



Northern Ireland  
Assembly

Ad Hoc Joint Committee on the Mental  
Capacity Bill

**OFFICIAL REPORT  
(Hansard)**

DHSSPS and DOJ Briefing

22 June 2015

# NORTHERN IRELAND ASSEMBLY

## Ad Hoc Joint Committee on the Mental Capacity Bill

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**Members present for all or part of the proceedings:**

Mr Alastair Ross (Chairperson)

Mr Patsy McGlone (Deputy Chairperson)

Mrs Pam Cameron

Mrs Jo-Anne Dobson

Mr Seán Lynch

Mr Kieran McCarthy

Mr Raymond McCartney

Ms Rosaleen McCorley

Mr Edwin Poots

**Witnesses:**

Ms Alison McCaffrey

Department of Health, Social Services and Public Safety

Ms Lisa Trueman

Department of Health, Social Services and Public Safety

Ms Clare Irvine

Department of Justice

**The Chairperson (Mr Ross):** Welcome back, Lisa, Alison and Clare. I think that we are doing Part 12 first, so start when you are ready, and then we will open up to questions.

**Ms Alison McCaffrey (Department of Health, Social Services and Public Safety):** OK, thank you, Chair. Before speaking about Part 12, I would like to make a few remarks about the Department's position on the Bill and children generally. It is fair to say that whether or not the Bill should apply to children has been one of the most talked about issues during the development of the Bill and one of the most difficult to get to grips with conceptually. As we acknowledged in the summary report that we published earlier this year, it was also a key point raised during the consultation. Indeed, it is an issue that we in the Bill team have grappled with in many meetings with colleagues in the Department. We have also attended many events at which the issue was discussed. We have genuinely engaged with all relevant stakeholders, including children, listening carefully to all the arguments.

I do not wish to oversimplify, but there appear to be two camps: one says that the Bill should apply to children otherwise they will be less protected than adults; the other argues that the Bill should not apply to children because it would alter the fundamental role that parents play in making decisions in respect of their children. We did not have to go too far into the provisions of the Bill to find support for the latter argument. As you know, Part 1 contains what is called the presumption of capacity. Under current law, that is the starting point for adults. For them, it is presumed that they have capacity, and that means that, legally, there is no one else who can give consent on behalf of an adult. Hence, the need for the Bill: to ensure that adults are protected when they are unable to make decisions for themselves. For children, however, the position is very different. They are gaining capacity, during which time — indeed, until they become an adult — there will always be a parent or someone acting in

that role to protect them and to act, where necessary, in their best interests. Applying the presumption of capacity in Part 1 to children would radically change the nature of the existing protective regime for children. Take, for example, an intelligent 10-year-old who refuses life-sustaining treatment. To comply with Part 1, the starting point would be for the doctor to assume that that child had capacity to make the decision for themselves, unless it is established otherwise. In other words, it would be doubtful whether any parent could lawfully step in and give the necessary consent. To develop the scenario in a different direction, if it were established that the child lacked capacity, as defined in Part 1 — there are issues with that too — the role of parents would be further displaced, as under Part 2 it would be the doctor, not the parents, making the best-interest decision on behalf of their child. That is an extreme example but a real one that parents and those working in the health and social care sector would face if the Bill applied to children. The implications are just as real at the other end of the spectrum, the more routine end, for things that some of us as parents do on a daily basis, like washing or dressing our younger kids, making decisions about after-school care or whether they should go to the dentist.

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

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

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

At this point, I turn to Part 12. Among other things, it contains significant new safeguards, specifically for children under the age of 16. They reflect what people during the consultation exercise told us and build on the protections already in place in the Mental Health Order that apply alongside the existing wider legal and policy framework for children. I will now briefly refer to each safeguard. They include the requirement that, when making decisions about the care or treatment of a child who is being assessed or treated for mental disorder, the responsible person's primary consideration must be the child's best interests. Putting this on a statutory footing is significant, as the new provisions also provide clear statutory rules on what needs to be done when making a best-interests determination about a child's treatment or care. The rules are similar to the rules in clause 7, but we adapted them to make them more child-focused. Crucially, they require the views of the child to be taken into account and the child's participation rights to be adhered to in line with the requirements of the United Nations Convention on the Rights of the Child and the United Nations Convention on the Rights of Persons with Disabilities. A further new safeguard for children provided for in Part 12 is the requirement for an independent advocate to be available for and to support children admitted to hospital for the assessment or treatment of a mental disorder, regardless of whether their admission is on a voluntary or a compulsory basis. There are also new safeguards in relation to particular treatments. For example, a second opinion must always be obtained in respect of electroconvulsive therapy. Finally, there is a new duty on trusts to provide age-appropriate accommodation, and that also applies to 16- and 17-year-olds who are being assessed or treated for a mental disorder under the Bill. All the amendments to the Mental Health Order are set out in schedule 8.

The Department recognises that this is a very important issue, and we take it very seriously. It touches on some fundamental issues that are outside the scope of the Bill — issues of legal, not mental, capacity, on which consensus is likely to be difficult to achieve. The approach that we have adopted, therefore, is intended to be a balanced one, one that allows us to improve things considerably for those currently without legislative safeguards and, at the same time, to strengthen the

existing protective framework that is already in place for children, of which the Mental Health Order is part.

We fully appreciate that the Committee will wish to take time to scrutinise that approach, including the additional safeguards that we have provided in schedule 8. We will of course provide the Committee with whatever assistance we can as it works through the provisions and the issues, including, if necessary, undertaking to seek further information from colleagues in the Department who are responsible for the existing legal and policy framework relating to children. That concludes my remarks. I am happy to take any questions.

**Mrs Cameron:** Thank you for your presentation. What changes did the Department make to the Bill as a result of the public consultation?

**Ms McCaffrey:** In relation to children specifically?

**Mrs Cameron:** Yes.

**Ms McCaffrey:** The most significant change is the inclusion of schedule 8, which contains the amendments to the Mental Health Order. Schedule 8 inserts the best-interests clause in the Mental Health Order and introduces the requirement to consult an independent advocate. The main differences in children's issues are the requirement to obtain a second opinion for certain types of treatment and for trusts to provide age-appropriate accommodation. Is there anything that I have missed, Lisa?

**Ms Lisa Trueman (Department of Health, Social Services and Public Safety):** No, that is it.

**Mrs Cameron:** What are the key differences between the safeguards that will apply to adults who are detained under the Bill and those that will apply to children who are detained under the 1986 Order as amended by schedule 8?

**Ms Trueman:** There will be some differences, obviously, because we are not comparing like with like. For example, some of the principles would not apply in the Mental Health (Northern Ireland) Order 1986 because they deal with capacity issues. The formal assessment of capacity does not apply in the 1986 Order because the Bill starts with the presumption that adults have capacity to make decisions for themselves. The framework for nominated persons is different in the Mental Health Order; it relates to nearest relatives. The child's parent is likely to be the nearest relative in that situation. There are second opinions in the Mental Health Order; as Alison said, there is the independent advocate safeguard and the authorisation and review of interventions. That is where the key differences or similarities lie.

**The Chairperson (Mr Ross):** We heard from a lot of charities that they are keen that the Bill would include under-18s. Have any of them expressed a view that rather than just updating the Mental Health Order, at some stage in future there should be a mental capacity Bill for young people? Is that something that anybody has asked for? Is it worthwhile giving consideration to that?

**Ms McCaffrey:** No one has specifically put it in those terms. The debate has been largely about the protections for children as they exist at the moment, bearing in mind that there is a framework for children, of which parents are a key point. I do not recall anybody specifically saying that there should be a capacity Bill for children.

**The Chairperson (Mr Ross):** OK. Does anyone have any further questions on this part of the Bill? We will move on, then.

**Ms Trueman:** I will now take you through the remaining parts of the Bill. Part 8 deals with research projects involving people who lack capacity; Part 11 deals with transfers of patients between jurisdictions; Part 13 sets out some offences; and Parts 14 and 15 cover miscellaneous and supplementary provisions. I will say a bit about each in turn, after which I will hand over to Clare to add anything further on the justice side.

Part 8 allows intrusive research to be lawfully carried out in respect of a person who lacks capacity to consent to it, provided that certain conditions and safeguards are met. By intrusive research, under the Bill, we mean research that would otherwise require the person's consent. It does not include

clinical trials, which are governed by other legislation. A natural question might be this: why does the Bill allow for research to be carried out where someone lacks capacity to consent to it? However, it is, of course, important that such research can be lawful; without it, less would be known about the conditions that cause or contribute to someone's inability to make a decision for themselves. The more we know about these conditions, the more we can do to improve the treatment of them and the care of people who suffer from them. In other words, it would be wrong to deny people who suffer from such conditions the benefit that research might bring.

Nevertheless, it is vital that, when research of this nature is being carried out, people's rights are safeguarded and protected. That is, in effect, what Part 8 is all about. Clause 130 requires the research to be approved, and clause 132 sets out the conditions for approval. First, the research must be connected with the person's condition or its treatment. It also needs to involve people who lack capacity to consent to taking part for it to be effective. In other words, the research cannot be carried out on someone who has capacity. The research must have the potential to benefit the individual or to provide knowledge about the causes of the person's condition or the care or treatment of people with the same or a similar condition, but, importantly, only if the risks are minimal. The researcher also has to be sure that any serious intervention would be lawful, for example, under Part 2 of the Bill, and that arrangements are in place to meet additional requirements, such as the need to consult the person's carer or someone appointed for the purpose of seeking advice on whether the person should be involved and what that person's views might be about the research itself. If that person indicates that the individual lacking capacity would be likely to decline to take part, they must be withdrawn from the project. Part 8 also makes it clear that, if the person who lacks capacity objects to something that is being done, unless it is necessary to protect the person, or if they indicate in any way that they wish to withdraw from the project, withdrawal must happen without delay.

Part 11 deals with the transfer of detained patients from Northern Ireland to a hospital in another part of the UK and vice versa. In short, it aims to facilitate the continuation of the current transfer scheme that already operates under the Mental Health Order and the equivalent legislation in the rest of the UK. Clauses 248 and 249 provide the framework for transfers from Northern Ireland and give the Department the power to authorise such transfers if certain conditions are met. The conditions include that the person must lack capacity in relation to the removal and that it would be in their best interests. Clauses 250 and 251 provide the framework for the opposite scheme — the transfers to Northern Ireland. They require certain things to be done for the relevant trusts here, so, once someone has been transferred to Northern Ireland, the trust must notify the Regulation and Quality Improvement Authority (RQIA) immediately and send a copy of a medical report within 28 days. Amendments will also be required to the corresponding legislation in the rest of the UK to take account of those new transfer provisions in the Bill, and that will be done by an Order in Council. The detail of the transfer scheme at this end will be provided for in regulations to be made under clause 252. Those will be drafted and published for consultation following consultation with our counterparts and with relevant bodies in England, Wales and Scotland. Finally, clause 252 makes it clear that the regulations must provide a right of review to the tribunal in respect of any authorisation for removal from Northern Ireland, and that is an important safeguard for people being removed.

Part 13 sets out some offences. Most importantly, clause 256 makes it an offence for a person to ill-treat or wilfully neglect a person who lacks capacity — that will be a new statutory offence for Northern Ireland — and there are a number of other offences; for example, it will be an offence to knowingly make or make use of false statements or documents. That includes certificates, reports and application forms under the Bill. It will also be an offence to knowingly detain a person who lacks capacity if the grounds for a detention are not met, nor can you assist someone to be absent from a place of detention or from a place where they are required to live. Those remaining offences have been carried over from the Mental Health Order and modified to reflect the nature of the Bill. Indeed, we have already had discussions about some of the offences in previous sessions.

As Part 14 gathers together various miscellaneous provisions, I will not go into the detail of each and every clause. Members may wish to note that clauses 265 to 268 explain that Part 2 applies to everyday small decisions on spending a person's cash; for example, a carer might want to spend money on behalf of someone that they care for who lacks capacity so that they can buy a pint of milk or get the shopping for that individual. For any larger decisions on money, you get into the territory of attorneys and deputies, which we covered last week. Importantly, clauses 273 and 274 set out matters that are excluded from the scope of the Bill; in other words, the sort of decisions that you could never make on behalf of another person because they are so personal. For example, you could not ever make a decision on someone else's behalf to get married or get divorced. Finally, clause 275 clarifies that nothing in the Bill affects the law relating to murder, manslaughter or assisted suicide.

Part 15 contains supplementary matters that relate to the code of practice. There are some further provisions on the detention process and, in particular, the trust panels and medical reports. Again, we largely covered those in the session on Part 2. Definitions, commencement and the short title of the Bill are also included.

Chair, that concludes my summary on the remaining parts of the Bill, but I know that Clare has a few points to add on the justice side. Of course, we will then be happy to take questions.

**Ms Clare Irvine (Department of Justice):** Thanks, Lisa. Chair, Lisa talked about Part 11, which deals with the transfer of patients between jurisdictions. Individuals who are detained in hospital as a result of the operation of the criminal justice system sometimes also require transfer outside the jurisdiction. Generally, that is done if the person requires detention in a high-security facility, because we do not have a high-security facility in Northern Ireland. It is usual that people are sent to the State Hospital in Carstairs, which is in Lanarkshire in Scotland. Transfers may also take place if special services are required that are not available in Northern Ireland. Such transfers are covered by guidance issued by DHSSPS. According to statistics that we obtained, we have seven people in Carstairs at the moment and one in the John Howard Centre in London, which is a medium-secure facility.

Being able to transfer individuals is important to the criminal justice system to ensure that people are detained in facilities that, first, best suit their needs and, secondly, are able to effectively manage the individual with a suitable level of security. The provisions in the Bill are not intended to be applicable to those who are detained in the criminal justice system. We do not intend to detain individuals on the basis that they lack capacity to make a decision about being detained but are instead detaining them on the basis that failing to do so would pose a risk linked to that impairment or disturbance in the functioning of their mind or brain or serious physical harm to other persons. Since we view access into hospital as being on the basis of this particular criterion, we also view the question of whether that person is transferred out of the jurisdiction as being relevant to the distinction that we have drawn there. We do not really see the matter of transfer out of the jurisdiction as a matter for the individual to decide if he is being detained because of a decision that the court has made in order to manage his risk.

We intend to bring forward amendments that will reflect this approach, and we are happy to liaise fully with the Committee as we do so. It is unfortunate that those are not in the Bill at present. We had to take some pragmatic decisions on the criminal justice side in order to progress this legislation, and, unfortunately, this is one of the areas where we had to be pragmatic. However, work is ongoing with our colleagues in Scotland, England and Wales to ensure that they are also content with our proposals, given their interest in receiving our patients. Lisa mentioned the transfer to Northern Ireland from the other jurisdictions. Obviously, criminal justice will have a role to play in that as well. It is rare that we have that type of traffic coming, but we need to make provision for, as Lisa said, the Order in Council mechanism that would be required to achieve that.

I will briefly mention Part 14. Clauses 263 and 264 concern the review tribunal. Article 70 of the Mental Health Order (Northern Ireland) 1986 creates a Mental Health Review Tribunal. We are retaining that clause, but we are changing the name of the tribunal to reflect the fact that it will have a much wider remit in future. If it is helpful to the Committee, not only do you need to look at clauses 263 and 264, you also need to look at articles 70, 81, 82 and 84 and schedule 3 to the 1986 Order, which will remain intact, although they will have slight amendments made to them by the Bill. It may also be helpful to look at schedule 8, which contains the amendments to the provisions of the 1986 Order that I have just mentioned that relate to the tribunal. Most of these amendments are consequential; they are a consequence of Bill provisions. Part 2 of the 1986 Order will in future apply only to those aged under 16.

In schedule 3, there is one substantive amendment that we draw to the Committee's attention. That refers to schedule 8, paragraph 75 of the 1986 Order that is being amended:

*"proceedings may with the consent of the parties be heard and determined in the absence of any one member other than the president".*

That is in order to be able to constitute the tribunal slightly more quickly and not have to wait until we can manage to have three members to constitute a panel. This is our attempt to avoid unnecessary delay.

Part 15 contains a number of clauses that DOJ has ownership of. We will create codes of practice for our stakeholders in the criminal justice system who will need guidance on how the Bill operates. I also draw the Committee's attention to clauses 280 and 281, which are around legal custody and escapes from legal custody. Clause 282 refers to special accommodation. That facilitates the use of special security in order to set up service provision for individuals who may need increased security to manage the risk that they pose. Clause 284 offers protection for acts done in pursuance of Parts 9 and 10. That is carried forward from the 1986 Order and is designed to protect against frivolous claims for those who operate in the health and justice systems.

That concludes my remarks, Chairman.

**The Chairperson (Mr Ross):** OK. Thank you.

**Mr McCarthy:** Thank you very much for your presentation. I have three questions. The first one is on Part 8 and is fairly straightforward. Has the Department amended Part 8 in light of the concerns raised in the consultation about the need for any research intervention to be in P's best interests? I think that was yours, Alison.

**Ms McCaffrey:** I can certainly answer. We have added an additional subsection to clause 132 which basically requires that anything serious that would be done as part of a research project can only be done if it would otherwise be lawful, which means, for example, that it would have to meet the conditions set in Part 2, one of which is best interests.

**Mr McCarthy:** Did that come about as a result of the concerns that were raised originally?

**Ms McCaffrey:** It was certainly raised during the consultation. We had been thinking about it too, but the consultation helped us to reach a decision.

**Ms McCaffrey:** My next question is on Part 13. What would constitute ill treatment or neglect under clause 256, and can you provide an example?

**Ms Trueman:** Ill treatment or wilful neglect is where someone intentionally does not intervene in the care of somebody to whom they owe a duty of care and when they know they should intervene. It could be intervening to give them an injection that they require, or even just to meet their basic care needs, such as help with washing or dressing.

**Mr McCarthy:** Just pure neglect.

**Ms Trueman:** Only if it is intentional.

**Mr McCarthy:** What about ill treatment?

**Ms Trueman:** Ill treatment or wilful neglect come within the same scope.

**Mr McCarthy:** Finally, clause 288 in Part 15 gives the Department the power to make wide-ranging regulations in connection with the Bill. Why is that power necessary?

**Ms Trueman:** This clause is included because, as we discussed in previous sessions, this is a complex and novel Bill. We have to provide some flexibility here, and that is ultimately why that clause is included.

**Ms Irvine:** Let me add a comment there. We have recent experience of dealing with clause 86 of the Justice Bill — I see the Chair smiling — and I dare say some lessons will filter down. Obviously we had this clause drafted before the issues with clause 86 arose, we can discuss it as we move forward.

**Ms McCaffrey:** The power is also necessary because of the age limit applied in the Bill. It allows for those cases where somebody is under 16 when something is proposed, but over 16 by the time it is done. We need to provide for that as well.

**Mr McCarthy:** That is grand. Thank you.

**The Chairperson (Mr Ross):** I suspect that we will want to examine it a bit more closely, just to make sure that we get a good answer on what it is exactly you think may go wrong or what other existing legislation is out there that you might not be aware of. It is something that is creeping in. I understand that this is a particularly large and complex Bill, and therefore, perhaps, the argument for a clause like this is stronger than for any other Bill. I know the Justice Minister gave a strong defence of the inclusion of clause 86, although the Justice Committee went against that and refined it a little, so we may wish to look at it in further detail.

**Mrs Dobson:** Following on from Kieran's point on Part 8 about research intervention, my first question relates to clause 132(4). It appears to allow the research intervention to take place where it has "potential to benefit" P, rather than being in P's best interests. Is this compatible with the principles of the Bill outlined in Part 1?

**Ms McCaffrey:** Part 8 of the Bill really creates a regime of its own in relation to research. It is important to include people who lack capacity in research projects, because that is how we will find out more about the causes of the conditions that result in a lack of capacity. We are trying to provide a regime that puts the person who lacks capacity in a similar position to somebody who has capacity. For example, I might agree to take part in a research project knowing that it might not benefit me in any way immediately, but might in the future, or might benefit somebody else with a similar condition. What we have tried to do, therefore, is to design a regime that allows people who lack capacity to participate in research projects, while ensuring that their rights and wishes are fully protected when they do so. That is the reasoning behind the slightly different approach.

**Mrs Dobson:** The potential benefit for P is further down the road.

**Ms McCaffrey:** It might be.

**Mrs Dobson:** I note you said earlier that it would be wrong to deny people the benefit of proper research, but it is important, if they lack capacity, that it is their best interests, rather than have a potential benefit down the line. There is a wee bit of ambiguity there.

**Ms Trueman:** It could be a direct or an indirect benefit. It could simply be a matter of analysing someone's medical notes or health and social care services that they have received, or there could be a direct benefit if a new treatment is being tested and P can see the effects of that.

**Ms McCaffrey:** If we did not have a slightly different test, it might prevent something quite innocuous being done that could benefit that person in the longer term or somebody else with a similar condition. The additional clause I mentioned earlier that we have inserted ensures that where anything serious is being done, which is really where the additional safeguards in Part 2 kick in, then best interests come into play.

**The Chairperson (Mr Ross):** Really it is more likely to benefit somebody else than the individual. There is a potential benefit to P, but in these sorts of research things, nothing happens that quickly. It is more likely to benefit somebody who comes along with a similar illness in years to come.

**Ms McCaffrey:** Yes, but we have made it clear in the Bill that where that might be the case, the risk to P has to be minimal, and, for example, nothing can be done that interferes with P's freedom or is unduly invasive or restrictive. Then additional safeguards also kick in, in the form of requirements to consult with somebody who is caring for the individual. If at any point that person indicates that the person who lacks capacity does not want to take part in the research project, they have to be withdrawn. Similarly, if P shows any sign of objecting or wanting to withdraw, they cannot be involved in the research project. There are even further safeguards here around the research.

**Mrs Dobson:** The carer can override that at any point, then.

**Ms McCaffrey:** Where somebody who has been consulted as part of this additional safeguard indicates that the wishes of P are not to take part in the research, then, yes.

**Mrs Dobson:** I am concerned, as the Chair said, that it would not be in the best interests of P in this case. The research is to benefit somebody else, but yet it is inflicted on the person without capacity, without their agreement. As long as the safeguards are fully understood and someone can intervene on their behalf to stop it —

**Ms McCaffrey:** Yes.

**Mrs Dobson:** That leads me on to clause 134. Again, this clause seems to allow a researcher to go ahead with a treatment intervention on a person who lacks capacity without consulting their carer or advocate, if the research is "a matter of urgency". How can research be a matter of urgency, if we have just agreed that research is usually carried out to benefit someone with a similar disease or condition further down the line, and not the person that the research is being carried out on? This appears to me to give very wide powers to a researcher to intervene and maybe override the wishes of the carer. Would this be in their best interests? Can you outline what you mean by "a matter of urgency", and why this clause is necessary? Surely it undoes the previous one we discussed.

**Ms Trueman:** To give an example, it might be in an intensive care unit where there is a need to start the research straight away, so they might need to take a blood sample, for example, and there would not be time to consult the carer if they are not there. That is an example of where it would be urgent. However, there are additional protections there because, when you propose to do the research in the first place, you have to have a plan as to what you would do if an urgent situation arose. That plan itself must be approved before the research can go ahead. Even then, you would only do that if you did not have time to consult.

**Mrs Dobson:** Would the advocates or carers have to agree that emergency situation? How can their wishes be overridden in a matter of urgency? Who agrees this plan?

**Ms Trueman:** I suppose that the emergency would come about if the carer was not there to consult, for example. As to who agrees the plan, it would be the appropriate research body as outlined in clause 132. When a researcher puts forward a proposal, part of it is to say what they would do in an urgent situation. That has to be approved so that, if an emergency situation comes up, they adhere to the plan that has already been approved, if that makes sense.

**Mrs Dobson:** This "matter of urgency" scenario that you have outlined about giving blood: if it is for research or whatever and there is no carer there, surely logic would dictate that it would not proceed?

**Ms McCaffrey:** If it was something that needed to be done as part of the person's care, I would probably refer to the clause that we inserted into the Bill after consultation. If the treatment is serious or urgent, which you would imagine that it might be in such scenarios, then again, best interests will apply as a result of the clause that we have inserted there, because —

**The Chairperson (Mr Ross):** But if it is for research and we have already established that it is more than likely to benefit somebody else, I do not see how that works.

**Ms McCaffrey:** If it is something that would be considered a serious intervention under Part 2 of the Bill, for example, this clause would require it to meet the safeguards in Part 2, one of which is best interests, in addition to the other safeguards.

**Mrs Dobson:** Surely it is not to save someone's life or whatever; it is research. We have already teased out that it would be to benefit somebody else, so I am somewhat confused. You outlined, Lisa, about taking bloods or whatever. The Chair has referred to the line of questions about it not benefiting this person but someone else, so why is it then deemed an emergency? Why the urgency with it?

**Ms Trueman:** Because part of the research might be how you deal with emergency situations, so it might be to further develop care in such situations. That is an example of where research would come into play.

**Mrs Dobson:** I think that it is cumbersome and confusing, Chair.

**The Chairperson (Mr Ross):** It is an area that we will want to examine further in detail around examples of exactly the circumstances that we are talking about.

**Mrs Dobson:** Yes. We have only had the outline of taking bloods, but if it is not to save someone's life — if it is purely research — I am somewhat confused about how that overrules or overrides that person's advocate or carer and their rights. Perhaps we should come back to that, Chair.

Clause 136 simply states that, if someone consents to take part in a research project but during the project they lose capacity, the Department "may" make regulations to deal with that. To me, that is, again, quite heavy-handed; the use of the word "may" seems to be a very loose approach without strong safeguards for the person and their rights. There may be research projects with older people who may have fluctuating capacity, perhaps because of dementia, so I fail to see how the clause would protect them. Can you outline your rationale on how, you think, it would protect them?

**Ms Trueman:** The purpose of the clause is to catch people who have perhaps consented now to take part in research but lose capacity after the Bill comes in. That research would not have been approved, so we need to set out specific safeguards for that group of people. That is what the regulations are intended to do. They will be very similar to what is in the rest of the part on research, but obviously will have to apply more to the transitional arrangements.

**Mrs Dobson:** If they lose capacity, for example, due to dementia, then currently the Department "may" make regulations. How does that then work? If they lose capacity, is it not down to their carer or advocate?

**Ms Trueman:** Is the concern that it says "may" instead of "must"?

**Mrs Dobson:** Yes, it just seems a wee bit loose. To me, it does not strengthen the safeguards for the person concerned if this is agreed while they do have capacity, and when they do not have capacity, it is going ahead anyway. That is concerning.

**Ms McCaffrey:** This is specifically to deal with a research project that was approved before the Bill came into effect — for example, under existing law around research. This is to deal with such a case. When the Bill comes into operation and then somebody loses capacity, what happens to that project that was already approved before the Bill came into play?

It is about allowing us to make regulations in order to be able to apply to that project some of the safeguards that are in Part 8 after the Bill comes into effect. We have powers in the rest of the Bill to make regulations around transitional cases, but this provision is just to highlight the fact that we will have to make regulations around those transitional cases and define in a little more detail what they should include, specifically to make sure that the additional safeguards in Part 8 do apply.

**Mrs Dobson:** If their carer or advocate did not agree to it and they had lost capacity, would that mean it would be overridden?

**Ms McCaffrey:** One of the things we will have to look at in developing the regulations made under these provisions is exactly what parts of Part 8 will apply for those purposes. That seems to me to be a logical and sensible route.

**Mrs Dobson:** That scenario is a bit concerning, too, Chair. Thank you.

**Mr McCartney:** I will concentrate on Part 13, but can I just ask a general question? In your opening remarks, Alison, you mentioned the issue around 16-year-olds. The Bill is framed in a way that does not cover them. Are you satisfied that the protections offered in the Bill are now also there for people who are under 16?

**Ms McCaffrey:** Sorry, could you repeat the question?

**Mr McCartney:** Obviously, 16-year-olds have been left out of this. You said that there was a process, and some were for and some against. Are you satisfied that the protections for people under 16 are as robust as what is proposed in the Bill?

**Ms McCaffrey:** The point I was making in the opening remarks is that we are not really comparing like with like in relation to children and adults. This Bill reflects the current law in relation to adults around capacity and consent, which begins with that presumption of capacity, and then puts in place arrangements and protections where an adult lacks capacity to make a decision for themselves.

There is already a framework in place for children. There is no framework for adults. The framework for children is made up of the fact that this Bill will apply to 16- and 17-year-olds. There is also the

common law around children, the Children (Northern Ireland) Order 1995 itself, the concept of parental responsibility, not forgetting the Mental Health (Northern Ireland) Order 1986, which is part of the protective framework around children. Of course, we are enhancing the protections in that.

**Mr McCartney:** Yes, but those who argue that it should cover 16-year-olds would say that they should get the same protections. Are you satisfied that the protections are there?

**Ms McCaffrey:** Within the existing legal framework around children, that is the position we have adopted, and we have further enhanced the protections around children.

**Mr McCartney:** OK. Clause 256 uses the terms "ill-treats" and "wilfully neglects". Have you any definition of what those mean in reality? What is your definition of "ill-treats", and can you provide a practical example?

**Mr McCarthy:** That is something like what I asked.

**Ms Trueman:** There are no definitions in the Bill itself, as you can see, but an example of "ill-treats" or "wilfully neglects" would be where someone fails to intervene to treat someone when, for example, they knew they had a duty of care and should have intervened — if they neglected the person and just left them. An example might be giving them an injection they are due to have, or it could just be basic care needs such as helping to wash or dress them. Those would be examples of those interventions.

**Mr McCartney:** Wilful neglect has to have intent. If a person is not given an injection or even their food but the person who is supposed to give them those things says, "I didn't mean to neglect them", it would not be wilful neglect. Yet, the person has still been neglected. How do you protect yourself against that?

**Ms McCaffrey:** It is important to point out that the offence is part of a wider set of criminal law measures and a wider framework around abuse and adult safeguarding that exists at the moment. There would be a wider framework within which this offence works. This is a new additional offence to bolster what is there already.

**Mr McCartney:** Even though there are similar offences, this is a specific offence, so it needs to be defined so that someone can be indicted for it. Could neglect and wilful neglect not both be included?

**Ms Trueman:** The intention is only to include wilful neglect. It is an offence that has been lifted from the Mental Capacity Act in England, which only uses wilful neglect. It will be crucial to explain how this will work on the ground in the code of practice. That might be where more examples and case scenarios come into play.

**Mr McCartney:** We are doing something new and different, so we do not have to do a straight lift from another Act. This is an opportunity to do things as we choose. You can get neglect that is obvious, but it might not be wilful.

**The Chairperson (Mr Ross):** Has anybody been charged with that offence in England since their Act was passed?

**Ms McCaffrey:** I do not have any statistics in front of me, but I think that, in the Winterbourne View scandal last year, people were charged under the equivalent provisions in the Mental Capacity Act.

**Mr McCartney:** Are the penalties on conviction a straight lift from the English Act as well?

**Ms McCaffrey:** They differ slightly. The penalty on summary conviction in the Mental Capacity Act is, from memory, 12 months. The difference can be explained by reference to current practice in Northern Ireland around the maximum penalty on summary conviction, which is six months. My DOJ colleague can keep me right on that.

**Mr McCartney:** Is that why it is six months?

**Ms Irvine:** I believe so. The DOJ's role in the creation of the offences is to ensure that they are constructed as proper offences. We would not necessarily have set the policy objective, but Alison's

point may well be entirely correct: it is giving cognisance to six months on summary conviction being the norm.

**Mr McCartney:** The maximum on indictment is five years: is it the same in England?

**Ms McCaffrey:** Yes.

**Mr McCartney:** Under clause 258, it is not an offence to detain someone who is under 18 who is not liable to be detained under this Bill.

**Ms McCaffrey:** That reflects the current law in that a parent or guardian may well still have a role in the decision-making for someone who is under 18. That does not mean, however, that the detention of somebody who is under 18 may not be lawful in circumstances other than under this offence. It is a technical provision to reflect that 16- and 17-year-olds are still children.

**Mr McCartney:** Does that mean that, for someone under 18 who is subject to another piece of legislation or a decision made by a parent or guardian, neglect may not be pursued?

**Ms McCaffrey:** This is specifically about the unlawful detention of a person.

**Mr McCartney:** Yes.

**Ms McCaffrey:** It is just to make clear that, under the Bill, it is an offence to unlawfully detain people who lack capacity. It applies in addition to the general criminal law that would apply, for example, to false imprisonment. It does not necessarily mean that no actions would be taken or that there would be no legal repercussions. The Bill specifically says that people who lack capacity cannot be unlawfully detained.

**Mr McCartney:** Do you have a scenario in mind where that would be the case?

**Ms McCaffrey:** Where somebody might be unlawfully detained?

**Mr McCartney:** Yes, but they are not liable to the Act.

**Ms Trueman:** It might be that you unlawfully detain someone because they do not meet all the criteria for detention. The criteria could be that they might have capacity, they might not lack capacity or the act might not be in their best interests. If the grounds for detention were not met, the detention would be unlawful.

**Mr McCartney:** It says here that a person has been detained, so you are assuming that they are lawfully detained. Are you saying that they could be unlawfully detained?

**Ms Trueman:** It might be that they were detained in the first place because the conditions for detention were met. It might be that, a week or two into the detention, it transpires that the conditions are no longer met; for example, the person might regain capacity. In that case, it would be unlawful to continue that detention.

**Mr McCartney:** Is that for someone under 18, or does it apply in all cases?

**Ms Trueman:** That is under the Bill.

**Mr McCartney:** This relates specifically to someone under 18. It is as if you are making a separate category for someone under 18.

**Ms Trueman:** For 16- and 17-year-olds.

**Ms McCaffrey:** It is for 16- and 17-year-olds because the Bill applies only to people over 16. It is in that category of 16- and 17-year-olds where there may still be a role —

**Mr McCartney:** What do you see being there specifically for a 16- or 17-year-old that is not there for an 18-year-old? Is it parental consent?

**Ms McCaffrey:** It reflects the fact that a parent still has a role until the child reaches the age of 18, albeit a diminishing role.

**Mr McCartney:** Clause 257(5) states:

*"The Department may by regulations amend subsection (3)."*

Will those regulations be subject to public consultation? What is the process for amending the regulations?

**Ms Trueman:** I believe that the intention is to have a public consultation on the regulations but that will happen once the Bill is enacted. The project team that is in place, working alongside the Bill's passage, is drafting regulations, and drafts will be shared with key stakeholders, hopefully, by the end of the year. The public consultation will not happen until the Bill is enacted.

**Mr McCartney:** Should that be referred to in the Bill?

**Ms Trueman:** I do not think that consultation on regulations is something that you would put in a Bill.

**Mr McCartney:** Where would you put it? In the schedule or just leave it —

**Ms McCaffrey:** Unless you wanted a specific body or organisation to be consulted, the normal practice would be to consult.

**Mr McCartney:** OK, thank you.

**The Chairperson (Mr Ross):** In what year do you reckon enactment will be?

**Ms Trueman:** I am sorry; what was the question?

**The Chairperson (Mr Ross):** It does not matter. I am just referring to Second Stage, when the amount of money that it will cost was discussed. That money is not currently in the Executive, and I wonder whether the Bill will ever be enacted and whether we will ever go out to consultation. It was a flippant remark; I do not need an answer to it.

**Ms McCorley:** Go raibh maith agat, a Chathaoirigh. I want to ask about clause 272. What is the impact of giving effect to the Convention on the International Protection of Adults signed at the Hague in 2000?

**Ms Trueman:** The impact of that would be to provide greater protections for people who are abroad.

**Ms McCorley:** OK, right. Clause 273 deals with giving consents under the Human Fertilisation and Embryology Acts 1990 and 2008: what would consent in those cases mean?

**Ms McCaffrey:** The purpose of clause 273 is to make clear that any decisions that are made in relation to actions under those Acts fall outside the scope of the Bill. Anything that could be done under those Acts falls outwith the scope of the Bill.

**Ms McCorley:** Right, OK, so they are nothing to do with it. I want to move onto clause 292. Why is "mental disorder" specifically defined when one of the key purposes of the Bill is to remove stigmatising references to mental disorders?

**Ms Trueman:** The purpose of the clause is in relation to a provision in Part 12. It is to provide 16- and-17-year-olds with an additional protection so that they are in child-appropriate accommodation, for example. We use the term "mental disorder" in that clause, which is why we then had to define it in clause 292.

**Ms McCorley:** OK, so it is in relation to it being a term that is used in an existing part of the Bill.

**Ms Trueman:** Yes, it is in another part of the Bill. It is an additional protection that we have given to 16- and-17-year-olds. Because we reference the term "mental disorder", we then need to define it, which is why it appears in clause 292.

**Ms McCaffrey:** The core framework does not differentiate at all in relation to decisions relating to mental disorder or a physical disorder.

**Ms McCorley:** I have another question. I think that it is on clause 131 or 132. It is about clinical trials and research. Is there a grey area between what could be defined as clinical trials and research? For instance, it says that it is not appropriate for use in clinical trials but is about laying out how you treat research. Is there a grey area that could come between the two?

**Ms Trueman:** Clinical trials is a very specific area of research. It is more broad under the Bill. Basically, the purpose of that clause is to make it clear that there is separate legislation that deals with clinical trials. There will be rules and safeguards around clinical trials that will apply. It will probably be something that we will have to make clear in training and, again, in the code of practice, so that people are clear on that. It is really just a declaratory provision.

**Ms McCorley:** I did see that that was what it was setting out to do, but I just wondered whether there could be ambiguous areas or types of actions that might fall between the two.

**Ms McCaffrey:** I think that that is probably a good point and why the measures that are in Part 8 are important. Anything that is being done in research involving a person who lacks capacity has to be approved by an appropriate body. So, at that point, you would imagine that any grey areas could be resolved and dealt with.

**Ms McCorley:** Dead on. That is OK. I have one last question. Clause 135, which deals with safeguards, states:

*"The interests of P must be assumed to outweigh those of science and society."*

Is that really robust enough? Why would you not say that the interests of P "must" outweigh those of science and society rather than "must be assumed"?

**Ms McCaffrey:** That is a direct lift from one of the existing conventions or agreements around research that applies at the moment. This part of the Bill is trying to increase the safeguards, so that subsection is one of a number of additional protections and safeguards that the Bill will bring in for people involved in research projects.

**Ms McCorley:** Is there a reason why you might not say "must outweigh"?

**Ms Trueman:** I suppose that, by saying "assumed to" be, it means that, as a starting point, it must be that the interests outweigh those of science or society. It is really a fundamental starting point.

**Ms McCorley:** So you are saying that it is robust enough.

**Ms Trueman:** It is certainly our view that it is robust enough.

**The Chairperson (Mr Ross):** Can I return to the first question that Rosie asked around clause 272? I still do not really understand it. It:

*"gives effect in Northern Ireland to the Convention on the International Protection of Adults signed at the Hague".*

Does that mean that it does not currently have effect?

**Ms McCaffrey:** Are you asking whether it does not currently apply?

**The Chairperson (Mr Ross):** Yes, is that what we are saying?

**Ms McCaffrey:** That convention is not part of domestic law here at the moment, so the purpose of that clause, if it is commenced, will be to give effect in Northern Ireland to the provisions that are in that convention.

**The Chairperson (Mr Ross):** So, currently, it does not apply in Northern Ireland.

**Ms McCaffrey:** It does not.

**The Chairperson (Mr Ross):** Remind me, what benefit does that give us? What are the practical outworkings of that?

**Ms McCaffrey:** Essentially, it provides protection for people who lack capacity who maybe travel or move abroad. Similarly, it protects people from other countries who come into Northern Ireland either on holiday or more permanently. It provides for the mutual recognition of an enforcement of protective measures around people who lack capacity.

**The Chairperson (Mr Ross):** In clause 273(1)(g) and (h) about giving consent under the Human Fertilisation and Embryology Act 1990 and the Human Fertilisation and Embryology Act 2008, can you give us examples of what exactly we are talking about?

**Ms Trueman:** I think that that might relate to fertility treatment, for example, and that would not fall within the scope of the Bill.

**The Chairperson (Mr Ross):** OK. Are there any other questions from members?

**Mr McCartney:** In relation to clause 262 — offences by bodies corporate — if someone within the named organisations in the explanatory notes commits an offence, is the corporate body also open to charge, or does it have to be proven that it was done with their connivance?

**Ms Trueman:** The purpose of that clause is to make it clear that bodies corporate would be liable for an offence committed under the Bill and not just the body itself; for example, it could be the director, the manager or secretary of that body corporate.

**Mr McCartney:** OK. Thank you.

**The Chairperson (Mr Ross):** No one else has any questions. Thank you very much. I appreciate that.