or Research under Part 5 of the Act* SE/2002/73 (2002) and Supplement SE/2002/111 (2002).

⁶⁴ Section 47 of the *Adults with Incapacity (Scotland) Act 2000*.

- Understands the nature of what is being asked and why;
- Has memory abilities that allow the retention of information;
- Is aware of alternatives;
- Has knowledge of the risks and benefits involved;
- Is aware that such information is of personal relevance to them;
- Is aware of the right to, and how to, refuse, as well as the consequences of refusal;
- Has ever expressed their wishes relevant to the issue where greater capacity existed;
- Is expressing views consistent with their previously preferred moral, cultural, family and experiential background.⁶⁵

The Code also emphasises the importance of ensuring that there are no barriers to consent such as undue suggestibility and sensory difficulties.⁶⁶

7.28 The Commission notes the practical utility of such guidelines on assessing capacity. The formulation of similar guidelines in this jurisdiction in the form of a statutorily backed code of practice is considered later in this chapter.⁶⁷

D Making Healthcare Decisions where an Adult Lacks Capacity

7.29 When an assessment is made that an adult lacks capacity to make a healthcare decision, this does not have the effect of removing

⁶⁵ *Adults with Incapacity (Scotland) Act 2000 Code of Practice for Persons Authorised to Carry Out Medical Treatment or Research under Part 5 of the Act SE/2002/73* (2002) at paragraph 1.6.

⁶⁶ *Ibid.*

⁶⁷ See paragraph 7.85 *ff* below.

a requirement for a legally effective consent. Non-emergency medical treatment given without consent gives rise to potential civil and criminal liability as well as potentially breaching constitutional and human rights.⁶⁸ Therefore where there is a suggestion that an adult may not have the capacity to make a healthcare decision, difficulties arise for medical professionals from a risk-management perspective. McMahon and Binchy aptly comment that:

“[p]rinciples of bodily integrity and autonomy should be given due weight; paternalism, outside the context of judicial exercise of its *parens patriae* jurisdiction, should not be let to run rampant, merely because the object of the benevolent intervention lacks the capacity to refuse it.”⁶⁹

7.30 This Consultation Paper focuses on issues concerning the legal definition of capacity. Nevertheless in the context of medical treatment it is appropriate to give some consideration to what will occur if an adult is considered not to have the capacity to consent to medical treatment as this will inform any understanding of capacity to make healthcare decisions. As outlined in Chapter 3,⁷⁰ it is the Commission’s intention that the formulation of an appropriate assisted and substitute decision-making regime for adults who lack capacity will be revisited in the final report in this area.

7.31 This Part focuses on the widespread practice of next of kin signing consent forms on behalf of adults who may lack capacity and considers the application of the common law doctrine of necessity in the sphere of healthcare. The Commission also examines the current role of the wardship and enduring powers of attorney regimes in the context of healthcare. The law governing clinical trials and research on adults who lack capacity and the subject of advance care decisions are considered in brief. It is against this backdrop that the capacity of adults to make healthcare decisions is assessed in practice.

⁶⁸ See paragraph 7.08 *ff* above.

⁶⁹ McMahon and Binchy *Law of Torts* (Butterworths 3rd ed 2000) at paragraph 22.73.

⁷⁰ See paragraph 3.13 *ff*.

(1) Next of Kin and Consent Forms

7.32 In law once a person has reached the age of majority their parents or guardians cannot legally consent to or refuse medical treatment on their behalf.⁷¹ Nevertheless where an adult does not have the capacity to make a decision to consent to or refuse treatment, it is common medical practice in Ireland to require their next of kin to sign a consent form in relation to the treatment.⁷² This practice gives rise to difficulties of both a practical and a legal nature.

7.33 Relying on a signature from a next of kin can give rise to issues on which there is no clear guidance:

- there may be no traceable near relative;⁷³
- there may be other persons with an interest in the person's welfare who do not come within the definition of next of kin;⁷⁴
- Medical practitioners may be unsure how to proceed where there is a disagreement between close relatives as to whether to consent to the proposed medical treatment.

7.34 Aside from these practical limitations, the practice of relying on a signature on a consent form from a next of kin involves a considerable but entrenched divergence between the letter of the law and healthcare practice.

⁷¹ See Madden *Medicine, Ethics and Law* (Butterworths 2002) at paragraph 9.18; page 12 above.

⁷² See Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at paragraph 6.63.

⁷³ The Commission understands that where a patient who lacks capacity lives in a residential care facility, there is a practice whereby the director of the facility may purport to 'give consent' on their behalf where no next of kin is available for this purpose.

⁷⁴ The Commission's *Consultation Paper on the Rights and Duties of Cohabitees* (LRC CP 32-2004) recommended that consideration should be given to including cohabitees within the definition of persons with whom a doctor treating a patient should confer if the patient is unable to communicate or to understand (at paragraph 9.06).

Skeggs has commented that:

“The better view is that there is no general doctrine whereby a spouse or near relative is empowered to give a legally effective consent to medical procedures to be carried out on an adult.”⁷⁵

7.35 In *Re A Ward of Court (No.2)*⁷⁶ the Supreme Court held that in the case of a Ward of Court it is for the court to make decisions on their medical treatment. However, the Court did not make any pronouncement in relation to the position of other adults who lack capacity but have not been made a Ward of Court. In the *Consultation Paper on Law and the Elderly*⁷⁷ the Commission stated that:

“the law on consent to medical treatment may need to be addressed because of the widespread false belief that family members and carers may make valid decisions on behalf of people who do not have legal capacity.”⁷⁸

7.36 The Medical Council’s Ethical Guidelines state that if a person with a disability lacks the capacity to give consent:

“a wide-ranging consultation involving parents/guardians and appropriate carers should occur. Where necessary, a second opinion should be considered before decisions on complex issues are made.”⁷⁹

The President of the Medical Council has acknowledged that problems exist for doctors and patients arising out of the lack of

⁷⁵ Skegg *Law, Ethics and Medicine* (Clarendon Press Oxford 1984) at 73. See also Madden *Medicine, Ethics and the Law* (Butterworths 2002) at paragraph 9.18.

⁷⁶ [1996] 2 IR 79.

⁷⁷ Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003).

⁷⁸ *Ibid* at paragraph 1.23.

⁷⁹ Irish Medical Council *A Guide to Ethical Conduct and Behaviour* (6th ed 2004) at paragraph 2.2.

proper legal structures supporting the care of vulnerable patients such as people with disabilities and the elderly:

“No adult can give consent for another adult unless the person is made a ward of court. Most of the people in the country who are vulnerable are not wards of court, and so are treated by doctors on an understanding that they consult widely, as in our ethical guidelines, but that does not give legal backing.”⁸⁰

7.37 *Daniels v Heskin*⁸¹ is authority for the proposition that a medical practitioner cannot be held to be negligent if he follows general and approved practice in the situation with which he is faced. However, in *O'Donovan v Cork County Council*⁸² Walsh J stated that this is subject to the qualification that while conforming with a widely accepted professional practice will normally rebut an allegation of negligence, this will not be the case where the common practice has inherent defects which should be obvious to any person giving the matter due consideration.⁸³ Therefore if the matter of whether the consent of next of kin was legally effective arose for consideration in the courts in a professional negligence case, it would not be a complete answer for a medical practitioner to give evidence of the widely established nature of the practice of next of kin signing consent forms in these circumstances.

(2) *The Doctrine of Necessity*

7.38 In some instances medical practitioners rely on what is known as ‘the doctrine of necessity’ in order to justify treatment of a person who lacks the required decision-making capacity to give informed consent. The common law doctrine of necessity which has been applied in relation to medical treatment has its origins in the law of

⁸⁰ Comments of Mr John Hillery, President of the Medical Council, reported in Ganly, “Changes sought on ‘vulnerable’ patients” *Irish Medical Times* Vol. 39 No.15, 15 April 2005 at 6.

⁸¹ [1954] IR 73. See also *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118.

⁸² [1967] IR 173.

⁸³ See also *Roche v Peilow* [1985] IR 232; *Dunne v National Maternity Hospital* [1989] IR 91; Madden *Medicine, Ethics and the Law* (Butterworths 2002) at paragraph 9.18.

agency's recognition of an agent of necessity.⁸⁴ Essentially this doctrine provides a legal justification for treating a person who does not have the capacity to consent where there is what is termed a 'necessity to act'.⁸⁵ Legally, the principle of necessity does not operate to provide an equivalent to having consent. Rather it would appear to operate as a defence if an action is subsequently challenged.⁸⁶ The law is not settled in Ireland in relation to the ambit of the doctrine of necessity, in particular the circumstances which will create the requisite 'necessity to act', and what such necessity to act entails.

7.39 The doctrine was recognised in Ireland in a medical context in the High Court decision of *Holmes v Heatley*.⁸⁷ In this case the parents of a minor had consented to an operation with a local anaesthetic. During the operation, the boy, who was of a nervous disposition, became restless and hysterical and had to be held down. In order to be able to stitch up the wound a general anaesthetic was administered. The patient died on the operating table. A claim for damages was brought by the parents on the basis that the administration of the general anaesthetic without consent constituted assault and battery. The High Court held that treatment which is necessary in an emergency situation is lawful and the doctor has a defence to a charge of battery.⁸⁸ Maguire J. stated that the surgeon was "bound to act as he did in the emergency with which he was faced."⁸⁹

⁸⁴ See *Re F (Mental Patient: Sterilisation)* [1989] 2 All ER 545, 564-565 per Lord Goff.

⁸⁵ See Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at paragraph 6.62.

⁸⁶ Skeggs *Law, Ethics and Medicine* (Clarendon Press Oxford 1984) at 73; House of Lords and House of Commons *Joint Committee on the Draft Mental Incapacity Bill* (2003) HL Paper 189-1; HC 1083-1 (The Stationery Office Limited) at paragraph 106. See also Law Commission of England and Wales *Mental Capacity* (Law Com No 231), Chapter 4.

⁸⁷ (1937) 3 Ir Jur Reports 74.

⁸⁸ See now sections 2 – 4 of the *Non-Fatal Offences Against the Person Act 1997*; paragraph 7.14 above.

⁸⁹ (1937) 3 Ir Jur Reports 74, 76.

7.40 The leading English case on the doctrine of necessity is the decision of the House of Lords in *Re F (Mental Patient: Sterilisation)*.⁹⁰ This case concerning the proposed sterilisation of a young woman⁹¹ was the first authoritative statement by the English courts or legislature (other than in the area of mental disorder) recognising the legality of treatment of an adult who is unconscious or otherwise incompetent to consent to medical treatment. Lord Goff explored the common law principle of necessity and found that it contained two limbs:

- (i) there must be a necessity to act when it is not practicable to communicate with the assisted person; and
- (ii) the action must be what a reasonable person would do in the circumstances acting in the best interests of the assisted person.

(a) *Necessity to Act*

7.41 Although it is often assumed that the doctrine only applies to emergency situations, it was expressed in broader terms in *Re F* where Lord Goff stated that “[t]he principle is one of necessity, not of emergency.”⁹² Therefore it was clearly contemplated that the activating principle is necessity in the broad sense rather than medical emergency.⁹³ Lord Goff in *Re F* suggested that the doctrine of necessity extends to routine treatment of persons lacking capacity and that in such cases doctors should:

- act on the basis of good professional practice;⁹⁴

⁹⁰ [1989] 2 All ER 545.

⁹¹ On the subject of non-consensual sterilisation, see further paragraph 6.52 *ff* above.

⁹² [1989] 2 All ER 545, 565.

⁹³ See also *Re A (Children)* [2001] FLR 1; *R v Bournewood Community and Mental Health Trust ex parte L* [1998] 3 All ER 289.

⁹⁴ This corresponds to the requirement in *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 to act in accordance with a responsible body of medical opinion. In relation to experimental treatment see *Simms v Simms; A v A* [2003] 2 WLR 1465.

- consult with relatives and others interested in the care of the individual; and
- act subject to the overriding requirement of acting in the person's best interests.

On this view, the doctrine may extend to elective surgery which is not strictly 'necessary'.

7.42 The necessity principle is recognised in Article 8 of the Council of Europe *Convention on Human Rights and Biomedicine*⁹⁵ which states:

“When because of an emergency situation the appropriate consent cannot be obtained, any medically necessary intervention may be carried out immediately for the benefit of the individual involved.”

7.43 In *Re a Ward of Court (No.2)*,⁹⁶ a case concerning medical treatment of a woman who had been made a Ward of Court, Denham J stated *obiter* that the exceptions to the requirement of consent to medical treatment by adults with capacity are rare e.g. the treatment of contagious diseases and in a medical emergency where the patient is unable to communicate.⁹⁷ In *JM v St Vincent's Hospital*⁹⁸ Finnegan P used the *parens patriae* prerogative to admit an unconscious woman who temporarily lacked capacity to wardship before making a decision on what medical treatment she should receive. However, the Irish courts have not had the opportunity to set clear boundaries to the scope of the doctrine of necessity and its application to medical treatment of adults who lack capacity to consent but have not been made a Ward of Court.

⁹⁵ *Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine* Oviedo, 4. IV.1997. Ireland is not yet a party to the Convention. See further paragraph 7.12 below.

⁹⁶ [1996] 2 IR 79.

⁹⁷ Denham J's dictum in this regard was cited by Hardiman J in *North Western Health Board v HW* [2001] 3 IR 622, 750-751.

⁹⁸ [2003]1 IR 321. See paragraph 7.57 below.

7.44 The Medical Council's ethical guidelines provide that:

“in an emergency where consent cannot be obtained e.g. an unconscious patient or a child not accompanied by a parent or guardian, a doctor may provide treatment that is necessary to safeguard the patient's life or health.”⁹⁹

This does not provide guidance on the provision of routine medical treatment to adults who lack the capacity to consent.

The *Charter of Rights for Hospital Patients* (1992) applies in all publicly funded hospitals. Its provisions state:

“Only in cases where a patient lacks the capacity to give or withhold consent, and where a qualified medical doctor determines that treatment is urgently necessary to prevent immediate or imminent harm, may treatment be given without informed consent.”

7.45 The Commission understands that the practical result of the lack of clarity as to the ambit of the doctrine of necessity in Ireland is twofold. Some medical professionals may err on the side of caution by carrying out medical treatment on a person who lacks capacity to consent only in situations where the necessity is of the highest order - in a life and death situation. Other practitioners may rely on the doctrine of necessity for all medical treatment of an adult who lacks the capacity to consent.

(b) *Best Interests*

7.46 Once a necessity to act has been determined, the doctrine of necessity requires that any action taken must be in the person's best interests. It is the best interests of the adult who lacks capacity which are relevant not the interests of other parties.¹⁰⁰ In relation to the

⁹⁹ Irish Medical Council *A Guide to Ethical Conduct and Behaviour* (6th ed 2004) at paragraph 18.4.

¹⁰⁰ The European Court of Human Rights' decision in *Glass v The United Kingdom* (2004) 38 EHRR 15, concerning a minor, suggests that in a life and death situation where the best course of action is not clear or there is a conflict between relatives and doctors, an emergency court application should be made seeking directions.

requirement to consult relatives, convenience to carers should not form the justification for a decision to treat.¹⁰¹ In *Re Y (Mental Capacity: Bone Marrow Transplant)*¹⁰² it was held that the fact that the donation of bone marrow by a woman who lacked capacity to consent to her sister would save her sister's life was not relevant if the donation would not serve the best interests of the donor. In *Re A (Male Sterilisation)* Butler-Sloss P stated that best interests encompasses "medical, emotional and all other welfare issues."¹⁰³ Thorpe LJ suggested a balance sheet approach to carrying out an evaluation of best interests whereby likely benefits would be listed on one side and counterbalancing disbenefits on the other along with an estimation of the possibility of that gain or loss accruing.¹⁰⁴

7.47 Lord Goff in *Re F (Mental Patient: Sterilisation)*¹⁰⁵ ruled out "officious intervention" as coming within the scope of the principle of necessity. Therefore intervention would not be justified when it is "contrary to the known wishes of the assisted person, to the extent that he is capable of forming such wish."¹⁰⁶

7.48 In *Re F (Mental Patient: Sterilisation)*¹⁰⁷ Lord Goff drew a distinction between a situation where a person is temporarily unable to consent, such as where the person has been temporarily rendered unconscious in an accident, and a situation where the lack of capacity is permanent or semi-permanent. In the first situation where the loss of capacity is likely to be temporary, Lord Goff stated that medical practitioners should do no more than is required in the best interests

¹⁰¹ *Re F (Mental Patient: Sterilisation)* [1989] 2 All ER 545, 571, per Lord Jauncey.

¹⁰² [1997] 2 FCR 172.

¹⁰³ [2000] 1 FLR 549. See also *Re SL (Adult Patient: Sterilisation)* [2000] 3 WLR 1288.

¹⁰⁴ "Obviously, only if the account is in relatively significant credit will the judge conclude that the application is likely to advance the best interests of the claimant." *Re A (Male Sterilisation)* [2001] 1 FLR 549, 560 per Thorpe LJ. This approach was approved by Munby J in *R (Burke) v General Medical Council* [2004] EWHC 1879.

¹⁰⁵ [1989] 2 All ER 545.

¹⁰⁶ [1989] 2 All ER 545, 566.

¹⁰⁷ [1989] 2 All ER 545.

of the patient before they recover consciousness and can then be consulted. The British Medical Association and Law Society state:

“Not only is a doctor able to give treatment to an incapacitated patient when it is clearly in that person’s best interests, it is a common law duty to do so. Nevertheless, this still only applies to treatment carried out to ensure improvement or prevent deterioration in health or the steps required to prepare for recovery to become an option.”¹⁰⁸

In *Re a Ward of Court (No.2)* Denham J stated:

“Whilst an unconscious patient in an emergency should receive all reasonable treatment pending a determination of their best interests, invasive therapy should not be continued in a casual or ill-considered way.”¹⁰⁹

7.49 The requirement that action taken be in the person’s best interests was endorsed by the Supreme Court in the context of a Ward of Court in *Re a Ward of Court (No.2)*.¹¹⁰ In the High Court, Lynch J referred to “deciding what is the balance or proportionality of the benefits to the burdens” having regard to all the circumstances. The standpoint of the Court in deciding on best interests would be that of “a prudent, good and loving parent.”¹¹¹ He also referred to taking into account what would be likely to be the individual’s wishes. This approach was upheld by the Supreme Court on appeal. The constitutional rights of the individual would also need to be taken into consideration. Relevant constitutional rights include the right to life, the right to bodily integrity and the right to privacy including the right to self-determination.¹¹²

¹⁰⁸ British Medical Association and The Law Society *Assessment of Mental Capacity: Guidance for Doctors and Lawyers* (2nd ed 2004) at 123. This would appear not to take account of the distinctions drawn by Lord Goff in *Re F (Mental Patient: Sterilisation)* [1989] 2 All ER 545 between a temporary lack of capacity and an ongoing lack of capacity.

¹⁰⁹ [1996] 2 IR 79, 158.

¹¹⁰ [1996] 2 IR 79.

¹¹¹ [1996] 2 IR 79, 99.

¹¹² See *Re a Ward of Court (No.2)* [1996] 2 IR 79, 97. See further paragraph 7.54 ff below.

(c) *Consultation Paper on Law and the Elderly*

7.50 In the *Consultation Paper on Law and the Elderly*,¹¹³ the Commission recommended that “the proposed new legislation should state, for the avoidance of doubt, that medical professionals are entitled to perform emergency medical procedures in the case of any adult without capacity to consent if [the proposed personal guardian] is not available to give consent where it is medically necessary and in the best interests of the person.¹¹⁴ The Commission suggested that the concept of emergency healthcare decisions could be the subject of an agreement between the Medical Council and the proposed Office of the Public Guardian.¹¹⁵

7.51 The Commission has given further consideration to this issue since the publication of the *Consultation Paper on Law and the Elderly* and its recommendations in this area are set out below.¹¹⁶

(3) *Wards of Court*

7.52 Where an adult has been made a Ward of Court,¹¹⁷ the President of the High Court has authority to make decisions on consent to medical treatment for that person. After obtaining medical advice, medical treatment matters should be referred by the Committee of the Person or by the clinical director of the relevant hospital to the Registrar of Wards of Court.¹¹⁸ In practice, the

¹¹³ Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003).

¹¹⁴ *Ibid* at paragraph 6.63.

¹¹⁵ *Ibid* at paragraph 6.64.

¹¹⁶ See paragraph 7.85 *ff* below.

¹¹⁷ See generally paragraph 4.02 *ff* above; O’Neill *Wards of Court in Ireland* (First Law 2004); Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003).

¹¹⁸ A form for medical practitioners to complete in relation to proposed treatment is available from the Registrar of Wards of Court. The form seeks information on the nature of the proposed procedure, the reasons for it, the risks involved, whether the procedure has been explained to the patient, whether the patient is capable of understanding the procedure and whether the patient has objected to the procedure being carried out. Confirmation is also required that the patient’s next of kin have been informed.

Registrar has delegated authority from the President of the High Court to consent to the carrying out of routine and non-controversial procedures in consultation with the person's next of kin.¹¹⁹

7.53 Where procedures are considered to be non-routine or there is a higher element of risk involved the consent of the President of the High Court must be obtained in relation the carrying out of a medical procedure including the administration of a general anaesthetic. The consent of the President of the High Court must also be obtained in respect of procedures "to which the ward, if capable of indicating consent, did not consent, or where the ward was incapable of consent, to which the ward's next of kin consent."¹²⁰

7.54 When a court makes a healthcare decision in respect of a person who has been made a Ward of Court, they will do so in the best interest of the Ward. This is clear from the leading case in this area, *Re a Ward of Court (No.2)*¹²¹ In this case a woman was in a near persistent vegetative state (PVS) since a minor gynaecological operation in 1972 under general anaesthetic. In 1974 she was made a Ward of Court. She was being fed by a gastronomy tube. The mother who was the Committee of the Ward sought directions from the High Court as to the proper care and treatment of the Ward, in particular as to the lawfulness of the withdrawal of artificial nutrition and hydration. It was argued that by virtue of Article 41.1 of the Constitution, the family had the right to make the decision to withdraw treatment.

7.55 Lynch J held that where there is a dispute between medical staff and family as to the withdrawal of life support, the dispute should be referred to the Court which would decide the matter on a best interests test "from the standpoint of a prudent, good and loving parent"¹²² having regard to the view of the family. He went on to hold that it was in the best interests of the woman that artificial

¹¹⁹ See O'Neill *Wards of Court in Ireland* (First Law 2004) at paragraph 3.8.

¹²⁰ O'Neill *Wards of Court in Ireland* (First Law 2004) at paragraph 3.8. This shows a bifurcation between the incapacity in law of a person who has been made a Ward of Court to consent to medical treatment, and their functional ability to make such a decision in practice.

¹²¹ [1996] 2 IR 79.

¹²² [1996] 2 IR 79, 99.

nourishment should be terminated, allowing her to die a natural death. The Attorney General, the institution in which the woman resided and her guardian *ad litem* appealed the decision to the Supreme Court.

7.56 The Supreme Court held that it is for the court to make a decision on behalf of the Ward, with the prime and paramount consideration being the best interests of the Ward, taking into account the view of the Committee and family.¹²³ The decision to withdraw artificial nourishment was upheld by the majority of the Supreme Court as in the best interests of the woman.

7.57 In some cases a person who lacks capacity in relation to a medical decision will be admitted to wardship so that a legal consent may be obtained in respect of treatment. *JM v St Vincent's Hospital*¹²⁴ is such a case. The case concerned a woman who had converted to her husband's religion as a Jehovah's Witness on marriage. She initially refused to take blood, then vacillated between consenting and refusing before going into a coma. She had a 60% chance of survival with medical treatment including a liver transplant and blood transfusion. Finnegan P used his *parens patriae* jurisdiction to admit the woman to wardship. He then directed that the hospital provide the required medical treatment. Finnegan P stated that "because of her cultural background and her desire to please her husband and not offend his sensibilities [she] elected to refuse treatment". Finnegan P appeared to adopt a form of substituted judgment test in stating that he did not regard her decision as having been finally made and that:

"I am strongly of the opinion that if [she] was now lucid and strong and aware of her husband's present decision, she would agree with a decision to have the treatment as she would have a desire to live, as has been seen. She would

¹²³ Denham J listed factors which should be taken into account by the Court in arriving at a decision including the person's constitutional right to life, privacy, bodily integrity, autonomy, dignity in life and dignity in death [1996] 2 IR 79, 167.

¹²⁴ [2003] 1 IR 321.

also be comforted by her husband's attitude to the decision."¹²⁵

7.58 Wardship is a cumbersome, time-consuming and costly procedure which is ill-suited to speedy decisions on medical treatment. The Commission recommended in the *Consultation Paper on Law and the Elderly* the establishment of an alternative substitute decision-making which would replace wardship whereby a personal guardian could be appointed to make decisions on behalf of an adult without capacity to make the relevant decisions.¹²⁶ The Commission recommended that personal guardians would be entitled to take minor or emergency healthcare decisions on behalf of a person without the capacity to do so.¹²⁷

(4) Enduring Powers of Attorney

7.59 A person with the requisite capacity may execute an enduring power of attorney ("EPA") giving another person the power to act on their behalf in the event that they lose mental capacity.¹²⁸ The decisions which may be made may relate to the person's property or affairs and/or "personal care" decisions. However, personal care decisions do not include decisions on medical treatment or surgery.¹²⁹ In the *Consultation Paper on Law and the Elderly*,¹³⁰ the Commission provisionally recommended that it should be permissible for attorneys under EPAs to be given power to make healthcare decisions.¹³¹ Clearly, extending the remit of enduring powers of attorney to include healthcare decisions would be desirable.¹³² This would allow a person

¹²⁵ [2001] 1 IR 321, 325. O'Neill notes that Finnegan P did not directly address the issue of mental capacity: O'Neill *Wards of Court in Ireland* (First Law 2004) at 118.

¹²⁶ Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at Chapter 6.

¹²⁷ *Ibid* at paragraph 3.14.

¹²⁸ See generally Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at Chapter 3; paragraph 4.37 *ff* above.

¹²⁹ *Ibid* at paragraphs 3.13 – 3.15.

¹³⁰ (LRC CP 23-2003).

¹³¹ *Ibid* at paragraph 3.15.

¹³² See paragraph 7.59 above; paragraph 7.67 *ff* below.

with capacity to plan ahead to entrust another person with decision-making powers in relation to healthcare matters should the donor lose capacity in the future. This would have the advantage of allowing an adult with capacity to choose the person who will make these decisions in the event that they lose capacity at a later date.

7.60 Extending enduring powers of attorney to cover certain healthcare decisions would not provide a solution for adults who have either (a) never possessed the capacity to execute an enduring power of attorney, or (b) did not execute an enduring power of attorney while they had the requisite capacity to do so and no longer possess the capacity. These difficulties would be addressed by the establishment of an assisted and substitute decision-making regime of the type recommended by the Commission in the *Consultation Paper on Law and the Elderly*.¹³³

(5) Clinical Trials and Research

7.61 Applications for authorisations of clinical trials in Ireland are made to the Irish Medicines Board. The *European Communities (Clinical Trials on Medicinal Products for Human Use) Regulations 2004*¹³⁴ (“the Clinical Trials Regulations”) which implemented the *Clinical Trials Directive*¹³⁵ govern clinical trials of medicinal substances.¹³⁶ Part 5 of Schedule 1 of the *Clinical Trials Regulations* lays down particular requirements in relation to the participation in clinical trials of persons over 16 who lack capacity to consent. Participation of a person who lacks capacity to give informed consent is only permitted where the trial cannot be conducted without the

¹³³ (LRC CP 23-2003).

¹³⁴ S.I. No. 190 of 2004.

¹³⁵ Council Directive 2001/20/EC on the approximation of the laws, regulations and administrative provisions of the Member States relating to the implementation of good clinical practice in the conduct of clinical trials on medicinal products for human use OJ L 121, 1.5.2001 at 34. See McHale “Health Law in Europe. A Matter of Convergence” (2003) 9 MLJI 17.

¹³⁶ The Clinical Trial Regulations supersede the regime in the *Control of Clinical Trials Acts 1987 and 1990*. Non-medicinal substances remain subject to the provisions of the *Control of Clinical Trials Acts 1987 and 1990*.

participation of persons who do not have the capacity to give informed consent. Furthermore, these adults may only be included in clinical trials where it is anticipated that the direct benefit to them will outweigh the risks.

7.62 A “legal representative” (a suitable person with a family relationship with the adult, or in default, a nominated solicitor) must give their informed consent to the adult’s participation. The adult must be given information regarding the trial according to their capacity of understanding. The parties who are entitled to make a decision regarding the participation of an adult who lacks capacity in a clinical trial may require to be amended in the context of the enactment of legislation providing for the appointment of personal guardians as recommended by the *Consultation Paper on Law and the Elderly*.¹³⁷ Subject to this comment, the Commission considers that the *European Communities (Clinical Trials on Medicinal Products for Human Use) Regulations 2004* implement best practice in this area and contain adequate safeguards to protect the interests of adults who lack capacity.

(6) *Advance Care Directives*

7.63 An advance care directive (or ‘living will’) involves advance stipulation by an individual with capacity of the type of treatment they would not wish to receive if they were to become incapable. The validity of advance care directives has been recognised by the English courts so that where a person had the capacity to make an advance care directive at the time it was made, it remains binding and effective notwithstanding their subsequent enduring loss of capacity.¹³⁸ The English *Mental Capacity Act 2005* gives statutory recognition in England and Wales to advance decisions to refuse treatment.¹³⁹

¹³⁷ Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at Chapter 6.

¹³⁸ See *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 115-116; *Re C (Adult: Refusal of Treatment)* [1994] 1 WLR 290; *Re AK (Medical Treatment: Consent)* [2001] 1 FLR 129; *HE v A Hospital NHS Trust* [2003] 2 FLR 408; *R (Burke) v General Medical Council* [2004] EWHC 1879.

¹³⁹ See sections 24 to 26 of the *Mental Capacity Act 2005*.

7.64 There has been no legislation or case law in Ireland specifically addressing the efficacy of advance care directives.¹⁴⁰ In the *Consultation Paper on Law and the Elderly*¹⁴¹ the Commission recognised that advance refusals of treatment raise important and contentious moral, ethical and legal questions.¹⁴² Doctors may regard the effect of an advance directive as contrary to their clinical judgment. Medical science may advance considerably in the period between the making of the advance directive and the medical situation provided for arising in practice. More fundamentally, advance care directives throw up the difficult issue of whether treatment should be withheld which is needed in order to prevent death. The complex moral, ethical and legal aspects of advance care directives require detailed consideration which is beyond the scope of this Consultation Paper. The Commission therefore confines itself at this juncture to noting that the subject may merit further consideration in the context of the establishment of a coherent legal framework for capacity and substitute decision-making.

E Reforms in the United Kingdom

(1) *Developments in England and Wales*

(a) *Practice Note concerning Medical Decisions for Adults who Lack Capacity*

7.65 In England and Wales, an Official Solicitor Practice Note was published in 2001 which summarised the common law in relation to medical and welfare decisions for adults lacking capacity.¹⁴³ The Practice Note highlighted that the High Court has jurisdiction to make declarations in relation to the best interests of an adult who lacks decision-making capacity in relation to healthcare decisions where

¹⁴⁰ See Tomkin and Hanafin “Medical Treatment at Life’s End: The Need for Legislation” (1995) MLJI 3.

¹⁴¹ Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at paragraphs 3.48 - 3.51.

¹⁴² See Irons “Living wills – the dilemma” [2004] NLJ 966.

¹⁴³ *Practice Note* [2001] 2 FCR 569. This superseded earlier Practice Notes.

there is a serious justiciable issue requiring a court decision.¹⁴⁴ The court will make a decision on the proposed procedure based on the best interests of the patient.¹⁴⁵ In this regard the emotional, psychological and social benefit to the patient is taken into account.¹⁴⁶ Where an application is made to court for a declaration, the hospital must present evidence¹⁴⁷ concerning the adult's capacity and best interests and evidence to the effect that performing the particular procedure would not be negligent. Particular guidance is given with respect to sterilisation cases¹⁴⁸ and cases where a person is classed as being in a 'permanent vegetative state'.

(b) *The Mental Capacity Act 2005*

7.66 The *Mental Capacity Act 2005* sets out new statutory rules on capacity.¹⁴⁹ It deals with substitute healthcare decision-making and advance decisions to refuse treatment.

(I) *Delegating Healthcare Decisions to Donee of Lasting Power of Attorney*

7.67 Section 9 of the *Mental Capacity Act 2005* makes provision for a lasting power of attorney ("LPA") which will be similar to the enduring power of attorney ("EPA") under Irish law.¹⁵⁰ However, in contrast to EPAs, it is envisaged that LPAs may be used to give the donee the right to make welfare decisions in relation to the donor's

¹⁴⁴ This jurisdiction was established in *Re F (Mental Patient: Sterilisation)* [1989] 2 All ER 545. Such declarations can be interim or final: see *NHS Trust v T* [2005] 1 All ER 387.

¹⁴⁵ See *Re SL (Adult Patient) (Medical Treatment)* [2000] 2 FCR 452. Specific Guidance is given in the Practice Note in relation to sterilisation and permanent vegetative state cases.

¹⁴⁶ *Re Y (Mental Incapacity: Bone Marrow Transplant)* [1997] 2 FCR 172; *Re A (Medical Treatment: Male Sterilisation)* [2000] 1 FCR 193; *A v A Health Authority* [2002] 1 FCR 481.

¹⁴⁷ Evidence is generally required from a psychiatrist or psychologist who has assessed the patient and applied the test in *Re MB (An Adult) (Medical Treatment)* [1997] 2 FCR 541.

¹⁴⁸ See paragraph 6.56 *ff* above.

¹⁴⁹ See further paragraph 3.04 above.

¹⁵⁰ See Chapter 4 above.

healthcare including medical, optical and dental treatment.¹⁵¹ An LPA which gives welfare powers to the attorney includes the power to make decisions on the carrying out or continuation of treatment.¹⁵² However, if the attorney's decision-making powers are to extend to decisions on life-sustaining treatment, this must be expressly set out in the LPA.¹⁵³ The attorney's powers are subject to the 2005 Act's provisions on advance decisions to refuse treatment.¹⁵⁴

7.68 An attorney with welfare powers relating to healthcare decisions must act in accordance with the general principles of best interest set out in Part 1 of the *Mental Capacity Act 2005* which include requirements to recognise and maximise the person's capacity and to allow their participation in decisions.

(II) *Appointment of Deputies*

7.69 The *Mental Capacity Act 2005* permits the appointment of a deputy to act on a person's behalf in relation to personal welfare matters including healthcare decisions where that person lacks capacity.¹⁵⁵ This will be useful in cases where the person lacks the capacity to execute an LPA.

(III) *General Authority to Act*

7.70 Section 5 of the *Mental Capacity Act 2005* contains a general authority allowing a person to act in connection with the care or treatment of another person where the actor reasonably believes the other person lacks capacity in relation to the matter in question and that he is acting in their best interests. This will permit medical treatment to be carried out without the issue of assault arising. However, it will not prevent an action for professional negligence in respect of the treatment given. In any case where there is a doubt in

¹⁵¹ See Department for Constitutional Affairs *Mental Capacity Bill: Draft Code of Practice* (2004) at paragraph 6.7.

¹⁵² Section 11(7)(c) of the *Mental Capacity Act 2005*.

¹⁵³ Section 11(8)(a) of the *Mental Capacity Act 2005*.

¹⁵⁴ Sections 24 – 26 of the *Mental Capacity Act 2005*; paragraphs 7.63 - 7.64 above.

¹⁵⁵ See sections 16 – 20 of the *Mental Capacity Act 2005*.

relation to the patient's best interests, an application can be made to the Court of Protection for a declaration.¹⁵⁶

(IV) *Mental Capacity Advocates*

7.71 The *Mental Capacity Act 2005* provides for local authorities to appoint independent mental capacity advocates who can represent and support persons in relation to decision-making in respect of the provision of serious medical treatment by the NHS.¹⁵⁷

(2) *Developments in Scotland*

(a) *Certificate of Incapacity System*

7.72 In Scotland there is a legal presumption that persons aged 16 or over can make decisions including healthcare decisions. That presumption can be overturned on evidence of lack of the requisite capacity. Before an adult who lacks the capacity to make healthcare decisions can be treated, Part 5 of the *Adults with Incapacity (Scotland) Act 2000* ("the Act") requires a Certificate of Incapacity to be produced for all medical treatment except in emergencies where the common law doctrine of necessity continues to apply.¹⁵⁸

7.73 The medical practitioner primarily responsible for the medical treatment of an adult¹⁵⁹ must certify in a prescribed form that they are of the opinion that the adult is incapable in relation to the making of a decision regarding the medical treatment in question. For the duration of the certificate that medical practitioner, or any other person authorised by him or her, has authority "to do what is reasonable in the circumstances, in relation to the medical treatment,

¹⁵⁶ See Department for Constitutional Affairs *Mental Capacity Bill: Draft Code of Practice* (2004) at paragraph 5.23.

¹⁵⁷ See sections 35 - 41 of the *Mental Capacity Act 2005*.

¹⁵⁸ The form of certificate was laid down in *The Adults with Incapacity (Medical Treatment Certificate) (Scotland) Regulations 2002* (No. 208) which came into force on 1 July 2002. Involuntary psychiatric treatment is excluded from the scope of the legislation.

¹⁵⁹ Primary responsibility is not defined in the *Adults with Incapacity (Scotland) Act 2000*.

to safeguard or promote the physical or mental health of the adult.”¹⁶⁰ The specified wording of the Certificate of Incapacity requires the medical practitioner to have “today examined” the adult. Some believe this adds unduly to the workload of medical practitioners. Others are of the view that such a requirement is central to the functional nature of capacity under the Act.

7.74 The certificate of incapacity has a maximum duration of one year.¹⁶¹ It may be revoked if circumstances change or a new certificate may be issued. Decisions as to medical treatment can be appealed by an interested party in some instances to the Court of Session.¹⁶² Some healthcare practitioners in Scotland have expressed the view that having to obtain certificates for minor or routine interventions is time-consuming and that some treatments could be excluded from the requirement for a certificate.¹⁶³ The argument has been made that other healthcare professionals, in particular, dentists should be empowered to sign a certificate of incapacity because they, rather than a medical practitioner, understand the nature of the treatment proposed¹⁶⁴ and it is planned to introduce amending legislation to facilitate this.¹⁶⁵

(b) *Appeal from decision of Medical Practitioner*

7.75 Where an appointed substitute decision-maker (a guardian or welfare attorney, or a person who has been authorised to make a

¹⁶⁰ Section 47(2) of the *Adults with Incapacity (Scotland) Act 2000*.

¹⁶¹ It is planned to introduce amending legislation to increase this to three years where the adult has a degenerative or progressive illness with no prospect of improvement or recovery. See Christie “Scotland: law paves way for guardians” *The Guardian* (London) 3 November 2004, Special Supplement at 5.

¹⁶² Section 50 of the *Adults with Incapacity (Scotland) Act 2000*.

¹⁶³ Scottish Executive *Social Research Review of the Code of Practice for Part 5 of the Adults with Incapacity (Scotland) Act 2000* (2004) at paragraph 11.4.

¹⁶⁴ Scottish Executive *Social Research Review of the Code of Practice for Part 5 of the Adults with Incapacity (Scotland) Act 2000* (2004) at Chapter 8.

¹⁶⁵ See Christie “Scotland: law paves way for guardians” *The Guardian* (London) 3 November 2004, Special Supplement at 5.

decision on medical treatment pursuant to an intervention order), agrees with the medical practitioner's view as to the course of action to take, it is nevertheless open to any other person having an interest in the adult's personal welfare to appeal the decision of the medical practitioner to the Court of Session.¹⁶⁶

7.76 Where the substitute decision-maker and the medical practitioner are not in agreement, the medical practitioner will request the Mental Welfare Commission to nominate a medical practitioner to give a second opinion.¹⁶⁷ If, having consulted with interested parties (a guardian, welfare attorney or person authorised under an intervention order, and if reasonable and practicable, a person nominated by them), the second medical practitioner is of the opinion that the medical treatment should be given, it can go ahead.¹⁶⁸ Following the determination of the nominated medical practitioner, an application may be made to the court by the primary medical practitioner or any person with an interest in the welfare of the adult to determine whether the proposed treatment should be given or not.¹⁶⁹

(c) *Treatments requiring application to the court*

7.77 Sterilisation where there is no serious malfunction or disease of the reproductive organs and surgical implantation of hormones for the purpose of reducing sex drive require court approval.¹⁷⁰ These forms of medical treatment can only be carried out in relation to an adult who lacks capacity to make a decision about that treatment if the court is satisfied, on application to it by the medical practitioner primarily responsible for the medical treatment, that the treatment will safeguard or promote the physical or mental health of the adult and that the adult does not oppose the treatment or resist it being carried out. The Court of Session is obliged to afford an opportunity

¹⁶⁶ Section 50(3) of the *Adults with Incapacity (Scotland) Act 2000*.

¹⁶⁷ Section 50(4) of the *Adults with Incapacity (Scotland) Act 2000*.

¹⁶⁸ Section 50(5) of the *Adults with Incapacity (Scotland) Act 2000*.

¹⁶⁹ Section 50(6) of the *Adults with Incapacity (Scotland) Act 2000*.

¹⁷⁰ Section 48(2) and (3) of the *Adults with Incapacity (Scotland) Act 2000* and *The Adults with Incapacity (Specified Medical Treatments) (Scotland) Regulations 2002* (No. 275), Schedule 1, Part I.

to any person having an interest in the personal welfare of the adult to make representations to it.

(d) *Treatments requiring a certificate from a practitioner appointed by the Mental Welfare Commission*

7.78 Certain treatments¹⁷¹ require a certificate (valid for not more than one year) from a practitioner appointed by the Mental Welfare Commission.¹⁷² They include drug treatment for the purpose of reducing sex drive (other than surgical implantation of hormones) and any medical treatment which is likely to lead to sterilisation as an unavoidable result. The practitioner appointed by the Mental Welfare Commission (who cannot be the adult's primary medical practitioner) must certify that the adult is incapable in relation to the decision and that, having regard to the likelihood of its safeguarding or promoting the adult's physical or mental health, the treatment should be carried out.

F Conclusions

(1) Issues for Resolution

7.79 The Commission's primary conclusion in relation to the law and practice relating to capacity to make healthcare decisions is that there is a need for guidance for medical practitioners in relation to:

- how capacity to make healthcare decisions should be assessed; and
- what action the law requires if a person is judged not to have the capacity to make a healthcare decision.

7.80 The current lack of certainty in relation to treating adults who may lack capacity has profound practical consequences for the health

¹⁷¹ Pursuant to Section 48(2) and (3) of the *Adults with Incapacity (Scotland) Act 2000* and *The Adults with Incapacity (Specified Medical Treatments) (Scotland) Regulations 2002* (No. 275).

¹⁷² The form of the certificate is set out in *The Adults with Incapacity (Specified Medical Treatments) (Scotland) Regulations 2002* (No. 275), Schedule 2.

of the adults in question, their families and carers who look after their welfare. Health professionals have to exercise personal judgment in assessing capacity and how to proceed if an adult is assessed as lacking capacity to make a healthcare decision rather than acting on the basis of a coherent legal and ethical framework in this area. In a non-emergency situation healthcare professionals find themselves in an invidious position. They may seek a signature on a consent form from a next of kin (a practice which, though well-established, is not based in law). They may decline to act on the basis that the procedure is not ‘necessary’ and as a matter of law nobody else can consent to medical treatment on the adult’s behalf. Alternatively they may rely on the doctrine of necessity to act because there is no other route available other than making an application to the courts unless the patient has been made a Ward of Court.

7.81 This current legal uncertainty is clearly not in the interests of patients and their families.¹⁷³ Nor is it in the interests of healthcare professionals. The Commission is strongly of the view that the law should not operate to deprive adults who may not have the capacity to consent to medical treatment of the treatment which adults with capacity could expect to receive in the same circumstances.¹⁷⁴ The Commission on the Status of People with Disabilities recommended that there should be no delay in treating people with disabilities¹⁷⁵ and that the Department of Health should issue a code of practice to deal with situations where it is legally possible to institute treatment without consent.¹⁷⁶ This has not happened to date.

¹⁷³ See NAMHI *Who Decides and How? People with Intellectual Disability and Decision Making* (2003) at Chapter 4.

¹⁷⁴ In England and Wales the *Mental Capacity Act 2005* was specifically designed to address the problem of serious healthcare decisions being delayed because the clinician is not clear of their legal ground. See Department for Constitutional Affairs *Mental Capacity Bill – Full Regulatory Impact Assessment* (2004) at paragraph 14.

¹⁷⁵ Commission on the Status of People with Disabilities *A Strategy for Equality: Report of the Commission on the Status of People with Disabilities* (1996) at paragraph 10.35.

¹⁷⁶ Commission on the Status of People with Disabilities *A Strategy for Equality: Report of the Commission on the Status of People with Disabilities* (1996) at paragraph 10.33.

(2) Methodology

7.82 Aside from emergency situations where the doctrine of necessity may justify remedial treatment in the absence of consent, there is a need for a comprehensive system of substitute decision-making for healthcare decisions. The Commission believes that much of the difficulties outlined in this chapter would be addressed by the introduction of a broad statutory system for the appointment of assisting and substitute decision-makers for adults who lack capacity such as that recommended in the Commission's *Consultation Paper on Law and the Elderly*¹⁷⁷ to replace the current wardship regime. The Commission envisages that its *Report on Vulnerable Adults and the Law* will address the specific aspects of the appointment of substitute decision-makers and the principles which must be followed in such assisted and substitute decision-making in order to act in the best interests of the adult. Bearing this in mind, the Commission's recommendations for reform in the area of capacity to make healthcare decisions relate to providing legal and practical certainty in relation to how capacity to make healthcare decisions should be understood in law and in practice.

(3) Functional Test of Capacity

7.83 In accordance with the Commission's endorsement of a functional approach to capacity¹⁷⁸ and its existence at common law in relation to healthcare decisions, the Commission considers that the statutory functional test of capacity and capacity legislation which this Consultation Paper recommends should apply to capacity to make healthcare decisions.¹⁷⁹

7.84 The Commission recommends that capacity to make healthcare decisions should be assessed on the basis of the statutory functional test of capacity proposed in this Consultation Paper.

¹⁷⁷ See generally Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003) at Chapter 6; paragraph 3.13 ff above.

¹⁷⁸ See Chapters 2 and 3 above.

¹⁷⁹ See Chapter 3 above.

(4) *Establishment of a Code of Practice*

(a) *Establishment of Working Group*

7.85 The Medical Council has an important role to play in providing guidance to its members. While the Medical Council's ethical guidelines¹⁸⁰ are of general assistance, they do not comprehensively address capacity issues. The Commission's conclusion is that there is a need for more detailed guidelines on capacity issues relating to healthcare which will be of assistance across the spectrum of healthcare professionals including, for example, nurses and dentists.

7.86 In order to facilitate the formulation of such guidelines, the Commission considers that the capacity legislation proposed in this Consultation Paper should make provision for the formulation of a code of practice dealing with issues in respect of adults who may lack capacity to make a healthcare decision ("the Code of Practice"). The Commission is in favour of the proposed capacity legislation¹⁸¹ enabling the Minister for Health to appoint a cross-section of representatives from professional bodies in the healthcare sector, professionals and lay persons to a working group with a view to formulating the Code of Practice ("the Working Group on Capacity to Make Healthcare Decisions").

7.87 Providing in statute for the establishment of the Working Group on Capacity to Make Healthcare Decisions in order to formulate a code of practice, rather than providing detailed rules in the legislation itself, would facilitate future revision of the Code of Practice without the need to amend the underlying legislation. This would allow for the guidelines to be responsive to changes in law, medical practice and ethics. It is envisaged that, as is the case in Scotland, the code would not be mandatory but would constitute best practice guidance in this area. Therefore breach of the Code of Practice would not necessarily constitute a breach of the law but would involve failure to comply with best practice.¹⁸²

¹⁸⁰ Irish Medical Council *A Guide to Ethical Conduct and Behaviour* (6th ed 2004).

¹⁸¹ See Chapter 3 above.

¹⁸² See paragraph 7.27 above.

7.88 *The Commission recommends that the proposed capacity legislation should give the Minister for Health the power to appoint a Working Group on Capacity to Make Healthcare Decisions which would formulate a code of practice in this area for healthcare professionals.*

(b) *Contents of the Code of Practice*

7.89 There are three principal aspects which the Code of Practice should cover:

- assessment of capacity;
- the operation of the doctrine of necessity;
- categories of decision which require to be adjudicated on by a court or specialist tribunal.

(I) *Assessment of Capacity*

7.90 The Commission considers that it is important that the Code of Practice include guidelines for the assessment of capacity to make healthcare decisions. The Working Group on Capacity to Make Healthcare Decisions would commence with the legal presumption of capacity and a functional approach to capacity as a starting point.¹⁸³ The Code of Practice would need to emphasise that this presumption of decision-making ability should not be displaced on the basis of age, disability or a diagnosis of a psychiatric or neurological condition but rather on the basis of an actual assessment of decision-making capacity in relation to the decision at hand.

7.91 While there is a legal presumption of capacity to consent in respect of adults, the assessment of a patient's capacity to make a healthcare decision is also a matter for clinical judgment. To assist medical practitioners in this task, guidelines in the Code of Practice would clarify the position for healthcare professionals and would ensure a congruent approach in the assessment of capacity. Such guidance would be required to proceed on the basis that any assessment of capacity involves an element of discretion to be

¹⁸³ See Chapters 2 and 3 above.

afforded to the assessor since capacity is not black and white and should not simply be reduced to a scientific test.¹⁸⁴ The Commission nevertheless considers that it would be useful for the Code of Practice to set out relevant factors to be taken into account in assessing a person's capacity to make a healthcare decision.

7.92 The Commission recommends that the code of practice for healthcare professionals should provide guidelines on the assessment of capacity to make a healthcare decision. Such guidelines should take account of factors such as whether the adult, after a discussion in relation to the healthcare decision which is pitched at a level appropriate to the adult's individual level of cognitive functioning,

- understands in broad terms the reasons for and nature of the healthcare decision to be made;*
- has sufficient understanding of the principal benefits and risks involved in the treatment option being presented and relevant alternative options after these have been explained to them in a manner and in language appropriate to their individual level of cognitive functioning;*
- understands the personal relevance of the decision;*
- appreciates the advantages and disadvantages in relation to the choices open to them;*
- makes a voluntary choice.*

(II) The Doctrine of Necessity

7.93 As the law stands, the common law doctrine of necessity performs a useful function in allowing health professionals to provide treatment where there is a necessity to do so. The Commission believes that it is appropriate to give a certain amount of latitude to medical practitioners who have to make difficult decisions in the heat of the moment. Indeed, inappropriate reliance on the doctrine of necessity would largely be addressed by the establishment of a workable mechanism for substitute and assisted decision-making for

¹⁸⁴ See paragraph 3.26 *ff* above.

adults who lack capacity as contemplated by the Commission's *Consultation Paper on Law and the Elderly*.¹⁸⁵

7.94 Therefore the Commission's preferred approach is not to statutorily circumscribe the common law doctrine of necessity. Rather, the Commission considers that it would be of assistance to medical practitioners if the Code of Practice devised by the proposed Working Group on Capacity to Make Healthcare Decisions provided some guidelines in relation to the type of situations in which treatment should be carried out without the consent of the adult concerned. These guidelines should also deal with the issue of the type of treatment which should be given if it is likely that the person will imminently recover capacity and therefore be able to make a decision on what treatment they would wish or not wish to receive. This would arise, for example, where the person is temporarily unconscious as opposed to permanently lacking in capacity to make relevant decisions.

7.95 *The Commission recommends that the code of practice for healthcare professionals should provide guidance concerning the type of urgent situations in which treatment may be carried out without the consent of the adult concerned and what type of treatment can be given if it is likely that the adult concerned will imminently recover capacity.*

(III) *Healthcare Decisions Requiring Court Approval*

7.96 A further issue which will require to be addressed in the *Report on Vulnerable Adults and the Law* is the question of whether, in the context of the formulation of capacity and substitute decision-making legislation, certain healthcare decisions in relation to an adult without the capacity to consent should be specified as requiring an application to court for approval.

7.97 It is clear that to specify that any proposed treatment of an adult lacking capacity to consent to treatment which carried a risk of death or serious injury would require court approval would lead to an

¹⁸⁵ Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23-2003), Chapter 6; paragraph 7.82 above.

overwhelming number of court applications.¹⁸⁶ However, it may be considered appropriate that certain major healthcare decisions should be referred to a court.

7.98 The type of decision in relation to a person lacking capacity to consent which could qualify in this category may include:¹⁸⁷

- Non-therapeutic sterilisation;¹⁸⁸
- Surgical implantation of hormones for the purpose of reducing sex drive;¹⁸⁹
- Withdrawal of artificial life-sustaining treatment;¹⁹⁰
- Psychosurgery;¹⁹¹
- Electro-convulsive therapy;¹⁹²
- The donation of non-regenerative tissue (organ donation) and regenerative tissue (for example, bone marrow);¹⁹³

¹⁸⁶ See Scottish Law Commission (Discussion Paper No.94) *Mentally Disabled Adults: Legal Arrangements for Managing their Welfare and Finances* (1991) at paragraph 3.26.

¹⁸⁷ See Law Commission *Mentally Incapacitated Adults and Decision-making: Medical Treatment and Research* (No. 129 1993) at Part VI.

¹⁸⁸ This accords with the Commission's recommendation at paragraph 6.62 above.

¹⁸⁹ See paragraph 7.77 above.

¹⁹⁰ See generally *Re a Ward of Court (No.2)* [1996] 2 IR 79; *R (Burke) v General Medical Council* [2004] 2 FLR 1121.

¹⁹¹ Where the adult is an involuntary patient under the *Mental Health Act 2001* psychosurgery requires the written consent of the patient and authorisation by a Mental Health Tribunal where it is considered to be in the best interests of the patient: section 58 of the *Mental Health Act 2001*. Such a decision may be appealed to the Circuit Court.

¹⁹² Where the adult is an involuntary patient under the *Mental Health Act 2001* ECT requires the approval by both the consultant psychiatrist and a second psychiatrist on the matter being referred to them: Section 59(1) of the *Mental Health Act 2001*. The Mental Health Commission is required to draw up rules governing the use of ECT.

- Experimental treatment of a medical condition outside the context of a clinical trial.¹⁹⁴

7.99 The Commission envisages that this subject is one which the Working Group on Capacity to Make Healthcare Decisions could consider.¹⁹⁵ The subject is one which will require to be revisited and the Commission welcomes views on the types of decisions which it is considered should require an application to court rather than a decision of a substitute decision-maker.

7.100 *The Commission recommends that the code of practice for healthcare professionals should provide guidance concerning healthcare decisions which would require an application to court. The Commission invites views on the type of decisions which should be included.*

¹⁹³ See de Cruz *Comparative Health Care* (Cavendish Publishing Limited 2001) at 283; *Strunk v Strunk* (1969) 445 SW 2d 145; see *Re Y* [1997] 2 FCR 172 for relevant factors considered by the court in relation to bone marrow harvesting from a woman with intellectual disability in order to benefit her sister. In *Re F* [1990] 2 AC 1, 52 Lord Bridge suggested that live organ donation by an adult without capacity to consent required similar safeguards to sterilisation. See also Law Reform Commission of Canada *Procurement and Transfer of Human Tissues and Organs* (Working Paper No.66 1992) at 174-175; Law Commission *Mentally Incapacitated Adults and Decision-making: Medical Treatment and Research* (No. 129 1993) at Part VI.

¹⁹⁴ See *Simms v Simms ; A v A* [2003] 2 WLR 1465; paragraph 7.61 *ff* above.

¹⁹⁵ See paragraph 7.85 *ff* above.

CHAPTER 8 SUMMARY OF PROVISIONAL RECOMMENDATIONS

8.01 The Commission recommends that the law on capacity should reflect an emphasis on capacity rather than lack of capacity and should be enabling rather than restrictive in nature, thus ensuring that it complies with relevant constitutional and human rights standards. [paragraph 1.47]

8.02 The Commission recommends that a predominantly functional approach should be taken to the issue of legal capacity. This would involve consideration of a person's capacity in relation to the particular decision to be made at the time it is to be made. The Commission also recognises that where an adult's lack of capacity is profound and enduring, a new functional determination may be unnecessary in every situation in which a decision has to be made. [paragraph 2.40]

8.03 The Commission recommends the enactment of capacity legislation for the following reasons:

- Existing legislative and judicial consideration of capacity matters has been piecemeal rather than systematic and wide-ranging;
- The law on capacity should be clear, transparent and accessible;
- Capacity legislation would permit a coherent uniform legislative understanding of legal capacity to be put in place which would apply in all situations;
- Capacity legislation could seek to achieve an appropriate balance between autonomy and protection by promoting the interests of vulnerable adults;

- Capacity legislation would also be an appropriate vehicle to deal with the consequences of a finding of lack of capacity, in particular through making provision for substitute and assisted decision-making structures of the type envisaged in the Commission's *Consultation Paper on Law and the Elderly*. [paragraph 3.12]

8.04 The Commission recommends that the proposed capacity legislation should use appropriate terminology to refer to persons who lack legal capacity. [paragraph 3.18]

8.05 The Commission recommends that the proposed capacity legislation should be drafted in terms which are enabling rather than restrictive in nature. [paragraph 3.19]

8.06 The Commission recommends that the proposed capacity legislation should set out a rebuttable presumption of capacity to the effect that every adult is presumed, until the contrary is demonstrated, to be capable of making decisions affecting them. [paragraph 3.25]

8.07 The Commission recommends that the proposed capacity legislation should contain a statutory definition of capacity. [paragraph 3.29]

8.08 The Commission recommends that the proposed capacity legislation should contain a functional definition of capacity which focuses on an adult's cognitive ability to understand the nature and consequences of a decision in the context of available choices. [paragraph 3.44]

8.09 The Commission recommends that an adult should not be regarded as unable to make a decision merely because they make a decision which would ordinarily be regarded as imprudent. [paragraph 3.46]

8.10 The Commission recommends that a person will lack capacity if they are unable to communicate their choices by any means where communication to a third party is required to implement the decision. [paragraph 3.49]

8.11 The Commission regards the use of phrases such as 'idiot', 'lunatic' and 'person of unsound mind' in the *Lunacy Regulation*

(Ireland) Act 1871 as out of step with the contemporary understanding of disability and recommends that they should not form part of any reforming legislation. [paragraph 4.51]

8.12 The Commission recommends that the proposed capacity legislation should ensure that a determination of a person's legal capacity complies with procedural fairness by ensuring that the person has appropriate assistance in terms of information, access to representation and other reasonable assistance which will enable them to understand the implications of the process and to make submissions in relation to their capacity. [paragraph 4.55]

8.13 The Commission recommends that where it has been determined that a person lacks capacity in a particular area which has an ongoing impact on their decision-making ability, the proposed capacity legislation should make provision for a system of automatic periodic review of that determination, with appropriate procedural safeguards to protect the rights of the person concerned. [paragraph 4.56]

8.14 The Commission recommends that the approach to capacity in the *Powers of Attorney Act 1996* be reviewed in the light of the definition of capacity recommended in this Consultation Paper. [paragraph 4.60]

8.15 The Commission recommends that a presumption of capacity to contract should form part of a statutory presumption of capacity. [paragraph 5.37]

8.16 The Commission recommends that the proposed capacity legislation should provide that a contract purportedly entered into by an adult whom it is alleged lacked contractual capacity may be referred to the Public Guardian by a party to the contract, a personal guardian or other person connected with a person in respect of whom it is alleged there was a lack of contractual capacity. The Commission further recommends that on such a contract being referred to it, the Public Guardian could, with the consent of the parties, refer the matter to mediation, or the Public Guardian could examine the matter. The Public Guardian should be given power to declare the contract binding on both parties or to declare the contract void for lack of capacity and to make any adjustment to the rights of

the parties considered just in the circumstances. A decision of the Public Guardian could be appealed to the Circuit Court and such an appeal would involve a full rehearing of the matter. [paragraph 5.40]

8.17 The Commission recommends that the proposed capacity legislation should provide that an adult who lacks the capacity to enter into a particular contract is nonetheless obliged to pay the supplier a reasonable amount for necessities supplied. [paragraph 5.43]

8.18 “Necessaries” should be statutorily defined as goods and services supplied which are suitable to the person’s reasonable living requirements but excluding goods and services which could be classed as luxury in nature. [paragraph 5.44]

8.19 The Commission invites views in relation to the reform of section 5 of the *Criminal Law (Sexual Offences) Act 1993*. In particular, views are invited as to whether the offence should be remodelled so that it would be an offence to have or attempt to have sexual intercourse or buggery with a person who lacked capacity to consent to the relevant act at the time because they did not understand the nature or reasonably foreseeable consequences of the act or could not communicate their consent or lack of consent. [paragraph 6.28]

8.20 The Commission recommends that the *Marriage of Lunatics Act 1811* be repealed. [paragraph 6.51]

8.21 The Commission recommends that the proposed capacity legislation should provide that any proposed non-consensual sterilisation of a person with limited decision-making ability where there is no serious malfunction or disease of the reproductive organs would require an application to court. [paragraph 6.62]

8.22 The Commission recommends that capacity to make healthcare decisions should be assessed on the basis of the statutory functional test of capacity proposed in this Consultation Paper. [paragraph 7.84]

8.23 The Commission recommends that the proposed capacity legislation should give the Minister for Health the power to appoint a Working Group on Capacity to Make Healthcare Decisions which

would formulate a code of practice in this area for healthcare professionals. [paragraph 7.88]

8.24 The Commission recommends that the code of practice for healthcare professionals should provide guidelines on the assessment of capacity to make a healthcare decision. Such guidelines should take account of factors such as whether the adult, after a discussion in relation to the healthcare decision which is pitched at a level appropriate to the adult's individual level of cognitive functioning,

- understands in broad terms the reasons for and nature of the healthcare decision to be made;
- has sufficient understanding of the principal benefits and risks involved in the treatment option being presented and relevant alternative options after these have been explained to them in a manner and in language appropriate to their individual level of cognitive functioning;
- understands the personal relevance of the decision;
- appreciates the advantages and disadvantages in relation to the choices open to them;
- makes a voluntary choice. [paragraph 7.92]

8.25 The Commission recommends that the code of practice for healthcare professionals should provide guidance concerning the type of urgent situations in which treatment may be carried out without the consent of the adult concerned and what type of treatment can be given if it is likely that the adult concerned will imminently recover capacity. [paragraph 7.95]

8.26 The Commission recommends that the code of practice for healthcare professionals should provide guidance concerning healthcare decisions which would require an application to court. The Commission invites views on the type of decisions which should be included. [paragraph 7.100]

**APPENDIX A LIST OF LAW REFORM COMMISSION
PUBLICATIONS**

First Programme for Examination of Certain Branches of the Law with a View to their Reform (December 1976) (Prl 5984)	€0.13
Working Paper No 1-1977, The Law Relating to the Liability of Builders, Vendors and Lessors for the Quality and Fitness of Premises (June 1977)	€1.40
Working Paper No 2-1977, The Law Relating to the Age of Majority, the Age for Marriage and Some Connected Subjects (November 1977)	€1.27
Working Paper No 3-1977, Civil Liability for Animals (November 1977)	€3.17
First (Annual) Report (1977) (Prl 6961)	€0.51
Working Paper No 4-1978, The Law Relating to Breach of Promise of Marriage (November 1978)	€1.27
Working Paper No 5-1978, The Law Relating to Criminal Conversation and the Enticement and Harboursing of a Spouse (December 1978)	€1.27

Working Paper No 6-1979, The Law Relating to Seduction and the Enticement and Harboursing of a Child (February 1979)	€1.90
Working Paper No 7-1979, The Law Relating to Loss of Consortium and Loss of Services of a Child (March 1979)	€1.27
Working Paper No 8-1979, Judicial Review of Administrative Action: the Problem of Remedies (December 1979)	€1.90
Second (Annual) Report (1978/79) (Prl 8855)	€0.95
Working Paper No 9-1980, The Rule Against Hearsay (April 1980)	€2.54
Third (Annual) Report (1980) (Prl 9733)	€0.95
First Report on Family Law – Criminal Conversation, Enticement and Harboursing of a Spouse or Child, Loss of Consortium, Personal Injury to a Child, Seduction of a Child, Matrimonial Property and Breach of Promise of Marriage (LRC 1-1981) (March 1981)	€2.54
Working Paper No 10-1981, Domicile and Habitual Residence as Connecting Factors in the Conflict of Laws (September 1981)	€2.22
Fourth (Annual) Report (1981) (Pl 742)	€0.95

Report on Civil Liability for Animals (LRC 2-1982) (May 1982)	€1.27
Report on Defective Premises (LRC 3-1982) (May 1982)	€1.27
Report on Illegitimacy (LRC 4-1982) (September 1982)	€4.44
Fifth (Annual) Report (1982) (Pl 1795)	€0.95
Report on the Age of Majority, the Age for Marriage and Some Connected Subjects (LRC 5-1983) (April 1983)	€1.90
Report on Restitution of Conjugal Rights, Jactitation of Marriage and Related Matters (LRC 6-1983) (November 1983)	€1.27
Report on Domicile and Habitual Residence as Connecting Factors in the Conflict of Laws (LRC 7-1983) (December 1983)	€1.90
Report on Divorce a Mensa et Thoro and Related Matters (LRC 8-1983) (December 1983)	€3.81
Sixth (Annual) Report (1983) (Pl 2622)	€1.27
Report on Nullity of Marriage (LRC 9-1984) (October 1984)	€4.44
Working Paper No 11-1984, Recognition of Foreign Divorces and Legal Separations (October 1984)	€2.54

Seventh (Annual) Report (1984) (PI 3313)	€1.27
Report on Recognition of Foreign Divorces and Legal Separations (LRC 10-1985) (April 1985)	€1.27
Report on Vagrancy and Related Offences (LRC 11-1985) (June 1985)	€3.81
Report on the Hague Convention on the Civil Aspects of International Child Abduction and Some Related Matters (LRC 12-1985) (June 1985)	€2.54
Report on Competence and Compellability of Spouses as Witnesses (LRC 13-1985) (July 1985)	€3.17
Report on Offences Under the Dublin Police Acts and Related Offences (LRC 14-1985) (July 1985)	€3.17
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