



**Law
Commission**
Reforming the law

Mental Capacity and Deprivation of Liberty



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(Law Com No 372)

Mental Capacity and Deprivation of Liberty

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The Law Commission

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Glossary of terms used in this report

Acid test	The test set out by Lady Hale in the <i>Cheshire West</i> case to determine if a person who lacks the requisite capacity is being objectively deprived of their liberty, namely that the person is not free to leave and is under continuous supervision and control.
ADASS	Association of Directors of Adult Social Services.
Advance decision	A decision to refuse specified medical treatment made in advance by a person who has capacity to do so. This decision will then apply at a future time when that person lacks capacity to consent to, or refuse, the specified treatment. This is set out in section 24 of the Mental Capacity Act 2005.
Appropriate person	A family member or other private individual able and willing to support and represent an adult (instead of an advocate) for certain decisions under the Care Act 2014 and the Social Services and Well-being (Wales) Act 2014.
Bournewood gap	The failure to provide Article 5 ECHR safeguards to compliant incapacitated persons being admitted “informally” to hospital rather than under the Mental Health Act 1983. This gap was identified by the Strasbourg court in the case of <i>HL v United Kingdom</i> (2005) 40 EHRR 32 (App No 45508/99) and was named after Bournewood Hospital, where HL had been detained.
Care Act	Care Act 2014.
Cared-for person	The term used in our draft Bill to describe the person who is or may be subject to arrangements authorised under the Liberty Protection Safeguards. It is a drafting term and not used in this report. Instead the report refers to the “person”.
Cheshire West	<i>P v Cheshire West and Chester Council</i> and <i>P and Q v Surrey County Council</i> [2014] UKSC 19.
Community treatment order	The legal authority under section 17A of the Mental Health Act 1983 for the discharge of certain patients from detention in hospital, subject to the possibility of recall to hospital for further medical treatment if necessary. Patients are expected to comply with the conditions specified in the community treatment order.
Conditional discharge	The discharge from hospital by the Secretary of State for Justice or a mental health tribunal of a restricted patient under the Mental Health Act 1983 subject to conditions. The patient remains subject to recall to hospital by the Secretary of State.

Consultation analysis	Law Commission, <i>Mental Capacity and Deprivation of Liberty: Consultation Analysis</i> (2017).
Consultation paper	Mental Capacity and Deprivation of Liberty (2015) Law Commission Consultation Paper No 222.
Deputy	A person authorised by the Court of Protection to make decisions on behalf of a person who lacks capacity. Deputies can be appointed to make decisions relating to property and financial affairs, and/or personal welfare.
Deeming rules	These provide that a person's ordinary residence remains with the local authority in which they were ordinarily resident immediately before moving into accommodation. So if, for example, a person has been placed by local authority A, into a care home in the area of local authority B, their ordinary residence remains with local authority A.
DoLS	Deprivation of Liberty Safeguards, contained in Schedule A1 to the Mental Capacity Act 2005.
DoLS Code of Practice	Ministry of Justice, <i>Mental Capacity Act 2005: Deprivation of Liberty Safeguards: Code of Practice to Supplement the Main Mental Capacity Act 2005 Code of Practice</i> (2008).
Donee	Someone appointed under a lasting power of attorney who has the legal authority to make decisions on behalf of the person (the donor) who made the lasting power of attorney. A lasting power of attorney can relate to health and welfare, and/or property and financial affairs.
Draft Bill	The Mental Capacity (Amendment) Bill contained in appendix A to this report.
ECHR	Convention for the Protection of Human Rights and Fundamental Freedoms (Rome, 4 November 1950) (European Convention on Human Rights)
Estyn	Office of Her Majesty's Inspectorate for Education and Training in Wales. It inspects and regulates services providing education and skills in Wales.
Fusion law	This term is commonly used to describe a single legislative scheme governing the non-consensual care or treatment of people suffering from physical and/or mental disorders, whereby such care or treatment may only be given if the person lacks the capacity to consent.
Gillick competence	A child under the age of 16 who is considered to have sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention that requires consent and who is therefore competent to consent to that intervention. The name refers to the case of <i>Gillick v West Norfolk and Wisbech Area Health</i>

Authority [1985] UKHL 7. Gillick competence is now considered to extend to consenting to admission to hospital as well as medical treatment.

Guardianship	The appointment under the Mental Health Act of a guardian to help and supervise people (aged 16 or over) in the community for their own welfare or to protect other people. The guardian may be either a local authority or someone else approved by a local authority (a private guardian).
Hospital order	An order by a court under Part 3 of the Mental Health Act for the detention for medical treatment in hospital of a mentally disordered offender, given instead of a prison sentence or other form of punishment. Hospital orders are normally made under section 37 of the Act.
Impact assessment	Law Commission, <i>Mental Capacity and Deprivation of Liberty: Impact Assessment</i> (2017).
Independent Mental Capacity Advocate	An advocate instructed under the Mental Capacity Act 2005 who is responsible for supporting and representing a person who lacks capacity to make certain decisions.
Independent Mental Health Advocate	An advocate who is responsible for supporting and representing a person who is subject to the Mental Health Act 1983.
Interim statement	Law Commission, <i>Mental Capacity and Deprivation of Liberty: Interim Statement</i> (2016).
LGA	Local Government Association.
Mental Capacity Act	Mental Capacity Act 2005
<i>Mental Capacity Act Code of Practice</i>	Department for Constitutional Affairs, <i>Mental Capacity Act 2005: Code of Practice</i> (2007).
Mental Health Act	Mental Health Act 1983
Mental health tribunal	The First-tier (Mental Health) Tribunal in England and the Mental Health Review Tribunal for Wales.
NHS continuing health care	A complete package of ongoing care arranged and funded solely by the NHS where it has been assessed that the person's primary need is a health need.
Ofsted	The Office for Standards in Education, Children's Services and Skills. It inspects and regulates services for children and young people and services providing education and skills in England.

Ordinary residence	This concept is used to establish which local authority is responsible for arranging care and support to a person with needs.
Private and domestic settings	Accommodation which is non-specialist and not intended specifically for occupation by disabled and older people. This description would cover, for instance, a person with learning disabilities who is living at home with their parents or a disabled person living on their own in a rented flat under a tenancy agreement.
Relevant person's representative	A representative appointed under the DoLS to maintain contact with and represent and support a person deprived of liberty. They are often a friend or relative of the person who is willing to act in this capacity, although they can also be a paid professional.
Responsible clinician	The clinician that has overall responsibility for care and treatment for certain patients being assessed and treated under the Mental Health Act.
Restriction order	An order under section 41 of the Mental Health Act, which is made in addition to a hospital order. The main effects are that the patient cannot be given leave of absence or be transferred to another hospital without the consent of the Secretary of State for Justice, and may not be discharged except by the Secretary of State or the mental health tribunal.
Section 131 of the Mental Health Act	This provision sets out that a patient can be admitted to hospital and receive treatment for their mental disorder informally, without being detained under the Mental Health Act.
Section 17 of the Mental Health Act	The power to grant leave to a patient detained under the Mental Health Act. Patients remain under the powers of the Act when they are on leave and can be recalled to hospital if necessary in the interest of the patient's health or safety or for the protection of other people.
Shared lives	A service that normally involves placements of disabled people in family homes where they receive care and support from a shared lives carer and have the opportunity to be part of the carer's family and support networks. In Wales this is referred to as adult placements.
Social Services and Well-being (Wales) Act	Social Services and Well-being (Wales) Act 2014
Strasbourg court	The European Court of Human Rights.
Supported living	Specialist or adapted accommodation or accommodation intended for occupation by people with care and support needs in which personal care is also available.

UN Convention on the Rights of Persons with Disabilities

Convention on the Rights of Persons with Disabilities (adopted 13 December 2006, entered into force 3 May 2008) 2515 UNTS 3 (CRPD)).

Zone of parental responsibility

Decisions concerning a child or young person that can be authorised by the consent of someone with parental responsibility for that child or young person. It is also referred to as the scope of parental responsibility.

Chapter 1: Introduction

- 1.1 It is now over 12 years since the European Court of Human Rights in Strasbourg handed down the landmark judgment in *HL v United Kingdom*.¹ This judgment identified a gap in the law, known as the “Bournewood gap”, as a result of which a group of people who lacked capacity to consent to treatment were being deprived of liberty for the purpose of mental health treatment under the common law, rather than under the Mental Health Act. The court held that this group were being denied the necessary procedural safeguards demanded by Article 5 of the European Convention on Human Rights (“ECHR”). In fact, this gap in protection dated back to the Mental Health Act 1959, which sought to enable mental health patients to enter hospital informally wherever possible, and was continued under section 131 of the Mental Health Act 1983.
- 1.2 A scheme for the assessment and authorisation of such deprivations of liberty was introduced by the Mental Health Act 2007 in order to close this gap. This applied not only in psychiatric hospitals but also in general hospitals and care homes in which people who lacked capacity to consent to their living arrangements were being deprived of liberty. The 2007 Act did this by adding a number of sections and two new schedules to the Mental Capacity Act 2005; these became known as the Deprivation of Liberty Safeguards (or “DoLS”).
- 1.3 It is therefore a matter of considerable concern that the law is still failing to deliver Article 5 safeguards to many people who lack capacity to consent to their care or treatment and are being deprived of their liberty. The official figures show, for example, a significant backlog of cases referred for authorisation under the DoLS, with the legal timescales for DoLS assessments being routinely breached and a significant number of cases not being assessed at all.² As detailed in this report, we have also received evidence of significant delays in reviews and renewals of DoLS authorisations, and that many NHS bodies and local authorities are not even considering deprivation of liberty cases outside hospital and care home settings or involving 16 and 17 year olds.³
- 1.4 This situation arises from the vastly increased number of cases in which deprivation of liberty needs to be authorised as a result of the 2014 Supreme Court judgment known as “*Cheshire West*”.⁴ This judgment gave a significantly wider definition of deprivation of liberty than had been previously understood (both by public authorities and the lower courts) to apply in the health and social care context. However, the difficulties associated with the DoLS pre-date 2014. Reporting on the situation pre-*Cheshire West*, the House of Lords Select Committee on the Mental Capacity Act found that the DoLS were “frequently not used when they should be, leaving individuals without the safeguards Parliament intended” and care providers “vulnerable to legal challenge”.

¹ *HL v UK* (2005) 40 EHRR 32 (App No 45508/99). This case is summarised in para 2.15 of this report.

² NHS Digital, *Mental Capacity Act (2005) Deprivation of Liberty Safeguards (England): England 2015-16 National Statistics* (2016). See also paras 2.22 to 2.24 of this report.

³ These cases cannot be authorised under the DoLS and require a much more costly application to the Court of Protection. For example, see paras 4.17 to 4.18.

⁴ *P v Cheshire West and Chester Council; P and Q v Surrey County Council* [2014] UKSC 19. The *Cheshire West* case is discussed from para 2.16.

The Committee concluded that “the legislation is not fit for purpose” and proposed its replacement.⁵

- 1.5 The statutory provisions for the DoLS are generally regarded as convoluted and tortuous. In *C v Blackburn with Darwen Borough Council* Mr Justice Peter Jackson observed:

It is a truly unhappy state of affairs that the law governing the fundamental rights and welfare of incapacitated people should be so complex. As this case shows, its intricacies challenge the understanding of professionals working in the field and are completely inaccessible to those for whose benefit the legislation has been devised, including those with a relatively high level of understanding, such as Mr C.⁶

- 1.6 Mr Justice Mostyn described one aspect of the legislation as:

a thicket of legislative drafting which seems to be designed to confuse and which is characterised by extreme opacity ... [T]he legislative scheme and language here is a veritable smorgasbord of double negatives and subordinate clauses, requiring a navigational exercise from provision to provision, which is an arduous task even for someone who administers justice in this field on a regular basis.⁷

- 1.7 This project represents a major and unique opportunity to overhaul the legal framework and address these problems. The recommendations set out in this report would create a clear and accessible scheme for authorising arrangements which give rise to a deprivation of a person’s liberty, which is capable of delivering practical and effective Article 5 rights.

THE REMIT OF OUR PROJECT

- 1.8 The purpose of the project was to consider how the law should protect people who lack capacity to consent to their care or treatment and need to be deprived of their liberty in order to receive that care or treatment. Article 5 of the ECHR provides that everyone has the right to liberty and security of the person.⁸ No one may be deprived of liberty except in six specified cases, including the detention of “persons of unsound mind” in accordance with a procedure prescribed by law. If a person is deprived of liberty, certain safeguards must be provided; these include entitlement to take proceedings by which the lawfulness of the detention is decided speedily by a court, and the person’s release if the detention is not lawful.

- 1.9 However, the project does not only address Article 5. It also considers Article 8 of the ECHR, which protects an individual’s right to private and family life.⁹ The Strasbourg court has recognised that “any deprivation of liberty ... entails by its nature a limitation on private and family life”.¹⁰ A person deprived of liberty continues to enjoy “all the

⁵ House of Lords Select Committee on the Mental Capacity Act: Report of Session 2013-14: Mental Capacity Act 2005: Post-legislative Scrutiny (2014) HL 139, para 32.

⁶ *C v Blackburn with Darwen BC* [2011] EWHC 3321 (COP), (2012) 15 CCLR 251 at [24].

⁷ *An NHS Trust v A* [2015] EWCOP 71, [2016] Fam 223 at [8], referring to sch 1A to the Mental Capacity Act, dealing with the interface between the DoLS and the Mental Health Act.

⁸ See also para 2.2 of this report.

⁹ See also para 2.3 of this report.

¹⁰ *Messina v Italy (No 2)* App No 25498/94 at [61].

fundamental rights and freedoms guaranteed under the ECHR save for the right to liberty”, and Article 8 demands that “when a person’s personal autonomy is already restricted, greater scrutiny be given to measures which remove the little personal autonomy that is left”.¹¹

- 1.10 The Strasbourg court has identified the need for steps to be taken to ensure that interferences with Article 8 rights are not arbitrary (both in the sense of complying with domestic law and in the broader sense of compatibility with the rule of law). The court has also emphasised that the greater the interference with the right to autonomy of a person of impaired decision-making capacity and / or with mental health problems, the stricter are the procedural safeguards that Article 8 requires.¹²
- 1.11 The project concerns mental capacity law in England and Wales. Legislative competence for mental health is devolved to the Welsh Assembly (subject to certain specific exceptions) under paragraph 9 of schedule 7 to the Government of Wales Act 2006. The law on mental capacity is part of general civil law and is not devolved. The Mental Capacity Act, including the DoLS, applies to England and Wales. However, it is Welsh Ministers who make regulations in respect of Wales under the DoLS. The Wales Act 2017 (due to come into force in 2018) provides expressly for the subject matter of the Mental Capacity Act to be reserved to the UK Government and that all regulation-making powers are transferred to the Welsh Ministers.
- 1.12 The remit of the project did not extend to Scotland or Northern Ireland. Separate mental capacity legislation applies there.¹³
- 1.13 As discussed further from para 13.17, the remit of the project did not extend to consideration of “fusing” mental capacity and mental health law (whether along the lines of the Mental Capacity Act (Northern Ireland) 2016 or otherwise). Further, it was outside our remit to seek to undertake a wholesale revision of the Mental Capacity Act to address all the potential demands that the UN Convention on the Rights of Persons with Disabilities might be said to make in the context of legal and mental capacity. This Convention is discussed from para 2.5 and appendix B.

STRUCTURE OF THE PROJECT

- 1.14 This project originated from a proposal from Mind for a review of the relationship between the DoLS and the Mental Health Act. In the light of the House of Lords Select Committee’s report and the *Cheshire West* decision, the Department of Health originally asked the Law Commission to undertake a limited review of deprivations of liberty in supported living arrangements and other community settings, and to consider the learning that could be applied to the DoLS.¹⁴ The project was included as part of the Law Commission’s 12th programme of law reform published in 2014. Following subsequent engagement and discussion with stakeholders, Ministers agreed that it would be more appropriate for the Law Commission to consider the legislation

¹¹ *Munjaz v UK* [2012] ECHR 1704 (App No 2913/06) at [79] to [80].

¹² See *Shtukaturov v Russia* (2012) 54 EHRR 27 (App No 44009/05), *X v Finland* [2012] ECHR 1371 and *Lashin v Russia* (2013) No 33117/02.

¹³ Adults with Incapacity (Scotland) Act 2000 and Mental Capacity Act (Northern Ireland) 2016.

¹⁴ Valuing Every Voice, Respecting Every Right: Making the Case for the Mental Capacity Act: The Government’s Response to the House of Lords Select Committee Report on the Mental Capacity Act 2005 (2014) Cm 8884, paras 7.27 and 7.29.

underpinning the DoLS in its entirety, in addition to our work on community settings (including supported living). This was formalised by a reference from the Department of Health to the Law Commission under section 3(1)(e) of the Law Commissions Act 1965.

1.15 The project was divided into three stages:

Stage 1: Pre-consultation	
Summer 2014 – July 2015	Meetings with stakeholders and drafting of a consultation paper
Stage 2: Public consultation	
7 July 2015	Publication of the consultation paper with provisional proposals for reform
7 July – 2 Nov 2015	Public consultation on the proposals
25 May 2016	Publication of an interim statement
Stage 3: Final Report and Draft Bill	
13 March 2017	Publication of the final report (setting out our final recommendations and draft Bill), consultation analysis and impact assessment.

1.16 Our project has benefited greatly from the strong and ongoing support of the Department of Health and the Welsh Government. Throughout the life of the project, we have met regularly with officials from the Department of Health, as the sponsoring department for this project, and the Welsh Government. These meetings have been invaluable in providing us with expert assistance and updates on developments in Government policy. Our recommendations represent, however, our own independent view of the best way forward.

Public consultation

1.17 We published the consultation paper on 7 July 2015. The paper contained 55 provisional proposals and 42 consultation questions. The public consultation period ran from publication until 2 November 2015. During this period we attended 83 events across England and Wales. These events covered a wide audience, including service users, patients, family members and other unpaid carers, health and social care professionals, academics, lawyers, service providers, regulatory bodies, and voluntary, charitable and campaigning organisations.

1.18 At each of the consultation events we attended, we received a wide range of views on various different aspects of our proposals. As a general observation, we were struck by the widespread support for our project and the need to reform this area of law as a matter of priority. A number of people shared with us the difficulties they were experiencing in relation to the DoLS. For example, care home staff told us that the whole

process had become a “rubber stamping exercise” which did not benefit the person concerned in any way, and family carers recalled their anger at being told that their loved ones were being deprived of their liberty, even though nobody objected to the care regime in place. Social care and health professionals frequently expressed their frustration at the sheer volume of cases they were expected to put through the DoLS assessment process and how the time spent on this impeded their ability to provide mainstream care and treatment. We also received evidence on current practice – such as on how practitioners carry out DoLS assessments, on the challenges presented by the current economic climate and about the practical difficulties in accessing the Court of Protection – which has been of enormous benefit in shaping our final recommendations.

- 1.19 We received 583 written responses to the consultation paper, from a range of different individuals and organisations. As a result of consultation, all of our proposals have been reviewed, and the vast majority have been revised or altered, some substantially. The consultation analysis is published alongside this report. We extend our gratitude to all those who participated in our consultation process.
- 1.20 The appendices to this report contain the draft Bill and explanatory notes, a statement on the compatibility of the draft Bill with the ECHR and the UN Convention on the Rights of Persons with Disabilities, and a list of our final recommendations.

AN OVERVIEW OF OUR RECOMMENDATIONS

- 1.21 Our task has been to design a scheme for the authorisation of deprivations of liberty that works better than the DoLS. Our recommended scheme, which we have called the Liberty Protection Safeguards, serves the same essential purpose as the DoLS and we have sought to make use where possible of existing mechanisms and procedures provided by health and social care and mental capacity legislation. Those with experience of these areas of law will notice a number of elements that are familiar. But in designing the Liberty Protection Safeguards we have in particular removed those features of the DoLS that we have identified as both inherently inefficient and indeed actively detrimental to the interests of people who are deprived of their liberty.
- 1.22 The DoLS require the care home or hospital in which a person is deprived of liberty to apply to a “supervisory body” – in most cases a local authority – for authorisation of the deprivation of liberty. They do not apply at all to deprivations of liberty in other settings in which people who lack mental capacity are commonly deprived of liberty, such as supported living and shared lives accommodation (these and other terms are explained in the glossary at page 1 of this report). Where deprivation of liberty occurs in those other settings an authorisation currently needs to be (but in practice is usually not) obtained from the Court of Protection.
- 1.23 In many cases the person to whom the application for authorisation relates has been placed in the care home by the social services department of the same local authority as has responsibility for granting a DoLS authorisation. Requiring the application to be made by care home managers and staff places on them a form-filling obligation that is quite unnecessary. It also means that the formal process of considering whether it is necessary and proportionate to deprive the person of their liberty only begins after the decision to subject the person to a deprivation of liberty has already been taken by the local authority.

- 1.24 Indeed, we have frequently been told that as a result of the pressures that local authorities are currently under, applications are often not made until the person has arrived at the care home. The DoLS enable care home managers and staff to grant themselves an “urgent authorisation” at the same time as applying to the supervisory body (a procedure that was not designed simply to enable authorisations to be applied for late in the day). We have been told that the paperwork burden associated with an urgent authorisation is onerous in itself. Urgent authorisations last for seven days, extendable by the local authority to 14 days, after which only a “standard” authorisation can legitimise the continued deprivation of liberty. Local authorities are – in most cases – currently not issuing standard authorisations within anything like that timeframe, leaving people unlawfully deprived of their liberty and care homes exposed to civil liability. The same can also be said in relation to those hospital settings where individuals are deprived of their liberty.
- 1.25 Once an application is made, the DoLS procedure requires a number of assessments to be carried out on behalf of the supervisory body in order to determine whether the deprivation of liberty is justified. This is a paperwork-heavy process, involving six separate assessments of varying degrees of complexity. Much of the assessment process goes over the same ground as has already been traversed by health and social care professionals in deciding to make the placement in the first place. In many (though not all) cases there will be no realistic alternative to granting the authorisation because the person’s condition makes a deprivation of liberty necessary. Those undertaking the assessment process are, nevertheless, directed to consider whether the deprivation of liberty is in the person’s best interests. It is not surprising that many of the best interests assessors told us that they feel they are engaged in a “rubber-stamping” exercise, particularly where the deprivation of liberty is already in place.
- 1.26 It is further clear from the evidence provided to us, and contained in the report by the House of Lords Select Committee on the Mental Capacity Act, that best interests decisions regularly fail to give essentially any weight to – let alone prioritise – the person’s wishes and feelings before arrangements are made to deprive them of their liberty. Cases such as *London Borough of Hillingdon v Neary* and *Essex County Council v RF* (summarised in the box below) illustrate the consequences of such failures.¹⁵

London Borough of Hillingdon v Neary

Stephen Neary was a young man with autism and learning disabilities. He lived at home with his father, with high levels of support services funded by Hillingdon Council. Steven lacked capacity to decide where or with whom he should live. In December 2009, his father reported to social workers that he was having difficulties coping. The local authority arranged for Steven to stay in a residential support unit. However, staff found Steven’s behaviour very challenging, particularly around food, and were concerned about him returning home. His father wanted him to stay for a couple of days but agreed to an extension of a couple of weeks in the expectation that Steven would then return home. In fact, the local authority kept Steven at the facility for a year, including a period when he was subject to the DoLS regime.

The Court of Protection held that Steven had been unlawfully detained and ordered that he must return home to live with his father. The court noted, in particular, that the local

¹⁵ *Hillingdon LB v Neary* [2011] EWHC 1377 (COP), [2011] 4 All ER 584 and *Essex CC v RF* [2015] EWCOP 1.

authority did not properly discuss its concerns or its plans with Steven's father, and that Steven expressed a desire to return home. The decision-making processes of the local authority were criticised by the court. The local authority was seen to be wearing "a number of hats" and it should have been made clear who was responsible for its direction. One sub-department of social services was responsible for social work, another for running facilities such as the support unit and senior social workers represented the supervisory body for authorising the deprivation of liberty. This resulted in a situation whereby there was an absence of decision-making where nobody was truly in charge. According to the judge, "the tail of service provision, however expert and specialised, should not wag the dog of welfare planning".

Essex County Council v RF

RF was a 91 year old retired civil servant, who had served as a gunner with the RAF during the war. He had lived alone in his own house with his cat Fluffy since the death of his sister in 1998. He was described as being a very generous man ready to help others financially if he believed they needed it, as well as making donations to various charities. He had dementia, and other health problems including difficulty in mobilising, delirium and kidney injury caused by dehydration. There were concerns regarding his finances and his vulnerability to exploitation. There were also issues as to his self-care.

In May 2013, RF was removed from his home by the local authority. The precise circumstances of his removal were contested, but the court noted that it appeared that he was removed in his dressing gown without trousers or pyjama bottoms and the social worker involved threatened to call the police if he did not leave. He was placed in a locked dementia unit. It was not clear that RF lacked capacity at the time and he was removed without any authorisation. When DoLS authorisations were belatedly put in place, they included, for a period, restrictions on his attendance at church and contact with friends. The local authority eventually accepted that he had been unlawfully deprived of his liberty for a period amounting to approximately 13 months, the total period of his deprivation of liberty amounting to 17 months, throughout which RF had been consistently asking to return home. Endorsing a consent order awarding RF substantial damages, the judge noted that he had been greatly troubled by the manner of RF's removal and placement, there being no evidence that consideration was given to the less restrictive option of supporting him at home in accordance with his wish to remain there. Further, as one of the triggers for the man's removal was said to have been concern about the risk to him from financial abuse, the judge "fail[ed] to understand why P's removal from his home of 50 years was considered to be a reasonable and proportionate solution to the problem or why his removal and detention was thought to be in his best interests".

- 1.27 The Liberty Protection Safeguards would dispense with the current carousel-like process in which, for example, a local authority makes a decision to place the person in a care home, the care home applies to the local authority for authorisation of the resulting deprivation of liberty and the local authority then decides whether to authorise a deprivation of liberty that they have already arranged. Our scheme would also bring forward formal consideration of the justification for a deprivation of liberty so that it occurs before the arrangements are made. It would remove urgent authorisations, replacing them with a statutory authority to deprive someone of liberty temporarily in truly urgent situations and in sudden emergencies, but only to enable life sustaining

treatment or to prevent a serious deterioration in the person's condition. Apart from those cases, it would not be possible under our scheme to impose a deprivation of liberty on someone until the proposed arrangements have been authorised.

- 1.28 Our intention in recommending this is to give prominence to issues of the person's human rights, and of whether a deprivation of their liberty is necessary and proportionate, at the stage at which arrangements are being devised. We want decision-makers to survey the range of possible options whilst they are all still options, before deciding in favour of an option that gives rise to a deprivation of liberty. An authorisation under the Liberty Protection Safeguards would not be an after the event exercise, or a rubber stamp of a decision already taken. The need to obtain it imposes discipline on the care and treatment planning process itself.
- 1.29 A DoLS authorisation simply authorises "deprivation of liberty". By contrast, an authorisation under the Liberty Protection Safeguards would authorise particular *arrangements* for a person's care or treatment insofar as the arrangements give rise to a deprivation of liberty. This is an important difference. It focuses attention at the authorisation stage not simply on the binary question of whether a person should be deprived of their liberty or not, but on the question of the ways in which a person may justifiably be deprived of liberty. Consideration of whether a deprivation of liberty is necessary and proportionate has always been a requirement of the Strasbourg case law. Our scheme would require the decision-maker to apply that test to any proposed arrangements which would give rise to a deprivation of liberty.
- 1.30 One of the inefficient aspects of the DoLS is that an authorisation is rigidly tied to one setting within the limited range of settings to which the DoLS apply. If a care home resident who needs to be deprived of liberty is admitted to hospital, a fresh DoLS authorisation must be obtained in the respect of the stay in hospital (and again on return). The Liberty Protection Safeguards would provide for an authorisation which can cover more than one setting, so as to take account of planned admissions to, for example, hospitals and respite care, and also arrangements for the person's travel between venues. We are also recommending a streamlined renewal process where an authorisation is due to expire.
- 1.31 Consistently with bringing human rights considerations formally into the initial decision-making process, the responsible body for authorising a deprivation of liberty under the Liberty Protection Safeguards would be the local authorities and hospital managers that are commissioning the person's care or treatment arrangements that will give rise to the deprivation of liberty.¹⁶ This replaces the "supervisory body" under the DoLS, which is normally a local authority. This is necessary in order to make the authorisation process truly part of the care or treatment planning process. It also removes from local authorities in England the burden that they currently undertake of authorising deprivations of liberty in hospital settings, and would help to ensure that the NHS becomes an active partner in protecting people's Article 5 rights.
- 1.32 Our recommended decision-making process requires the local authority or NHS decision-makers to have formally assessed the deprivation of liberty as being justified. That assessment then needs to be confirmed in an internal review or, in two categories of sensitive cases, to be confirmed following a separate assessment by an Approved Mental Capacity Professional. This new role is modelled on that of the Approved Mental

¹⁶ In the case of self-funders where there is no commissioning body, the responsible body will be a local authority.

Health Professional in mental health legislation; we intend it to involve similar levels of professional qualification and independence.

- 1.33 The requirement of approval by an Approved Mental Capacity Professional applies in cases where it appears that the person does not wish to reside or receive care or treatment at a particular place or proposed accommodation, or if the arrangements are wholly or mainly for the protection of people other than the person being placed.
- 1.34 These procedures are designed to make the authorisation process more streamlined than the DoLS while giving further protection, in particular, to people who object to their proposed placement. We believe that our two-tiered approach, with independent reviewers and Approved Mental Capacity Professionals, strikes a proportionate balance between responding efficiently to the volume of cases requiring authorisation since *Cheshire West* and giving proper safeguards to people whose objections are too easily over-ruled under the current law.
- 1.35 The restructuring of the authorisation process that we put forward under the Liberty Protection Safeguards is designed to make the safeguarding of the right to liberty more effective. It is accompanied by enhanced rights to advocacy, and periodic checks on the care or treatment arrangements.
- 1.36 Other aspects of our recommended reforms would improve decision-making across the Mental Capacity Act as a whole, not just in relation to people deprived of liberty. All decision-makers would be required to consider the person's ascertained wishes and feelings when a best interests determination is being made. Furthermore, professionals would be unable to rely on the Mental Capacity Act section 5 defence in respect of certain key decisions unless there is a contemporaneous written record.¹⁷ The record must include (amongst other matters) confirmation that a formal capacity assessment has been undertaken and rights to advocacy have been implemented. These reforms would help to ensure, for example, that there is proper consideration, in advance of the decision being made, of the necessity of removing individuals from their own home and placing them into a care home, in the name of their best interests. These wider reforms complement the Liberty Protection Safeguards and are integral to the overall approach that we set out in the Bill and explain in this report.
- 1.37 Where arrangements are being put in place or commissioned by a body other than an NHS body or local authority – as in the case of private medical treatment or self-funders in care homes – it will be incumbent upon the private care or treatment provider to apply to the responsible body for authorisation. Our draft Bill provides a sanction for failure to do so by creating a new civil claim for damages where private care or treatment providers put in place arrangements that give rise to a deprivation of liberty which are unauthorised.

STRUCTURE OF THE REPORT

- 1.38 The report is divided into 15 chapters:
 - (1) chapter 1 is the introduction;

¹⁷ The section 5 defence is explained in para 3.8 of this report.

- (2) chapter 2 discusses the ECHR, the UN Convention on the Rights of Persons with Disabilities, the Human Rights Act 1998 and the concept of deprivation of liberty (including consideration of *HL v United Kingdom* and *Cheshire West*);
- (3) chapter 3 describes the Mental Capacity Act (apart from the DoLS) and other relevant health and social care legislation;
- (4) chapter 4 looks describes the DoLS and sets out the case for replacing them;
- (5) chapter 5 summarises the replacement scheme put forward at consultation (which we called “protective care”) and the views of consultees, and sets out our revised approach under the Liberty Protection Safeguards;
- (6) chapter 6 provides a brief overview of the Liberty Protection Safeguards;
- (7) chapter 7 examines the scope of the Liberty Protection Safeguards, in terms of the arrangements that may be authorised and the position of 16 and 17 year olds;
- (8) chapter 8 considers which bodies should be responsible for authorising arrangements that would give to a deprivation of liberty;
- (9) chapter 9 looks at the assessments that must be carried out before an authorisation under the Liberty Protection safeguards can be given (the capacity assessment, the medical assessment, and the assessment of whether the arrangements are necessary and proportionate);
- (10) chapter 10 discusses the “procedural” conditions that must be met before an authorisation can be given. These conditions cover the following areas: the required consultation, the conflicting decision of a donee or deputy, the independent review and approval by an Approved Mental Capacity Professional;
- (11) chapter 11 discusses how authorisations would operate in practice. Specifically it considers the effect of an authorisation, the need to keep an authorisation record, and the duration, review and suspension of authorisations;
- (12) chapter 12 considers the safeguards that must be delivered when a responsible body has authorised arrangements under the Liberty Protection Safeguards in respect of a person. There are four key safeguards discussed: reviews, independent advocacy, rights of legal challenge, and monitoring and reporting;
- (13) chapter 13 looks at the interface between the Liberty Protection Safeguards and the Mental Health Act;
- (14) chapter 14 sets out wider reforms to the Mental Capacity Act aimed at ensuring that the person concerned is placed at the heart of decision-making. These reforms cover best interests determinations under section 4, immunity from legal proceedings under section 5, and supported decision-making; and
- (15) chapter 15 looks at various matters, namely advance consent, interim and emergency deprivation of liberty, unlawful deprivation of liberty, and amendment of the Coroners and Justice Act 2009.

The team working on the project

- 1.39 The following members of the public law team have worked on this report at various stages: David Connolly (team manager); Tim Spencer-Lane (team lawyer); Alex Ruck Keene (consultant); Olivia Bird (research assistant); Thomas Jones (research

assistant); Niamh McEvoy (research assistant); and Patrick Tomison (research assistant). The following also contributed to the consultation paper: Richard Percival (team manager); Horatio Waller (research assistant); Thomas Pontre (research assistant); and Tansy Hutchinson (seconded – policy analyst).

Chapter 2: International conventions, the Human Rights Act and the concept of deprivation of liberty

2.1 Most of the recommendations set out in this report seek to build on existing safeguards and protections contained in domestic legislation and international conventions. It is therefore important that our new scheme is seen in the context of these safeguards and protections. This chapter discusses the relevant international conventions (the ECHR and UN Convention on the Rights of Persons with Disabilities), the Human Rights Act 1998, and the concept of deprivation of liberty. Chapter 3 describes the Mental Capacity Act (apart from the DoLS) and other relevant health and social care legislation. Chapter 4 sets out the DoLS and considers the case for their reform.

THE EUROPEAN CONVENTION ON HUMAN RIGHTS

2.2 Article 5(1) of the ECHR provides that no-one shall be deprived of liberty unless the deprivation is carried out in accordance with a procedure prescribed by law and is necessary in a democratic society on one of a number of grounds (including “unsoundness of mind”). Article 5(4) provides that everyone deprived of their liberty is entitled to take proceedings by which the lawfulness of their detention shall be decided speedily by a court, and their release ordered if the detention is not lawful. The underlying aim of Article 5 is to ensure that no one is deprived of liberty arbitrarily.

2.3 Article 8(1) provides that “everyone has the right to respect for his private and family life, his home and his correspondence”. The right is qualified, and State interferences with the various aspects of the right are permitted where they are in accordance with the law and necessary in a democratic society in the interests of, for example, the protection of health.

2.4 The compatibility of the recommendations set out in this report with Article 5 and Article 8 is discussed in appendix B. Claims that a contracting state has infringed the Convention can be brought before the European Court of Human Rights, which sits in Strasbourg and is generally referred to in this report as the “Strasbourg court”.

UN CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES

2.5 The UN Convention on the Rights of Persons with Disabilities was ratified by the United Kingdom in 2009. The Convention’s purpose is to protect the rights of people who have long-term physical, mental, intellectual, or sensory impairments. Whilst not directly incorporated into our domestic law, it is applied both by the Strasbourg and domestic courts as an aid to interpretation of the ECHR, including by Lady Hale in *Cheshire West*.¹

¹ *Cheshire West* at [36].

2.6 The Convention has been lauded as a new paradigm and as a revolution in human rights law for persons with disabilities.² Its stated purpose is to:

promote, protect, and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.³

2.7 The Convention has a wide field of application and encompasses civil and political rights as well as economic, social and cultural ones. These rights are extensive and cover matters such as the right to life, access to justice, independent living, education, work and cultural life. Two articles of the Convention are particularly relevant for the purposes of mental capacity law and the DoLS. Article 12 sets out the right of persons with disabilities to enjoy to legal capacity on an equal basis with others. Article 14 of the Convention stipulates that the “existence of a disability shall in no case justify a deprivation of liberty”. The Convention is considered further in appendix B.

THE HUMAN RIGHTS ACT

2.8 The Human Rights Act 1998 gives effect to rights and freedoms guaranteed under the ECHR by bringing these rights into the sphere of domestic law. The Act makes it unlawful for a public authority, such as a local authority, to act in a way that breaches a person’s Convention rights.⁴ A court may grant such relief or remedy, or make such order, within its powers as it considers just and appropriate. In determining the amount of any award of damages, a court is required to take into account the principles applied by the Strasbourg court in relation to awarding compensation under Article 41 of the ECHR (which affords “just satisfaction” to the injured party).⁵

THE CONCEPT OF DEPRIVATION OF LIBERTY

2.9 The Mental Capacity Act provides that deprivation of liberty for the purposes of the Act has the same meaning as in Article 5(1) ECHR.⁶ We do not recommend departing from this approach. It is therefore necessary to outline the approach taken by both the Strasbourg and the domestic courts to Article 5(1) of the ECHR in the context of the delivery of care and treatment.

2.10 The Strasbourg court has confirmed that a deprivation of liberty for the purposes of Article 5(1) has three elements, which apply in all cases:

- (1) the objective element of confinement in a restricted space for a non-negligible

² See, for example: E Flynn and A Arstein-Kerslake, “Legislating Personhood: Realising the right to Support in Exercising Legal Capacity” (2014) *International Journal of the Law in Context* 81.

³ Convention on the Rights of Persons with Disabilities, adopted by the UN General Assembly on 13 December 2006 (Resolution A/RES/61/106), art 1.

⁴ Human Rights Act 1998, s 6. Section 73 of the Care Act also provides that a registered care provider is a public authority for the purposes of the Human Rights Act if it is providing care to a person in their home or in residential accommodation, and such care has been arranged or funded (in part or in whole) by a local authority.

⁵ Human Rights Act 1998, s 8.

⁶ Mental Capacity Act, s 64(1).

period of time;

(2) the subjective element that the person has not validly consented to that confinement; and

(3) the detention being imputable to the State.⁷

2.11 These elements are discussed in turn below.

The objective element

2.12 In most of the key cases before the Strasbourg court it has been common ground that consent is absent and that the State has responsibility; therefore most attention has been focused on the objective element.

2.13 The Strasbourg case law operates on the *Guzzardi* principle that the starting point in assessing whether there has been a deprivation of liberty is “the concrete situation” of the person and the consideration of “a whole range of criteria such as the type, duration, effects and manner of implementation of the [restrictive] measure in question”. The difference between deprivation of liberty and restriction upon liberty is “merely one of degree or intensity, and not one of nature or substance”.⁸

2.14 When considering the deprivation of liberty of those with mental health problems, the Strasbourg case law has focused almost entirely on confinements in psychiatric hospitals, as well as care homes.⁹ It has not given detailed consideration to the position of those in general hospitals, and has not given any consideration to those who are in supported living, shared lives and private and domestic settings.¹⁰ So far, only the domestic courts have considered these matters.

The “HL case” (also known as the Bournemouth case)

2.15 For present purposes, the most significant of the Strasbourg court’s decisions on Article 5 is *HL v United Kingdom*.¹¹ A summary of the case is provided below.

HL was a 48 year old man who had suffered from autism since birth and had always been incapable of consenting to medical treatment. From the age of 13, he lived in a psychiatric institution (Bournemouth Hospital). In 1994 he was discharged, after a period of over 30 years, to live with paid carers.

In 1997, following an incident when he reportedly became agitated at a day-care centre, HL was taken back to hospital. He was assessed by a psychiatrist as needing inpatient treatment and, because he appeared “quite compliant” and had “not attempted to run

⁷ *Storck v Germany* (2005) 43 EHRR 96 (App No 61603/00) at [74] and [89].

⁸ *Guzzardi v Italy* (1980) 3 EHRR 333 (App No 7367/76) at [92] and [93].

⁹ For care homes, see in particular *Stanev v Bulgaria* (2012) 55 EHRR 22 (App No 36760/06) (Grand Chamber decision).

¹⁰ Limited consideration of the general hospital setting was given in a permission application, *Järvinen v Finland* No 30408/96.

¹¹ *HL v UK* (2005) 40 EHRR 32 (App No 45508/99).

away”, he was admitted “informally” rather than under the formal detention powers of the Mental Health Act. This was common practice at the time, and meant that he did not have access to the safeguards provided to formally detained patients (such as the right to apply to the (then) Mental Health Review Tribunal for his release).

According to his consultant psychiatrist, HL was fully compliant with his care regime in hospital and always accepted his medication. Others, however, suggested that HL was in fact objecting and needed sedative medication in order to manage his behaviour. Once in hospital, his carers were prevented from visiting him, in case he would want to go home with them, and clear instructions were given that he should be detained under the Mental Health Act if he tried to leave the hospital. His care and treatment was justified on the basis of the common law doctrine of necessity.

His carers took the case to court. The House of Lords (by a majority) held that HL was not falsely imprisoned for purposes of the common law on the basis that he was not, in fact, imprisoned, but (unanimously) that any imprisonment was justified on the basis of necessity. The House of Lords did not consider the question of whether HL was deprived of his liberty for the purposes of Article 5 of the ECHR. The carers applied to the Strasbourg Court; that court did not consider the conclusion that HL was not falsely imprisoned for the purposes of the common law to be determinative of the question of whether he was deprived of his liberty for the purposes of Article 5. The court considered the key factor to be that the health care professionals treating HL exercised complete and effective control over his care and movements from the moment he presented acute behavioural problems. It found both that HL had been deprived of his liberty and that that deprivation of liberty had taken place without the necessary procedural safeguards.

Cheshire West

2.16 On 19 March 2014 the Supreme Court handed down its judgment in *Cheshire West*. This was a conjoined appeal of two cases, *P v Cheshire West and Chester Council* and *P and Q v Surrey County Council*, which are summarised in the table below.

Mr P

The Cheshire case concerned Mr P, who was born with cerebral palsy and Down’s syndrome. Until he was 37 he lived with his mother, but when her health deteriorated the local authority obtained orders from the Court of Protection that it was in his best interests to live in accommodation providing 24 hour care. Since 2009, he had lived in a staffed bungalow with two other residents near his mother’s home, in which there were normally two members of staff on duty during the day and one “waking” member of staff overnight. Mr P required prompting and help with all activities of daily living, getting about, eating, personal hygiene and continence. He sometimes required intervention when he exhibited challenging behaviour, but was not prescribed any tranquilising medication. He was unable to go anywhere or do anything without one to one support; such one to one support was provided at such a level (98 hours a week) as to enable him to leave the home frequently for activities and visits.

The Court of Protection held that these arrangements did deprive him of his liberty but that

it was in Mr P's best interests for them to continue. The Court of Appeal substituted a declaration that the arrangements did not involve a deprivation of liberty, after comparing Mr P's circumstances with the life which another person with his disabilities might be leading.

P and Q (MIG and MEG)

The Surrey case concerned P and Q (otherwise known as MIG and MEG) who were sisters and had learning disabilities. Both became the subject of care proceedings in 2007 when they were respectively 16 and 15.

MIG was an 18 year old with a moderate to severe learning disability. She had the cognitive ability of a 2 to 3 year old, experienced problems with her sight and hearing, communicated with difficulty and required help crossing the road because she was unaware of danger. MIG was living with a foster mother whom she regarded as "Mummy". Her foster mother provided her with intensive support in most aspects of daily living. MIG was not on any medication. She was not restrained or locked in. She had never attempted to leave the home by herself and showed no wish to do so, but, if she had done so, her foster mother would have restrained her. MIG attended a further education college daily during term time and was taken on trips and holidays by her foster mother.

MEG was a 17 year old with mild learning disabilities and the cognitive ability of a 4 to 5 year old. She lived with three others in a small NHS residential home for learning disabled adolescents with complex needs. She had occasional outbursts of challenging behaviour towards the other three residents and sometimes required physical restraint. MEG was prescribed (and administered) tranquilising medication to control her anxiety. She was not in a locked environment, but had one to one and sometimes two to one support. Continuous supervision and control was exercised so as to meet her care needs. MEG was accompanied by staff whenever she left. She attended the same further education college as her sister daily during term time, and had a full social life. She showed no wish to go out on her own, and so there was no need to prevent her from doing so, but it was concluded by Mrs Justice Parker that if she had tried to leave, she would have been restrained or brought back for her own safety.

The Court of Protection held that the living arrangements for both MIG and MEG did not amount to a deprivation of liberty, and that in making this determination it is permissible to look at the reasons why they were living where they were. The arrangements were found to be in their best interests. This decision was upheld by the Court of Appeal.

- 2.17 On the appeals to the Supreme Court, which were heard together, it was common ground that none of the individuals had the capacity to consent to the arrangements. It was also common ground that the arrangements were imputable to the State. The only issue before the Supreme Court was whether the objective element of confinement was present.
- 2.18 The Supreme Court held that MIG, MEG and Mr P had all been deprived of their liberty. The decision was unanimous in the case of Mr P and a majority decision in the case of

MIG and MEG.¹² Lady Hale, giving the leading judgment, held that human rights are the same for everyone:

If it would be a deprivation of my liberty to be obliged to live in a particular place, subject to constant monitoring and control, only allowed out with close supervision, and unable to move away without permission even if such an opportunity became available, then it must also be a deprivation of the liberty of a disabled person.¹³

2.19 Lady Hale emphasised that the fact that the living arrangements were comfortable, and made life enjoyable, made no difference – “a gilded cage is still a cage”. For that reason, Lady Hale rejected the “relative normality” approach taken by the Court of Appeal in the case of P. Instead, she set out the “acid test”, revealed in a line of cases in the Strasbourg court dating back to *HL v United Kingdom*, which involves determining whether the person concerned is under continuous supervision and control, and not free to leave. Both conditions must be satisfied in order to give rise to a deprivation of liberty.¹⁴

2.20 Lady Hale also agreed with submissions advanced by the National Autistic Society and Mind that the following were not relevant to the question of whether a person is deprived of liberty:

- (1) the person’s compliance or lack of objection;
- (2) the relative normality of the placement (whatever the comparison made); and
- (3) the reason or purpose behind a particular placement.¹⁵

The acid test: a summary

The acid test set out by Lady Hale in *Cheshire West* provides that the objective element of a deprivation of liberty is satisfied if a person is:

- (1) under continuous supervision and control; and
- (2) not free to leave.

2.21 Lord Carnwath, Lord Hodge and Lord Clarke dissented in the cases of MIG and MEG. They considered that the degree of intrusion was relevant to the existence, or not, of a deprivation of liberty, and noted that the care regimes in question were no more intrusive or confining than was required for the protection and well-being of the persons concerned. They were concerned that nobody using ordinary language would describe persons living happily in a domestic setting, like MIG and MEG, as being deprived of their liberty. They also argued that the formulation of an “acid test” goes against the

¹² Lord Kerr, Lord Neuberger and Lord Sumption agreed with Lady Hale.

¹³ *Cheshire West* at [46].

¹⁴ As above at [46] to [49].

¹⁵ As above at [50].

grain of Strasbourg case law which has always applied a case-specific test involving a range of criteria.¹⁶

- 2.22 The decision has produced much debate and controversy.¹⁷ Most concerns relate to the practical and financial implications of the judgment for the State, particularly local authorities and the NHS. The *Cheshire West* decision widened considerably the numbers of people understood to be considered to be deprived of liberty and requiring additional safeguards.¹⁸ The official figures indicate that hospitals and care homes in England made 195,840 DoLS applications in 2015-16 (the highest number since the DoLS were introduced), 30% more than the 137,540 applications the previous year and more than 14 times the 13,700 applications in 2013-14 (the year prior to the judgment).¹⁹ In Wales, there was a 16 fold increase in DoLS applications in 2014-15 (the year following the judgment).²⁰
- 2.23 The official figures also show an increasing number of DoLS referrals being left unassessed and statutory time-scales being routinely breached; in England, only 43% of the 195,840 DoLS cases referred to local authorities for during 2015-16 were completed during the year, and of those only 29% were completed within the 21-day time limit set in regulations.²¹
- 2.24 Our impact assessment estimates that the cost of full compliance with the DoLS regime following *Cheshire West* would be £2.2 billion per year – approximately two per cent of the entire budget of NHS England.²²
- 2.25 The impact of *Cheshire West* is returned to in chapter 4.²³

A non-negligible period of time

- 2.26 In order for a deprivation of liberty to arise, a person must be confined for more than a negligible period of time. There is no fixed definition of how long such a period would be, and it will vary according to the individual circumstances, including the nature and consequences of the restrictions. For example, the Strasbourg court has considered (in an admissibility decision) that forcing a blood test on a person against their will could give rise to a deprivation of liberty even if the confinement lasted only for a very short period.²⁴ Conversely, it has also been held that periods of seclusion of a patient already

¹⁶ As above at [105].

¹⁷ Consultation paper, paras 1.15 to 1.22.

¹⁸ If the person is deprived of their liberty in a hospital or care home, then these safeguards can be delivered through the DoLS. In all other cases, a court authorisation is required.

¹⁹ NHS Digital, *Mental Capacity Act (2005) Deprivation of Liberty Safeguards (England): England 2015-16 National Statistics* (2016).

²⁰ Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales, *Deprivation of Liberty Safeguards: Annual Monitoring Report for Health and Social Care 2014-15* (2016).

²¹ NHS Digital, *Mental Capacity Act (2005) Deprivation of Liberty Safeguards (England): England 2015-16 National Statistics* (2016). The 21-day time limit is established by reg 13(1) of the Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations SI 2008 No 1858.

²² Impact assessment, p 26.

²³ See paras 4.17 to 4.19 of this report. See also para 5.36 of this report.

²⁴ *X v Austria* App No 8278/8 at [2].

detained under the Mental Health Act lasting up to 18 days might not constitute a further deprivation of their liberty requiring separate justification.²⁵ In the domestic case of *ZH v Commissioner of Police for the Metropolis*, the Court of Appeal rejected the submission that the Strasbourg court would usually view a detention of less than 30 minutes as not coming within the scope of Article 5.²⁶ In this particular case it was held that the “intense” restraint of a 16 year old boy with autism for 40 minutes amounted to a deprivation of liberty.

The subjective element

2.27 A person can only be considered to have been deprived of their liberty if they have not provided “valid consent” to the confinement in question.²⁷ But if a person does not have capacity to consent, then consent cannot have been given.²⁸

2.28 In *M v Ukraine* the Strasbourg court held that:

A person’s consent to admission to a mental health facility for in-patient treatment can be regarded as valid for the purpose of the ECHR only where there is sufficient and reliable evidence suggesting that the person’s mental ability to consent and comprehend the consequences thereof has been objectively established in the course of a fair and proper procedure and that all the necessary information concerning placement and intended treatment has been adequately provided to him.²⁹

2.29 Case law has also established that that the parents of a child aged under 16 may give valid consent to what would otherwise constitute a deprivation of that child’s liberty, where this is within the “zone of parental responsibility”.³⁰ But it has also been held that a parent cannot consent to what would otherwise amount to a deprivation of liberty of a 16 or 17 year old.³¹ The position of children and young people is discussed further from para 7.20.

2.30 The subjective element is further discussed in para 9.2 and para 15.3.

Imputability to the state

2.31 A confinement must be imputable to the State in order for a deprivation of liberty to arise within the meaning of Article 5. Plainly, the State will be directly responsible if the confinement takes place in a hospital or care home which is run by a public authority (such as the NHS), or if the person has been placed in a care home by a public authority. But the responsibility of the State may be engaged even in the absence of such features. First, if there are proceedings concerning the situation of the person, the courts will have responsibility to apply domestic law in conformity with the spirit of Article 5.

²⁵ *Munjaz v UK* (2012) ECHR 1704 (App No 2913/06) at [71].

²⁶ *ZH v Commissioner of Police for the Metropolis* [2013] EWCA Civ 69, [2013] 1 WLR 3021.

²⁷ *Storck v Germany* (2006) 43 EHRR 96 (App No 61603/00) at [74].

²⁸ *HL v UK* (2005) 40 EHRR 32 (App No 45508/99).

²⁹ *M v Ukraine* App No 2452/04 at [77].

³⁰ *Trust A v X* [2015] EWHC 922 (Fam), [2016] 1 FLR 142.

³¹ *Birmingham CC v D* [2016] EWCOP 8. An appeal against this decision was heard by the Court of Appeal in February 2017 but the outcome was not known at the time of publishing this report.

Secondly, the Strasbourg jurisprudence establishes a positive obligation on the State to protect all of its citizens against interferences with their liberty, whether by State agents or by private individuals. Public authorities are therefore obliged to take measures providing “effective protection of vulnerable persons”, including “reasonable steps to prevent a deprivation of liberty of which the authorities have or ought to have knowledge”.³²

2.32 Imputability may thus arise as a result either of the State’s “direct involvement” in the person’s detention or of the State’s positive obligations to protect the person against interferences with their liberty carried out by private persons.³³ The State’s positive obligations are discussed from para 7.2.

³² *Storck v Germany* (2006) 43 EHRR 6 (App No 61603/00) at [102].

³³ As above, at [89].

Chapter 3: The Mental Capacity Act and relevant health and social care legislation

MENTAL CAPACITY ACT

- 3.1 The Mental Capacity Act provides the legal framework in England and Wales for acting and making decisions for and on behalf of people aged 16 and over who lack the mental capacity to make particular decisions for themselves. The Act is intended to be “enabling and supportive of people who lack capacity, not restricting or controlling of their lives”. It aims to protect people who lack capacity to make a decision, and also to “maximise their ability to make decisions, or to participate in decision-making, as far as they are able to do so”.¹
- 3.2 The Mental Capacity Act, in its original conception, did not provide any express mechanism for authorising the deprivation of liberty of people who lacked capacity to consent to it; such authority had to be obtained by way of a court order (either of the Court of Protection or High Court). The DoLS were introduced separately at a later stage by amendment to the Mental Capacity Act by the Mental Health Act 2007. The DoLS are summarised from para 4.2.

The principles

- 3.3 The Mental Capacity Act can be described as a principles-led piece of legislation. In section 1 it sets out principles which apply to people acting or making decisions under the Act, which are expanded upon in the sections that follow. The principles are that:
- (1) a person must be assumed to have capacity unless it is established that he or she lacks capacity;
 - (2) a person is not to be treated as unable to make a decision unless all practicable steps to help him or her to do so have been taken without success;
 - (3) a person is not to be treated as unable to make a decision merely because he or she makes an unwise decision;
 - (4) an act done, or decision made, under the Act for or on behalf of a person who lacks capacity must be done, or made, in his or her best interests; and
 - (5) before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.

Assessing capacity

- 3.4 The determination of capacity, as governed by sections 1 to 3 of the Mental Capacity Act, is always decision-specific. Thus, capacity is required to be assessed in relation to

¹ *Mental Capacity Act Code of Practice*, p 19.

a specific decision at the time the decision needs to be made, and not to a person's capacity to make decisions generally.

3.5 Section 2(1) sets out that a person lacks capacity in relation to a matter if, at the material time, he or she is unable to make the decision in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain. This is commonly known as the “diagnostic test”. Section 3(1) provides that a person is “unable to make a decision” if he or she is unable to:

- (1) understand the information relevant to the decision;
- (2) retain that information;
- (3) use or weigh that information as part of the process of making the decision; or
- (4) communicate the decision (whether by talking, using sign language or any other means).

This is commonly known as the “functional test”.

3.6 Case law has confirmed that, whilst the diagnostic test is in practice often applied before the functional test, the correct approach, and the wording of the Act, require the functional test to be considered first. The courts have also emphasised the importance of establishing the “causative nexus” between being unable to make the decision and the impairment of, or a disturbance of, the mind or brain.²

Best interests

3.7 As noted above, the Mental Capacity Act requires that any action or decision for or on behalf of a person who lacks the requisite capacity must be done, or made, in his or her best interests.³ The notion of a person’s “best interests” is not defined in the Act. However, section 4 sets out a series of matters which must be, or must not be, considered when a decision-maker is making a determination. These matters include considering the person’s past and present wishes and feelings (including written statements), the person’s beliefs and values, and any other factors that the person would be likely to consider if they were able.⁴

Acts in connection with care or treatment

3.8 Section 5 of the Act offers protection against civil and criminal liability for certain acts done in connection with the care or treatment of a person. In broad terms, a person providing care or treatment will not incur any liability that they would not have incurred if a person of full capacity had consented to the care or treatment, subject to certain conditions; these are that:

- (1) the person is reasonably believed to lack the capacity to consent;

² *York CC v C* [2013] EWCA Civ 478, [2014] 2 WLR 1 at [58] to [59].

³ Mental Capacity Act, s 1(5).

⁴ As above, s 4(6).

- (2) consideration has been given to the principles of the Act; and
- (3) the action taken is in the person's best interests.

3.9 In addition, section 6 provides that the use of restraint will not attract protection against liability unless the individual taking the action reasonably believes it is necessary to do so in order to prevent harm to the person; the act must also be a proportionate response to the likelihood of harm and the seriousness of that harm.

Independent Mental Capacity Advocates

3.10 The Mental Capacity Act provides that an Independent Mental Capacity Advocate must be instructed to represent a person who lacks the requisite capacity, when it is proposed that the person should receive "serious medical treatment" or be provided with long-term accommodation in a hospital or care home by the NHS or residential care by a local authority. The duty to instruct an Independent Mental Capacity Advocate applies if there is no person (other than a professional or paid carer) who can be consulted in determining the person's best interests.⁵ Independent Mental Capacity Advocates have prescribed statutory functions, including gathering evidence and preparing a report on the person's best interests.

3.11 A person who is subject to a DoLS authorisation will also have rights to an Independent Mental Capacity Advocate in certain circumstances. The duty to instruct an Independent Mental Capacity Advocate under the DoLS and the advocate's role are described from para 12.20.

The Court of Protection

3.12 The Mental Capacity Act also established the Court of Protection which has, amongst other matters, the power to make a declaration as to whether a person lacks or has capacity to make any decision. If the person lacks capacity, the Court can make decisions on the person's behalf in relation to personal welfare, and property and affairs.⁶ It also has the power to hear applications challenging DoLS authorisations.⁷

SOCIAL CARE LEGISLATION

3.13 Local authorities' responsibilities for the provision of adult social care are governed in England by the Care Act, and in Wales by the Social Services and Well-being (Wales) Act. Social care services are not defined by this legislation, and local authorities are given broad discretion to provide a range of care and support.

3.14 Local authorities in England and Wales are given a number of general duties towards the local community. These include, for example, a duty to take steps to prevent, reduce, or delay needs for care and support for all local people, and to establish an information service for people in their area.⁸ In addition, there are duties towards individual adults, including duties to assess, to meet needs for care and support which

⁵ As above, ss 35 to 39.

⁶ As above, ss 15 and 16.

⁷ As above, s 21A.

⁸ Care Act, ss 1 to 7 and Social Services and Well-Being (Wales) Act, ss 15 to 17.

meet the eligibility criteria, and to prepare a care and support plan. Similar duties are owed to carers.⁹ Local authorities are also required to make safeguarding enquiries in cases of actual or suspected abuse or neglect.¹⁰

- 3.15 Local authorities are required to arrange for an independent advocate to be available to represent and support the adult or carer, if he or she would otherwise experience substantial difficulty in understanding, retaining, using, or weighing information, or communicating the individual's views, wishes, or feelings. The duty to arrange an advocate does not apply if the local authority is satisfied there is an "appropriate person" (who is not a professional or paid carer) to represent and support the adult.¹¹
- 3.16 Local authorities have powers to charge for services, subject to a means test. Only those with capital below a certain level qualify for financial help, which based on a sliding scale. Many people who use social care will pay all the costs. This is known as being a "self-funder". It is estimated that self-funders account for 40% all care home placements.¹² But the duties to assess and to undertake safeguarding enquiries apply regardless of the level of the adult's financial resources.¹³
- 3.17 Social care provision for 16 and 17 year olds is governed primarily by part 3 of the Children Act 1989 and parts 4 and 6 of the Social Services and Well-being (Wales) Act 2014. In England, part 3 of the Children Act sets out the duties owed by local authorities to children and families in their area. Services provided under section 17 are available to children who are "in need", in accordance with the definition found in that section. Local authorities have a duty to provide accommodation for certain children in need, under section 20. Many of the other functions under part 3 arise as a result of a child being a "looked after child". The Social Services and Well-being (Wales) Act does not replicate the concept of a child in need. Instead section 21 requires local authorities to assess whether a child has needs for care and support, and section 37 sets out the conditions that must be met for a local authority to be under a duty to meet those needs. The powers and duties relating to looked after children and accommodation are contained in part 6.

HEALTH CARE LEGISLATION

- 3.18 The National Health Service is governed in England by the National Health Service Act 2006 and in Wales by the National Health Service (Wales) Act 2006. In England, health care is commissioned from providers by local clinical commissioning groups under the supervision of the National Health Service Commissioning Board. Providers may include private providers and NHS Trusts and NHS Foundation Trusts providing, as the case may be, primary, secondary, and tertiary care in acute hospitals, ambulance

⁹ Care Act, ss 8 to 41 and Social Services and Well-Being (Wales) Act, ss 18 to 20, and 24 to 27.

¹⁰ Care Act, s 42 and Social Services and Well-Being (Wales) Act, s 126.

¹¹ Care Act, ss 67 to 68. In Wales the advocacy provisions are contained in Welsh Government: *Social Services and Well-Being (Wales) Act 2014: Part 10 Code of Practice (Advocacy)* (2015).

¹² LaingBuisson, *Care of Older People: UK Market Report, 27th edition* (2015) p 198.

¹³ Care Act, ss 9(3)(b) and 42(1)(a) and Social Services and Well-Being (Wales) Act, ss 19(3)(b) and 126(1)(b).

services and mental health services. In Wales, local health boards are responsible for planning, securing and delivering services in their areas.

- 3.19 The legislation places a number of general duties on NHS bodies to provide a range of services. In broad terms, the Secretary of State and Welsh Ministers are required to promote a comprehensive health service, designed to secure improvement:
- (1) in the physical and mental health of the people of England and of Wales; and
 - (2) in the prevention, diagnosis, and treatment of illness.¹⁴
- 3.20 The Secretary of State and Welsh Ministers must arrange for the provision of a number of services to such extent that they consider necessary to meet all reasonable requirements, such as hospital accommodation, nursing services, and services and facilities for the prevention of illness.¹⁵
- 3.21 NHS continuing health care is a package of care that is arranged and funded solely by the NHS for individuals who are not in hospital and have been assessed as having a "primary health need". NHS continuing health care is available to those based in their own home or in a care home. NHS continuing health care is free of charge, unlike social care services.¹⁶

SECTION 117 AFTER-CARE

- 3.22 Section 117 of the Mental Health Act requires health authorities and local social services authorities, in co-operation with voluntary agencies, to provide after-care to patients previously detained in hospital for treatment under section 3, 37, 45A, 47, or 48 of the Act. Case law has confirmed that section 117 imposes an enforceable joint duty on health bodies and local social services authorities to consider the after-care needs of each individual to whom the duty relates.¹⁷ Furthermore, authorities cannot charge for services provided under section 117.¹⁸

¹⁴ NHS Act 2006 s 1 and NHS (Wales) Act 2006, s 1.

¹⁵ NHS Act 2006 s 3 and NHS (Wales) Act 2006, s 3.

¹⁶ See, for example, Department of Health, *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care: November 2012 (revised)* and Welsh Government, *Continuing NHS Healthcare: The National Framework for Implementation in Wales: June 2014 (revised)* (2014).

¹⁷ *R v Ealing DHA ex p Fox* [1993] 1 WLR 373.

¹⁸ *R (Stennett) v Manchester CC* [2002] UKHL 34, [2002] 2 AC 1127.

Chapter 4: The Deprivation of Liberty Safeguards and the case for reform

- 4.1 This chapter considers the case for reforming this area of law. It looks at the DoLS and examines the consultation responses on how the DoLS operate in practice and whether they should be replaced.

THE DEPRIVATION OF LIBERTY SAFEGUARDS

- 4.2 The DoLS are contained in schedules A1 and 1A to the Mental Capacity Act, added by the Mental Health Act 2007. As we have mentioned, they were a response to the decision in *HL v United Kingdom* summarised from para 2.15.¹

- 4.3 The DoLS aim to ensure that adults who lack capacity to consent to being accommodated in a hospital or care home for the purpose of being given care and treatment are only deprived of liberty if it is considered to be in their best interests. In simple terms, the DoLS do this by establishing an administrative process for authorising a deprivation of liberty and a means to challenge any such deprivation. The DoLS apply to all hospitals (including general hospitals and psychiatric hospitals) and care homes (including private care homes). They do not extend to deprivations of liberty in supported living, shared lives, and private and domestic settings.

- 4.4 The DoLS provide that a hospital or care home (referred to in the legislation as the “managing authority”) must apply to the “supervisory body” for authorisation of a deprivation of liberty on their premises.² A supervisory body is the relevant local authority (usually the local authority for the place where the person is ordinarily resident), except in the case of hospitals in Wales where the supervisory body is the Local Health Board.³ The supervisory body must then arrange for six assessments to be conducted by a minimum of two assessors – a “best interests assessor” and a “mental health assessor” – to see if the following “qualifying requirements” are met. In broad terms, the qualifying requirements can be summarised as follows:

- (1) the person is an adult aged 18 or over (the age requirement);
- (2) the person is suffering from a mental disorder within the meaning of the Mental Health Act (“any disorder or disability of the mind”) (the mental health requirement);
- (3) the person lacks capacity to decide whether or not they should be accommodated in the hospital or care home for the purpose of being given the relevant care or treatment (the mental capacity requirement);

¹ *HL v UK* (2005) 40 EHRR 32 (App No 45508/99).

² Mental Capacity Act, sch A1, paras 21 to 24.

³ As above, sch A1, paras 181 and 182.

- (4) the deprivation of liberty is in the person’s best interests, is necessary to prevent harm to them and is a proportionate response to the likelihood and seriousness of that harm (the best interests requirement);
 - (5) the person is “eligible” for deprivation of liberty under the DoLS – in very broad terms this means that they are not detained under the Mental Health Act or other similar legislation, the authorisation would not be inconsistent with a requirement imposed under certain other provisions of the Mental Health Act (such as guardianship or a community treatment order) or, if the person is “within the scope” of the Mental Health Act, they are not objecting to the proposed psychiatric treatment (the eligibility requirement); and
 - (6) the proposal to deprive the person of their liberty does not conflict with a valid advance decision by them to refuse any part of the treatment to be provided, or a valid decision by a donee of a lasting power of attorney or a deputy appointed by the Court of Protection about where the person should be cared for or treated (the no refusals requirement).⁴
- 4.5 The timescales for assessments are contained in regulations. An assessor must complete the assessment within 21 days from the date on which the supervisory body receives a request from a managing authority (in England) or 21 days from the date on which the assessors were instructed by the supervisory body (in Wales). If an urgent authorisation is already in force (see para 4.8), the assessments must be completed before the urgent authorisation expires (in England) or within five days of the date of instruction (in Wales).⁵
- 4.6 If the assessments show that each of the six qualifying requirements is met, the supervisory body must grant a standard authorisation for the detention. If any of the qualifying requirements are not met, then the supervisory body may not grant any such authorisation.⁶
- 4.7 The best interests assessor may recommend that particular conditions be attached to the authorisation, and the supervisory body must have regard to these recommendations when deciding what conditions to impose on managing authorities.⁷
- 4.8 In the absence of an application from the managing authority, anybody may request that the supervisory body decide whether or not an unauthorised deprivation of liberty is taking place, provided he or she has already requested that the managing authority make an application for a DoLS authorisation and the managing authority has not done so within a reasonable period of time. If what may be a deprivation of liberty is already occurring, or will occur imminently, the managing authority can grant itself an “urgent authorisation” for seven days, pending the supervisory body’s consideration of its

⁴ As above, sch A1, paras 12 to 18.

⁵ Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008, SI 2008 No 1858, reg 13 and Mental Capacity (Deprivation of Liberty: Standard Authorisations and Disputes about Residence) (Wales) Regulations 2009, SI 2009 No 783 (W 69), reg 9.

⁶ Mental Capacity Act, sch A1, para 50.

⁷ As above, sch A1, para 53.

application for a standard authorisation. An urgent authorisation can be extended once, by the supervisory body, up to a maximum of 14 days.⁸

- 4.9 A “relevant person’s representative” must be appointed by the supervisory body if a standard authorisation is granted.⁹ The role of the representative is to keep in touch with the person to whom the authorisation relates and to represent them and support them in all matters relating to the authorisation. The representative is often a relative or friend of the person, who is willing to act in this capacity. If there is no suitable person to perform this role, the supervisory body must appoint someone to perform the role in a professional capacity.¹⁰
- 4.10 A further key safeguard for people subject to a DoLS authorisation is the right to independent advocacy. In general terms, the supervisory body must instruct an Independent Mental Capacity Advocate where the adult or their representative would otherwise be unable to exercise their rights. Advocates are given a number of specific functions, such as helping the person and their representative to understand the authorisation, any conditions, the DoLS assessments and relevant rights at play. They must also help the person take steps to exercise the right to apply to court and exercise the right of review.¹¹ Rights to advocacy under the DoLS are discussed from para 12.20.
- 4.11 The managing authority is under a duty to monitor each authorisation so that it can request a review if circumstances change. The supervisory body can be asked to undertake a review by the managing authority, by the adult or their representative, on the grounds that certain circumstances have changed. The supervisory body must carry out a review if asked by any of these parties, and may do so at any other time. Any person (including the adult) can make an application to the Court of Protection to challenge the authorisation.¹²
- 4.12 The Care Quality Commission has a statutory role to monitor and report on the use of the DoLS in England, but does not have explicit inspection or enforcement powers under the legislation. In Wales, the monitoring and reporting role is carried out by the Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales.¹³

CRITICISMS OF THE DOLS

Our consultation paper

- 4.13 The DoLS have been subject to heavy criticism since their inception. Our consultation paper discussed the following concerns:
- (1) *the narrow focus on Article 5*: a deprivation of liberty within the meaning of Article 5 is a complex and sometimes controversial concept; it is a question of both law and fact, and based on case law which has been on occasion contradictory.

⁸ As above, sch A1, paras 67 to 69 and 76.

⁹ The DoLS use the term “relevant person” to refer to the adult who is the subject of a DoLS authorisation.

¹⁰ Mental Capacity Act, sch A1, part 10.

¹¹ As above, ss 39A to 39D.

¹² As above, sch A1, part 8.

¹³ As above, sch A1, para 162.

Nevertheless, the DoLS assume that care home and hospital staff can easily identify and respond to deprivations of liberty. Also, in focusing exclusively on Article 5, the DoLS have little to say about the adult's Article 8 rights. Many Article 8 issues – such as restrictions on contact with friends and family, and deciding where he or she should live – will be of greater significance to the adult and their family than the technical question of deprivation of liberty;

- (2) *disconnect with the Mental Capacity Act*: the DoLS are seen as incompatible with the style and empowering ethos of the Mental Capacity Act, to which they are attached. The two are often regarded as separate legislation with different legal and philosophical histories;
- (3) *local authority conflicts of interest*: tensions arise between, on the one hand, local authorities' commissioning and safeguarding functions, and, on the other hand, their role as supervisory body under the DoLS. For example, local authorities are often responsible for arranging and funding the services which deprive the person of liberty (see para 3.14), and the perception therefore arises that authorities are more likely to authorise deprivations of liberty, rather than alter care and support arrangements and possibly incur more costs as a result;
- (4) *limited scope*: the DoLS apply only to hospitals and care homes, and not to other care settings, such as supported living and shared lives accommodation. Other than in hospitals and care homes, deprivations of liberty must be authorised by the Court of Protection. However, barriers to accessing the Court, and evidence of the failure of local authorities and the NHS to bring cases to court when necessary, suggest that this is unlikely to provide the safeguards intended;
- (5) *one-size-fits-all approach*: the DoLS impose a single approach irrespective of the setting in which the person is deprived of their liberty. Thus, deprivations of liberty in general hospitals are dealt with in the same way administratively as in a long-stay care home. The DoLS process seems particularly ill suited in hospices and end-of-life care where it will often provide no tangible benefit for the person, and the added formalities at such a sensitive time can cause additional distress to families;
- (6) *lack of oversight and effective safeguards*: particular difficulties arise in monitoring compliance with conditions attached to a standard authorisation, and in many cases the person may face many practical obstacles in challenging decision-makers. Evidence suggests that few advocates and representatives support the person to appeal against their deprivation of liberty, and supervisory bodies rarely refer cases to the Court of Protection;
- (7) *length and complexity*: the statutory provisions are widely acknowledged to be poorly drafted, lengthy, complex and overly bureaucratic;
- (8) *ill-suited and inadequate terminology*: many stakeholders criticised the terminology used by the DoLS. In particular, the label "Deprivation of Liberty Safeguards" is seen as providing a disincentive for care providers to seek an authorisation because of its negative connotations; and

- (9) *scale of the problem*: the DoLS were designed to provide a comprehensive set of safeguards for a relatively small number of “extreme” cases; the Government’s original impact estimated that on a worst case scenario only 21,000 people would be subject to the DoLS in England and Wales, and indeed that the numbers of people subject to such authorisations would decline over time, with an estimated 1,700 authorisations per year by 2015-16. The DoLS were not intended to deal with the numbers of cases (currently 195,840 applications in England alone, see para 2.22) that have been apparent post *Cheshire West*.¹⁴
- 4.14 The consultation paper further highlighted concerns that safeguards are often not being delivered when it is being proposed that a person should be moved from their own home into care home, supported living or shared lives accommodation (in circumstances that do not amount to a deprivation of liberty), even though this is a key stage where the person is often in a vulnerable position and in most need of additional safeguards. We noted that the courts have been highly critical of local authorities that have removed people from their homes – sometimes unlawfully and on the basis of unsubstantiated safeguarding alerts – and followed this with a DoLS authorisation in an attempt to legitimise the removal.¹⁵
- 4.15 The consultation paper concluded that there was a compelling case for replacing the DoLS. We considered that many – though not all – of the criticisms were convincing. It was argued that the DoLS were deeply flawed, and this could not be addressed simply by minor amendments or better implementation.¹⁶

Consultation responses

- 4.16 The majority of consultees agreed that the DoLS should be replaced.¹⁷ There was a strong message that the current regime was in crisis, and needed to be overhauled. The DoLS were described as “an administrative and bureaucratic nightmare” and criticised for placing additional pressure on an already over-stretched system.¹⁸ A number of responses from families described how distressing and confusing the DoLS process had been for their loved ones. Hospital clinicians argued that the DoLS process delivered no tangible benefits to the person’s treatment plan (particularly in intensive care units and end of life care). Consultees described the language adopted by the DoLS as, at best, unhelpful, and felt that the DoLS were out-of-kilter with the empowering philosophy of the Mental Capacity Act.¹⁹

¹⁴ Consultation paper, paras 2.12 to 2.40.

¹⁵ As above, paras 6.87 to 6.104. See also summaries of *Hillingdon LB v Neary* and *Essex CC v RF* at para 1.26.

¹⁶ Consultation paper, para 2.41.

¹⁷ Consultation analysis, PP 2-1, para 2.1.

¹⁸ Professor Rob Heywood.

¹⁹ Consultation analysis, para 2.38.

4.17 Many responses (particularly from NHS bodies and local authorities) pointed to the practical and financial impact of *Cheshire West*, such as:

- (1) significant increases in the numbers of DoLS referrals, reviews, and renewals locally (for example, the Association of North East Councils);
- (2) an increasing backlog of cases, which means that many DoLS referrals are being left unassessed (particularly in so-called “uncontroversial cases”) (for example the NELFT NHS Foundation Trust);
- (3) the legal timescales for DoLS assessments being frequently breached (for example, the Royal Hospital for Neuro-Disability);
- (4) significant delays in reviews and renewals of DoLS authorisations (for example, several local authorities and care providers);
- (5) shortages of best interests assessors and advocates (for example, several local authorities and consultation events with best interests assessors); and
- (6) many local authorities and NHS bodies not even considering deprivation of liberty cases that are not covered by the DoLS, such as those outside hospital and care home settings, or involving 16 and 17 year olds (for example, reported by attendees at a roundtable event organised by ADASS and the LGA).²⁰

4.18 Stakeholders from the hospital and care home sectors told us that, following *Cheshire West*, it was now common for the supervisory body to have failed to arrange the assessments for a standard authorisation within the maximum 14 day period for urgent authorisations, thus leaving the person potentially unlawfully deprived of liberty and the providers at risk of violating their regulatory standards (see para 15.28).

4.19 It was apparent that some local authorities have developed “triage systems” based on a screening tool published by ADASS following *Cheshire West*, which aims to assist local authorities to respond to the increase in DoLS cases.²¹ Cases given high priority include those involving one-to-one care during the day or night, new and unstable placements, and where medication is used to control behaviour. Those given lower priority include end of life care and intensive care situations which may meet the acid test but where the safeguards will bring no benefit to the person from the safeguards. We were told that, in many cases, this meant that the assessment process had not even started before the person had died, been discharged, or moved out of the place in which they were deprived of liberty.

4.20 It was reported that hospital and care home staff are confused by the DoLS and struggle to understand what constitutes a deprivation of liberty, often resulting in “inappropriate referrals” or “blanket referrals” of all residents / patients.²² Some responses suggested that doctors could charge significant sums for undertaking a DoLS mental health

²⁰ Deprivation of liberty in these cases cannot be authorised under the DoLS and requires a more costly application to the Court of Protection.

²¹ ADASS, *Advice Note November 2014: Guidance for Local Authorities in the light of the Supreme Court decisions on Deprivation of Liberty Safeguards* (2014).

²² As reported by several local authorities and at consultation events with best interests assessors.

assessment even when it involved a simple confirmation of a lifelong diagnosis. We were told of an increasing number of freelance best interests assessors, who could sometimes negotiate large fees due to the shortage of “in-house” assessors, and that it was not uncommon for staff to resign from the statutory sector in order to work freelance, after completing the best interests assessor course (usually paid for by their local authority employer).

- 4.21 A small number argued that, whilst the DoLS should be replaced, the solution did not lie in amending the Mental Capacity Act, but rather in a modified form of guardianship under the Mental Health Act.²³ Some suggested undertaking a comprehensive review of the situation in other European countries in order to formulate an alternative legal structure. Others felt that there was no need for a separate legal process for authorising deprivation of liberty, and instead argued that capacity assessments and best interests decision-making undertaken in accordance with the Mental Capacity Act provided sufficient protection of a person’s Article 5 rights, and were universally understood and straightforward.
- 4.22 A minority disagreed with the view that the DoLS should be replaced.²⁴ Some best interests assessors provided examples of the use of DoLS that had transformed people’s lives and led to less restrictive care plans. Others were concerned that introducing a new system would create additional disruption, with cost implications in embedding new roles and processes, and argued that it would be better to focus resources on making the existing system work as intended. We were told that the DoLS should be retained but with greater screening, so that DoLS teams could focus their expertise on situations where tangible benefit would be achieved.

Discussion

- 4.23 In our view, there remains a compelling case for replacing the DoLS. There is widespread agreement that the DoLS are overly technical and legalistic, and too often fail to achieve any positive outcomes for the person concerned or their family. Consultation further suggested that the best interests assessment tends to “rubber stamp” the decision already taken by the care team, meaning that the DoLS are not really a safeguard. This is compounded by the urgent authorisation system which too often leads to the justification for a deprivation of liberty only being considered after the event.
- 4.24 Consultation also confirmed that the DoLS were not designed to deal with the increased numbers of people considered deprived of their liberty following *Cheshire West*. The widespread reports of backlogs, breached statutory timescales and increased workloads mean that any notion that the DoLS can be patched up to cope even in the short term is, in our view, not sustainable. Article 5 rights must be practical and effective. It is not acceptable to continue with the current system where many people’s rights have become theoretical and illusory.
- 4.25 Nevertheless, we did receive individual examples of cases where the DoLS had delivered less restrictive care plans, particularly through the use of conditions and

²³ Consultation analysis, para 9.25.

²⁴ As above, para 2.15.

advocacy support.²⁵ There is also, in our view, a legitimate concern over the possible disruption and costs generated by the introduction of any new scheme. Therefore, whilst we remain convinced that a new scheme is needed as a matter of pressing urgency, in developing our recommendations we have been mindful not to abandon all elements of the DoLS and where possible to build on existing good practice. We have, for instance, built on the existing role of the best interests assessor (see from para 10.27) and current rights to advocacy (see from para 12.20).

- 4.26 Whilst many consultees argued that the *Cheshire West* judgment has introduced a simplified test of deprivation of liberty which is easy to understand, many still felt that the concept was difficult to apply in practice. This point is discussed further at para 5.38.
- 4.27 We do not agree that an amended version of guardianship under the Mental Health Act could provide the solution. It is likely that guardianship would be even more expensive to implement than the current DoLS system (for example, in practice it requires assessments by two doctors and an Approved Mental Health Professional in each case), and would require extensive revision which would change its entire character (at present it does not authorise deprivation of liberty). Moreover, it is our view that the empowering principles of the Mental Capacity Act provide a more sound and justifiable basis for law reform.
- 4.28 We have reviewed the laws governing deprivation of liberty in continental Europe (including France, Spain and Germany) and commonwealth jurisdictions (such as Australia and Canada). Many of these regimes are based in different legal traditions and do not provide direct assistance in identifying a solution. For example, some use “guardianship” systems where blanket determinations of incapacity are made or family members can authorise detention. Others use “custodianship” orders which can be accessed through the family court system. Many countries have federal systems under which detention powers are delegated to local regions and therefore much variation arises (for example, some regions make use of courts or mental health law to address these cases). Many countries allow authorisation by a single doctor and have no tradition of the formal involvement of non-medical staff (such as social workers) in decision-making. Some of these differences can also be explained by the funding arrangements for health and social care, which are often based on insurance systems rather than direct State provision. However, many commonwealth jurisdictions have been innovative in developing formal supported decision-making developing schemes that are intended to enable people to make their own decisions whenever possible. This is something that we consider could be included in the new legislative framework and is discussed from para 14.43.
- 4.29 It is doubtful that the requirements of Article 5(1) would be satisfied simply by improved best interests decision-making, rather than through a separate authorisation process. The Strasbourg court has pointed to the importance of “fixed procedural rules”, and in particular the need for “formalised admission procedures”, in order to provide the necessary degree of legal certainty and protect the individual from arbitrariness for the purposes of Article 5.²⁶ We consider that it is necessary to establish a specific procedure which ensures that those who may be depriving others of their liberty and, more

²⁵ For example, through a survey of best interests assessors by Steven Richards (Edge Training).

²⁶ *HL v UK* (2005) 40 EHRR 32 (App No 45508/99) at [120].

importantly, those who may be subject to such deprivation of liberty, as well as those assisting and supporting them, understand clearly what is required before such action can take place. However, we also consider that the procedure need not be as complex or bureaucratic as the DoLS.

Recommendation 1.

The DoLS should be replaced as a matter of pressing urgency.

This recommendation is given effect by paragraph 2(c) of schedule 2 to the draft Bill.

Chapter 5: Our provisional proposals and revised approach – the Liberty Protection Safeguards

PROTECTIVE CARE

5.1 The consultation paper put forward a comprehensive replacement scheme for the DoLS, which we called “protective care”. Broadly speaking, protective care had three parts: the supportive care scheme, the restrictive care and treatment scheme, and the hospitals and palliative care scheme. These are summarised below.

Supportive care

5.2 The consultation paper argued that the decision to move to new accommodation (such as a care home or supported living) can have significant consequences for an individual, and will frequently engage rights to privacy, family life and the home under Article 8 of the ECHR. The purpose of supportive care was to provide protection for people whose Article 8 rights are at risk, but who do not require forms of care and treatment which impinge on their liberty.

5.3 Supportive care would therefore have applied where a person (aged 16 or over) was living in, or being considered for a move into care home, supported living, or shared lives accommodation, but lacked capacity to make decisions about their living arrangements. It would have put an emphasis on preventing the deterioration of the person’s health or social care needs, thus seeking to reduce the need for more intrusive interventions in the longer term.

5.4 Where a local authority considered that a person might qualify for supportive care, it would have been required to undertake or arrange an assessment, or confirm that one had taken place. The assessment could have been undertaken by anyone that the authority thought was appropriate, including social workers or nurses already working with the person. We argued that in the vast majority of cases, an assessment should have already taken place (for instance under the Care Act or the Social Services and Well-being (Wales) Act) and could be used for this purpose.

5.5 If the assessment indicated that the person was eligible for supportive care, a number of ongoing safeguards would have applied. These would have included the appointment of an independent advocate or an “appropriate person”. Amongst other matters, advocates and appropriate persons would have been tasked with ensuring that the person had access to the relevant review or appeals process (for example the social care complaints system or the Court of Protection).

5.6 Supportive care would also have required local authorities to:

- (1) keep the person’s health and care arrangements under review, including checking whether a referral to the “restrictive care and treatment” scheme (see below) was needed; and
- (2) ensure that the person’s care plan included a record of capacity and best interests assessments, set out any restrictions being placed on the person and

confirmed the legal arrangements under which the accommodation was being provided.

- 5.7 We argued that it should already be the case that, for most people, assessments and ongoing reviews would be happening, for instance pursuant to the Care Act, the Social Services and Well-being (Wales) Act or the Mental Capacity Act. In such cases, it would simply have been a matter of the local authority linking with existing reviews to discharge this responsibility.

Restrictive care and treatment

- 5.8 The restrictive care and treatment scheme was intended to provide the direct replacement for the DoLS. But it was not organised around the concept of a deprivation of liberty. Instead, the scheme would have delivered formal safeguards in a wider set of circumstances.

- 5.9 A person (aged 16 or over) would have been eligible for the safeguards if:

- (1) they were moving into, or living in, care home, supported living or shared lives accommodation;
- (2) some form of “restrictive care or treatment” was being proposed; and
- (3) they lacked capacity to consent to the restrictive care or treatment.

- 5.10 The meaning of “restrictive care and treatment” would have been determined by reference to an illustrative list of factors and circumstances. The list would have included those deprived of liberty in accordance with the “acid test”, as well as people not free to leave (but not subject to continuous supervision and control) or subject to continuous supervision (but free to leave). It would also have extended to cases where the person was not allowed to leave the premises unaccompanied or was unable to leave those premises unassisted by reason of physical impairment. It would also have included cases where barriers were being used, the person’s actions were controlled, the person objected, or significant restrictions were being placed on diet, clothing or contact.

- 5.11 We proposed that the restrictive care and treatment scheme would be based around a revised role for the best interests assessor (which we re-named the “Approved Mental Capacity Professional”). Referrals to this scheme would be sent to an Approved Mental Capacity Professional who would be required to undertake an assessment or arrange for an assessment to be completed by another professional (such as the person’s allocated social worker or nurse).

- 5.12 Where a person satisfied the eligibility requirements identified above, an Approved Mental Capacity Professional would have been allocated to their case on an ongoing basis, and required to ensure that:

- (1) the ongoing care and treatment processes complied with existing legal requirements (such as those under the Care Act, the Social Services and Well-being (Wales) Act, the Mental Capacity Act and NHS continuing health care);
- (2) regular review meetings took place (involving the family); and

- (3) an Independent Mental Capacity Advocate (or appropriate person) and a relevant person's representative had been appointed.
- 5.13 The Approved Mental Capacity Professional would also have had power to discharge the person from restrictive care and treatment where appropriate, and impose conditions and make recommendations on the care and treatment authorised by the care plan. It was proposed that people subject to the scheme would have had the right to apply to a tribunal to challenge their care and treatment arrangements.
- 5.14 In cases where the restrictive care and treatment arrangements amounted to a deprivation of liberty, an Approved Mental Capacity Professional would have been required to expressly authorise the deprivation of liberty, or seek alternative solutions to avoid the need for it (such as the provision of additional support services so as to remove the need for a deprivation of liberty).
- 5.15 In order to give an authorisation, the Approved Mental Capacity Professional would have been required to certify in the person's care plan that objective medical evidence had been provided, and that the deprivation of liberty was in the person's best interests. The person would have received the same safeguards as those provided under the restrictive care and treatment scheme described above, including rights to review.

Hospital settings and palliative care

- 5.16 We proposed that a separate scheme would apply in general hospitals and palliative care. This scheme would have delivered safeguards in cases where a patient required (or there was a real risk the patient would require) care or treatment in his or her best interests that amounted to a deprivation of liberty, but the patient lacked capacity to consent to such care or treatment.
- 5.17 Based on the assessments of two clinicians, the hospital managers would have had powers to authorise the care and treatment for up to 28 days. The hospital managers would have been required to appoint an advocate or appropriate person for the patient, and to assign a clinician to take responsibility for their care and treatment. It was proposed that people subject to the scheme would have had the right to apply to a tribunal to challenge their care and treatment arrangements. The authorisation could only be extended beyond 28 days following an assessment by an Approved Mental Capacity Professional.

CONSULTATION RESPONSES

- 5.18 The main strengths of protective care were perceived by consultees to be its emphasis on prevention and improving mainstream health and social care practice, and its location within the wider health and social care system.¹ Consultees noted that the use of assessments and reviews generated by legislation such as the Care Act, the Social Services and Well-being (Wales) Act and Mental Capacity Act would be an important way of avoiding duplication and promoting improved outcomes.² Social workers, in

¹ Consultation analysis, PP 2-1, from para 2.22.

² For example, Care Forum Wales.

particular, felt that the principles of protective care chimed with their professional values and ethics.

- 5.19 Many argued that the proposals would streamline the process of obtaining authorisations and enable a person-centred approach. There was widespread agreement that care plans should provide the authority for deprivation of liberty, rather than a separate system of bureaucracy.³ Some welcomed the emphasis on professional discretion over legalism, and the ability to utilise the skills of mainstream professionals who are already working with the person.
- 5.20 Many supported the different levels of safeguards provided by supportive care, and restrictive care and treatment. The different levels were described as offering graduated protections to those with impaired decision-making capacity at one end of the spectrum, through to those being deprived of liberty at the other.⁴ There was strong support for the inclusion of Article 8 rights, rather than focusing exclusively on the notion of deprivation of liberty.
- 5.21 Others felt that different levels of safeguards would be cumbersome, overly complex and bureaucratic, and generate additional financial costs. Many felt that, following the *Cheshire West* judgment, the distinction between supportive and restrictive care was without meaning as virtually every person who lacked the requisite capacity and lived in a care home or some other form of care environment would satisfy the acid test.⁵ A number of consultees were concerned that supportive care merely duplicated existing legal requirements and good practice, and was therefore unnecessary.
- 5.22 The proposal for a bespoke scheme for hospital settings received majority support.⁶ Many agreed that it recognised the different context of deprivation of liberty in a hospital – where patients are often discharged before the DoLS assessment has been completed – compared to the context of long-stay care homes. Some felt that the proposal would ensure that NHS staff would become “active partners” to local authorities, whereas currently the DoLS are seen as a “local authority matter” and there was little interest or understanding of deprivation of liberty within the NHS. Those who disagreed with the proposal frequently argued that a 28-day initial authorisation was too long and that, due to widespread non-compliance with the Mental Capacity Act amongst hospital clinicians, independent oversight was essential.
- 5.23 Many consultees pointed to the impact of the current economic climate on the statutory sector.⁷ A significant number of local authorities reported that they are failing to cope with existing demands, not just those imposed following *Cheshire West* but also those arising from the recently implemented Care Act in England, an aging population, and the national living wage. Some felt that our proposals underestimated this economic reality or failed to take it seriously.

³ For example, Paul Greening.

⁴ For example, Sue Garwood.

⁵ For example, Sunderland City Council.

⁶ Consultation analysis, PP 8-1, para 7.1.

⁷ For example, Housing LIN and Integritas Support Ltd.

- 5.24 Some consultees argued that any system which was based on the *Cheshire West* interpretation of deprivation of liberty will be unsustainable.⁸ Many submissions pointed to the practical implications of *Cheshire West*. Some argued that the acid test defies common sense; the most frequently quoted examples being end-of-life care and intensive care units. Many queried why the Law Commission was not seeking to overturn or legislate away the acid test.
- 5.25 Many consultees commented on our proposed title “protective care”.⁹ Some felt that it was clear and accessible and chimed with general principles of health and social care, while for others it was too “paternalistic” and “euphemistic”. There was no consensus on alternative labels.
- 5.26 Most agreed that the introduction of the new scheme should be accompanied by a new Code of Practice, and the UK and Welsh Governments should also review the existing *Mental Capacity Act Code of Practice*.¹⁰

DISCUSSION

- 5.27 Most consultees welcomed the general thrust of our provisional proposals and indicated support for the core elements of protective care. But a number of concerns were raised about the financial implications. Many felt that protective care, whatever its merits, would be too costly to implement, particularly in the current economic climate. Consultees argued that any new scheme needed to focus much more on securing cost efficiencies and value for money.
- 5.28 There is some force in these arguments. However, we do not consider that safeguards should be reduced to the bare minimum or that we should reject reforms that may generate additional costs. We remain committed to the principle that the new scheme must deliver tangible benefits and improved outcomes for the person concerned and their family. Moreover, there are some reforms that we consider are fundamental to our new scheme and would need to be properly financed, such as new rights to advocacy (discussed from para 12.20).
- 5.29 Nevertheless, it is our view that the new scheme must demonstrably reduce the administrative burden and associated costs of complying with the DoLS by providing the maximum benefit for the minimum cost. With this in mind, we have concluded that the new scheme should focus solely on ensuring that those deprived of their liberty have appropriate and proportionate safeguards, and should not seek to go as widely as the protective care scheme. Our intention is to deliver a more straightforward, streamlined and flexible scheme for delivering Article 5 safeguards. In particular there would be a reduction of bureaucracy and greater flexibility in how arrangements are authorised, through greater use of equivalent and previous assessments (see para 9.78), allowing multiple arrangements to be authorised (see para 7.12) and the introduction of a renewal process (see para 11.36).

⁸ Consultation analysis, para 2.74.

⁹ Consultation analysis, PP 2-1, from para 2.38.

¹⁰ Consultation analysis, PP 2-2, para 2.49.

- 5.30 A major defect in the DoLS is that they enable the assessment for an authorisation to take place after the person has been deprived of their liberty. As noted in para 4.23, the best interests assessment tends to “rubber stamp” the decision already taken by the care team, meaning that the DoLS are not really a safeguard. This is compounded by the system of urgent authorisations resulting in the consideration of the justification for a deprivation of liberty often coming after the event. Under the new scheme it is vital to establish consideration of the justification for a deprivation of liberty before the event, except in a genuine emergency.
- 5.31 In part, our recommendations aim to do that by moving the authorisation process to the earlier stage at which arrangements are being devised rather than after they have been decided. It would not be left to hospitals or care homes to identify actual or potential cases of deprivation of liberty; the NHS body or local authority which is making or funding the arrangements would become responsible (see para 8.14). There would also no longer be a system of urgent authorisations. Instead, our recommendations would provide that while the NHS body or local authority is determining whether to authorise arrangements, a person may only be deprived of their liberty to enable life sustaining treatment or action believed necessary to prevent a serious deterioration in the person’s condition (see para 15.32).
- 5.32 By way of amendments to the remainder of the Mental Capacity Act, we also seek to maintain the Article 8 protections contained in the supportive care scheme as much as possible, but without the machinery of a separate scheme that would place demands upon services. The amendments would have the effect that a person acting in a professional capacity or for remuneration could not rely on the section 5 defence of the Mental Capacity Act in respect of acts done pursuant to certain key decisions unless a written record has been prepared, which must include (amongst other matters) confirmation that a formal capacity assessment has been undertaken and any rights to advocacy have been given effect.
- 5.33 The amendments would also provide that in all cases particular weight is given to the person’s ascertained wishes and feelings when a best interests determination is being made. These reforms (discussed in chapter 14) would help to ensure, for example, that there is proper consideration of the necessity of removing individuals from their own home and placing them into care home, supported living or shared lives accommodation in advance of the decision being made. The failures of public bodies in this regard have been evident in high-profile cases such as *London Borough of Hillingdon v Neary* and *Essex County Council v RF*.¹¹
- 5.34 We also recommend that private residential care providers should become liable in civil law for any unauthorised deprivation of liberty (see para 15.46). At present, they are only liable if the person’s accommodation has been arranged or funded by a local authority, and are treated, as regards that person’s residential care, as a public authority for Human Rights Act purposes.¹²

¹¹ *Hillingdon LB v Neary* [2011] EWHC 1377 (COP), [2011] 4 All ER 584 and *Essex CC v RF* [2015] EWCOP 1. These cases are summarised at para 1.26 of this report.

¹² Care Act, s 73.

- 5.35 In the light of our revised approach, there is not the same necessity to establish a bespoke general hospital scheme. We consider that our new system is sufficiently clear and straightforward to apply in any setting where a deprivation of liberty for the purposes of Article 5 may occur. This includes hospitals, care homes, supported living and shared lives accommodation, and private and domestic settings. The scope of the scheme in this respect is discussed in chapter 7.
- 5.36 Many consultees were critical of the Supreme Court judgment in *Cheshire West* and argued that it was wrong as a matter of law. However, it is important not to forget the virtues of *Cheshire West*. In particular the judgment pushes to centre-stage the understanding that human rights are universal and that what it means to be deprived of liberty must be the same for everyone, whether or not a person is disabled. Nevertheless, we have some degree of sympathy with the concerns that were raised. It is difficult to divorce *Cheshire West* from its resource implications. The official figures confirm that hospitals and care homes in England made 195,840 DoLS applications in 2015-16 (the highest number since the DoLS were introduced).¹³ These figures are likely to only be the tip of the iceberg, as they do not cover deprivations of liberty outside hospitals and care homes, or those involving 16 and 17 year olds.
- 5.37 Some responses called for a statutory definition of deprivation of liberty which was narrower than that set by the acid test. In our view, this would be misguided. The meaning of deprivation of liberty reflects our ECHR obligations under Article 5, and is based on Strasbourg case law (which must be taken into account by the domestic courts under section 2 of the Human Rights Act 1998). If our draft Bill set a narrower statutory definition of deprivation of liberty, the courts would continue to apply the test as they perceive it to have been set down by the Supreme Court based on the evolving Strasbourg case law. This would almost certainly mean that the new scheme would be incomplete; it would not cover everyone being deprived of liberty within the meaning of Article 5, and a court authorisation would be needed for those individuals. The greater the mismatch between any statutory definition and the definition given by the courts, the greater the number of people in respect of whom (more expensive and cumbersome) court authorisation would be required. We therefore consider that the best option is to continue to tie the definition of deprivation of liberty to the ECHR, not least because the definition continues to be subject to considerable evolution in case law.
- 5.38 Our decision to base the scheme on deprivation of liberty, rather than the wider criteria that we had proposed for the restrictive care and treatment scheme was finely balanced; we recognise that deprivation of liberty is an inevitably imprecise concept. However, we consider that its outlines are now clearer following the decision of the Supreme Court in *Cheshire West*. Moreover, it will be possible to give practical guidance regarding the meaning of deprivation of liberty in the Code of Practice, which can address how the concept may apply in different settings.

¹³ NHS Digital, *Mental Capacity Act (2005) Deprivation of Liberty Safeguards (England): England 2015-16 National Statistics* (2016). See also para 2.22 of this report.

The Liberty Protection Safeguards

5.39 There was no consensus on the name to be given to our new scheme, either at consultation or following the call for suggestions in our interim statement.¹⁴ However it was clear that most responses agreed that the inclusion of the term “deprivation of liberty” in the title would be detrimental to the new scheme for the reasons set out in para 4.13(8), and that it was important to emphasise the notion of promoting people’s liberty. We have therefore called the new scheme the Liberty Protection Safeguards. This name does not appear in the draft Bill itself because a name for the scheme is not required as a matter of law.

Code of Practice

5.40 It will be essential for the Liberty Protection Safeguards to be accompanied by a new Code of Practice. This could be done by a separate code (as is currently the case under the DoLS), or by adding to the main *Mental Capacity Act Code of Practice*. We see clear benefits in producing a combined code, not least of which are that it would help to avoid the new legislation being seen as a “bolt-on” and philosophically separate from the Mental Capacity Act. A combined code would also enable a much-needed review to take place of the main *Mental Capacity Act Code of Practice* so as to incorporate developments in case law and health and social care practice. We make a number of suggestions concerning the content of the new Code of Practice throughout this report.

5.41 Some consultees called for the retention of a single code across England and Wales. The benefits of having a single code include the need to ensure a consistent approach across England and Wales. However there will necessarily be differences in how the Liberty Protection Safeguards are implemented in England and in Wales because of the different contexts that apply (for instance, Wales has local health boards and its own health and social care legislation) and because Wales has devolved secondary legislation powers in this area. Whether any such differences are reflected in a separate code for Wales, or a single code for England and Wales, is ultimately a matter for the Welsh Government. We make no specific recommendation on this.

Recommendation 2.

The Liberty Protection Safeguards should provide for the authorisation of care or treatment arrangements which would give rise to a deprivation of liberty within the meaning of Article 5 of the ECHR. Deprivation of liberty should have the same meaning as in Article 5(1) of the ECHR.

This recommendation is given effect by schedule 1 to the draft Bill (new paragraphs 1(1)(a) and (b) and 4(1) of schedule AA1 to the Mental Capacity Act).

¹⁴ Interim statement, para 1.48.

Recommendation 3.

The Liberty Protection Safeguards should be accompanied by the publication of a new Code of Practice which covers all aspects of the Mental Capacity Act.

This recommendation is given effect by paragraph 9 of schedule 2 to the draft Bill.

Chapter 6: Overview of the Liberty Protection Safeguards

The draft Bill replaces the DoLS in their entirety, with a new administrative process for authorising arrangements which would give rise to a deprivation of liberty, designed to cope with the increased number of people considered to be deprived of liberty following *Cheshire West*, to be less bureaucratic and complex than the DoLS and to provide improved safeguards at lower cost.

Who do the Liberty Protection Safeguards apply to?

The person must be aged 16 or over, lack capacity to consent to the arrangements that are proposed or in place, and be of “unsound mind” within the meaning of Article 5(1)(e) of the ECHR.

Which arrangements can be authorised?

The Liberty Protection Safeguards apply to arrangements which are proposed or in place to enable the care or treatment of a person, and which would give rise to a deprivation of that person’s liberty.

The following arrangements can be authorised:

- a person is to reside in one or more particular places;
- a person is to receive care or treatment at one or more particular places; and
- the means by and manner in which a person can be transported to a particular place or places.

In most cases, arrangements that involve the person being in hospital for assessment or treatment of a mental disorder cannot be authorised. Arrangements cannot conflict with requirements arising under legislation relating to mental health (such as a requirement imposed by a community treatment order or guardianship under the Mental Health Act).

Who can authorise arrangements?

The responsible body may authorise the arrangements. If the person is receiving treatment in hospital or in receipt of NHS continuing health care, the responsible body will be the relevant NHS body (for example, the hospital trust, clinical commissioning group or local health board). Otherwise the responsible body will be the local authority (including where the person is a “self-funder”).

What are the conditions for authorisation of arrangements?

The Liberty Protection Safeguards include a prescribed list of “conditions” that must be met in order for the responsible body to authorise arrangements which would give rise to a deprivation of a person’s liberty. Some of these are positive conditions; they would need to be met before authorisation is granted. The rest are negative conditions; if one of the conditions is met, an authorisation cannot be granted.

The positive conditions are as follows:

- (1) the person lacks capacity to consent to the arrangements;
- (2) the person is of “unsound mind”;
- (3) the arrangements are necessary and proportionate;
- (4) the required consultation has been carried out;
- (5) an independent review has been carried out; and
- (6) in certain cases, the approval of an Approved Mental Capacity Professional has been obtained.

The negative conditions are that the arrangements do not conflict with a valid decision of:

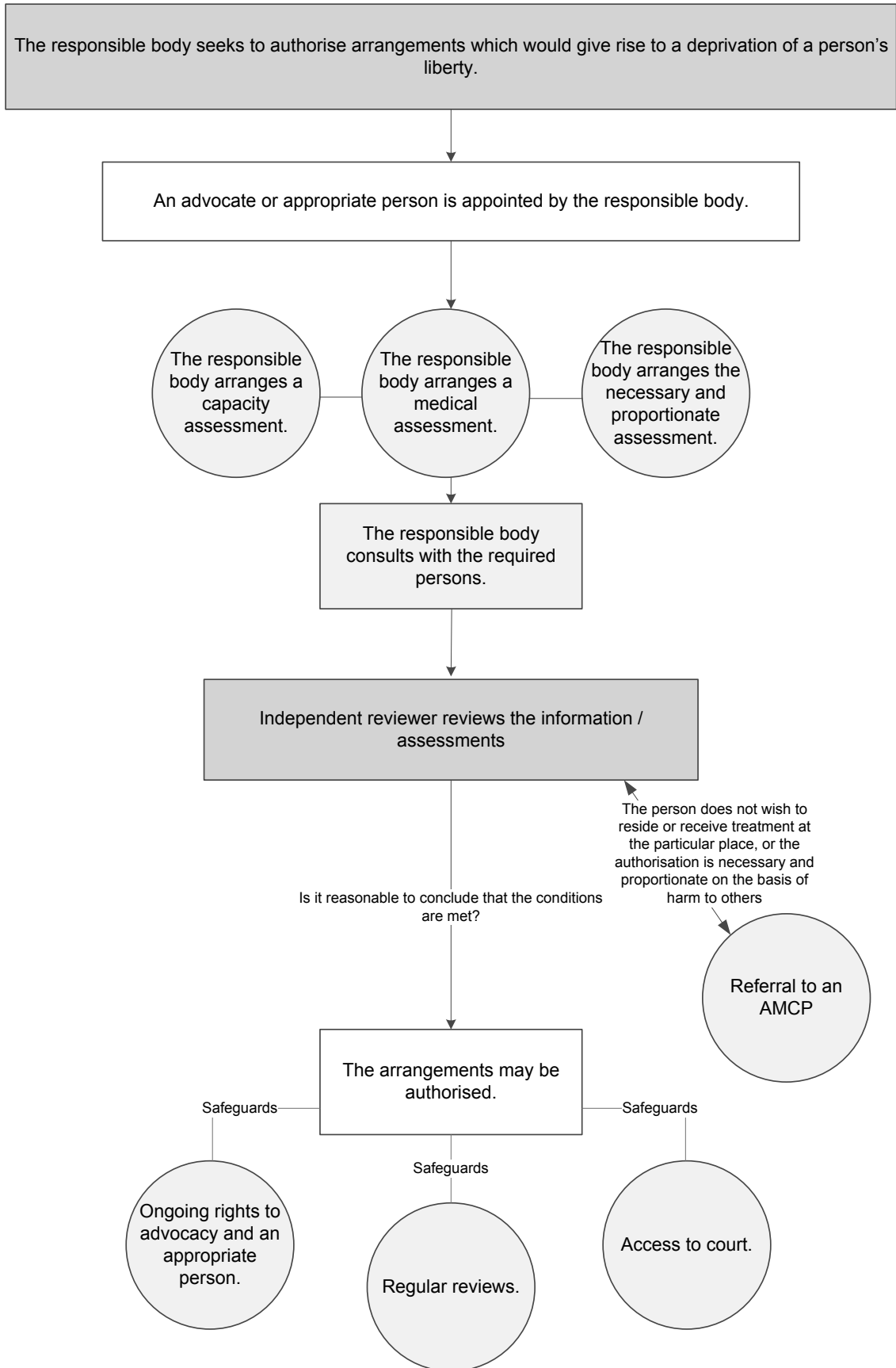
- (1) a donee of a lasting power of attorney; or
- (2) a court appointed deputy.

What safeguards must be provided?

A person subject to the Liberty Protection Safeguards will have regular reviews of the authorised arrangements (and the right to request a review), as well as the provision of an advocate or appropriate person to represent and support them both during the initial authorisation process and during the period of the authorisation itself. They will also have the right to challenge the deprivation of liberty in court.

The diagram opposite sets out the stages in the procedure. These are explained in the chapters that follow. We hope that readers will find it helpful as an overview at this stage of outlining our recommendations and as something to refer back to in the course of reading those chapters.

The Liberty Protection Safeguards Summary of steps



Chapter 7: The scope of the Liberty Protection Safeguards

7.1 This chapter considers the scope of the Liberty Protection Safeguards. Specifically, it discusses the arrangements that can be authorised under the Liberty Protection Safeguards and the position of 16 and 17 year olds.

THE ARRANGEMENTS THAT CAN BE AUTHORISED

7.2 The DoLS apply only to hospitals and care homes. However, Article 5 of the ECHR can be engaged in a wider range of settings, such as supported living, shared lives, and private and domestic settings. A person's confinement in a place must be imputable to the State in order for a deprivation of liberty to arise within the meaning of Article 5; as noted from para 2.31, imputability may arise as a result either of the State's "direct involvement" in the person's detention or of the State's positive obligations to protect the person against interferences with their liberty carried out by private persons.¹

7.3 Lord Neuberger in *Cheshire West* remarked that many people might "react with surprise" at being told that "a person living in a domestic setting could complain of deprivation of liberty".² Nevertheless, deprivations of liberty falling within the scope of Article 5 in private and domestic settings can and do occur, both as a result of the State's direct involvement and through its positive obligations. Direct State involvement would arise, for example, when a local authority has put in place an extensive care package to enable the person to remain at home, consisting of round-the-clock support by paid carers and in circumstances that amount to a deprivation of liberty. The State's positive obligations would also be triggered if, for example, a local authority became aware of a potential deprivation of liberty as a result of a carer's assessment, a referral from a GP, or a safeguarding enquiry.

7.4 In *A Local Authority v A* the court considered whether care provided at home by their parents to a child and an adult amounted to a deprivation of liberty. Both were being locked in their bedroom at night for their own safety by their parents. In both cases, the local authority provided care and support services (but not for the period when they were locked in their rooms) and were aware of the night-time arrangements. It was held that where the State (in this case the local authority) "knows or ought to know" that a person is subject to restrictions of their liberty imposed by a private individual that may give rise to a deprivation of liberty, then its positive obligations under Article 5 will be triggered. These obligations include carrying out an investigation, taking "reasonable and proportionate measures" to bring the state of affairs to an end (such as providing additional services), seeking the assistance of the court to determine whether there is a deprivation of liberty and, if so, obtaining authorisation.³ Whilst this judgment applied

¹ *Storck v Germany* (2006) 43 EHRR 6 (App No 61603/00) at [89].

² *Cheshire West* at [71].

³ *A Local Authority v A* [2010] EWHC 978 (Fam), (2010) 13 CCLR 404 at [95].

pre-*Cheshire West* case law to the objective element of a deprivation of liberty, its dicta on imputability of the State remain good law and have been applied by other judges.⁴

- 7.5 In *Secretary of State for Justice v Staffordshire County Council* it was held that the State's positive obligations were triggered in a case involving the victim of a road traffic accident whose private care package was being funded through an award of damages and arranged by his deputy.⁵ The local authority had no knowledge of the case until it received a letter from the deputy informing it that SRK might be deprived of his liberty. The positive obligations were held to have arisen from the State's knowledge of the circumstances as a result of the court awarding damages, the appointment of a deputy and the role of the deputy to whom the damages were paid.
- 7.6 Currently, deprivations of liberty that fall outside the scope of the DoLS must be authorised by the Court of Protection. The consultation paper argued that this was unnecessarily onerous and expensive for public authorities, and potentially distressing for the person and family concerned. We therefore provisionally proposed that the new scheme should be extended to include supported living, shared lives and private and domestic accommodation. We considered that the benefits of Article 5 safeguards being delivered through an administrative scheme, rather than via the Court of Protection, would outweigh the perception that the scheme was overly intrusive and unnecessary.⁶
- 7.7 We also proposed that the scheme should include powers to authorise other arrangements such as for transporting the person between different locations.⁷

Consultation responses

- 7.8 A majority of consultees agreed that the new scheme should extend beyond hospitals and care homes to include supported living, shared lives and private and domestic accommodation.⁸ Many agreed that requiring every case of deprivation of liberty outside hospitals and care homes to be taken to a court was unrealistic and too slow and costly. It was argued that the need for judicial approval of "routine" cases meant that the courts have less capacity for disputed or complex cases, which would derive greater benefit from the court's expertise. There was some concern that the current system leaves people at risk of being unlawfully deprived of their liberty, due to the impracticalities associated with going to court: many reported that, following *Cheshire West*, local authorities are not prioritising cases outside hospitals and care homes. Some argued that individuals should not be treated differently, or be entitled to lesser safeguards (in the sense of, for example, not being entitled to advocacy or means-tested legal aid), on the basis of the setting in which they were deprived of liberty. Several consultees suggested that the new scheme should go further still and include additional settings, such as day centres, respite care, children's homes, residential special schools, and foster care.

⁴ For example, *SRK v Staffordshire CC* [2016] EWCOP 27, [2016] 3 WLR 867 at [36] and *Haringey LB v R* [2016] EWCOP 33 at [48] to [51].

⁵ *Secretary of State for Justice v Staffordshire CC* [2016] EWCA Civ 1317.

⁶ Consultation paper, paras 4.16 to 4.25.

⁷ As above, para 7.207.

⁸ Consultation analysis, PP 4-1, para 4.1.

- 7.9 Those who disagreed with the proposal argued that it would produce an unmanageable amount of extra work for the NHS and local authorities, and be impractical to monitor and implement (particularly in private and domestic settings). Some were concerned that it would be perceived as unwanted and unnecessary State involvement in people's lives.
- 7.10 The majority agreed that the new scheme should include powers to authorise arrangements such as transport and that authorisations should be capable of applying to deprivations of liberty in more than one setting.⁹ Some consultees provided examples of the problems caused by the lack of express powers under the DoLS to return people to their place of residence or convey them between different places. Many argued that the current position under the DoLS – whereby new authorisations must be sought if, for example, the person is admitted to hospital or respite care – was a waste of resources. Those who disagreed with the proposal frequently argued that being detained in a different setting will necessarily alter the care or treatment regime, and that the person should have the right to be assessed afresh.

Discussion

- 7.11 Consultation confirmed our view that the new scheme should extend beyond hospitals and care homes. The current requirement of a court authorisation for every deprivation of liberty outside a hospital or care home is costly, ineffective, and potentially distressing for the person and family concerned. In our view, an administrative authorisation process would be a far more effective and efficient way of dealing with deprivations of liberty. For these reasons, we agree that the scheme should also be capable of authorising arrangements in, for example, supported living accommodation, shared lives schemes, respite care, children's homes, residential special schools, foster care, and private and domestic settings. Accordingly, we have concluded that the Liberty Protection Safeguards should not be limited to specific forms of accommodation or residence, and instead should encompass any situation where Article 5(1)(e) is potentially engaged. In other words, the type of setting is not a criterion in the new scheme at all.
- 7.12 A DoLS authorisation simply authorises "deprivation of liberty".¹⁰ By contrast, the Liberty Protection Safeguards provide for the authorisation of particular *arrangements* which give rise to a deprivation of liberty.¹¹ This is an important difference. It focuses attention at the authorisation stage not simply on the "binary" question of whether a person should be deprived of their liberty or not, but on the question of the ways in which a person may justifiably be deprived of liberty. Consideration of whether a deprivation of liberty is necessary and proportionate has always been a requirement of the Strasbourg case law.¹² Our scheme would require the decision-maker to apply those tests to any proposed arrangements that would give rise to a deprivation of liberty. It seems to us that authorising arrangements is the nub of the issue, and has the additional advantage of making it possible for authorisations to cover transport between places and arrangements carried out in more than one place (for example if a person living at home

⁹ As above, PP 7-36, para 6.377.

¹⁰ Mental Capacity Act, sch A1, paras 1 and 2.

¹¹ Draft Bill, sch 1 (new para 1(a) and (b) to sch AA1 of the Mental Capacity Act).

¹² See para 9.20 of this report.

needs regular respite care in a care home). As noted above, these were major issues that were raised frequently by consultees.

- 7.13 The meaning of “arrangements” is intentionally broad. For example, it would be possible under our scheme to authorise arrangements to return a person to a specified place (or places) if they had absconded or wandered off. The Liberty Protection Safeguards could also be used to authorise arrangements in community settings such as day centres. We were told at consultation that it is not uncommon for people with dementia and learning difficulties to be prevented from leaving day centres unaccompanied and to be under constant supervision and control.
- 7.14 Our intention is that arrangements should be authorised which are proposed, or in place. An authorisation can have effect immediately on the responsible body determining that the conditions for authorisation are met (see chapters 9 and 10), or on a later date specified by the responsible body, being no later than 28 days from the day the responsible body made the determination that the conditions are met.¹³ Our intention is that arrangements should be authorised, wherever possible, in advance of being implemented as part of advance care planning, and that this should be made clear in the new Code of Practice. If steps are only taken when the deprivation of liberty arises, a move into institutional accommodation may become irreversible, for instance by the person’s house no longer being available for them to return to.¹⁴ However, we recognise that there may be situations in which it is simply not possible for such advance planning to take place (most obviously in the case of emergency admissions to hospital), so the authorisation procedure can be initiated in such cases upon the need for deprivation of liberty being identified. Interim and emergency deprivation of liberty is discussed in from para 15.25.
- 7.15 It is important to emphasise that the Liberty Protection Safeguards require decision-makers to be clear and precise about the particular arrangements that are being authorised. Arrangements cannot be authorised in terms which are vague and broad. Authorisations can only be given in respect of a “particular place” or “particular places”, and an authorisation record must “specify” the arrangements which are authorised.¹⁵ This would mean, for example, that the particular arrangements that give rise to a deprivation of liberty must be set out in detail and the places where the person will reside or receive care or treatment must be named in the authorisation record. We would expect that the new Code of Practice would emphasise that unless the proposed arrangements are clear and specific, the authorisation is unlikely to be effective in law. The authorisation record is discussed in from para 11.2.
- 7.16 It is also important to emphasise that the Liberty Protection Safeguards can only authorise arrangements that would give rise to a deprivation of liberty. They cannot be used to authorise arrangements which instead provide (for example) for a person’s contact with friends, family members and others to be restricted. This maintains the position in case law that DoLS authorisations should not to be used by a public authority as a means of “getting its own way” on matters engaging Article 8 of the ECHR, such

¹³ Draft Bill, sch 1 (new para 34 of sch AA1 to the Mental Capacity Act).

¹⁴ See in particular, in the context of DoLS, *AJ v A Local Authority* [2015] EWCOP 5, [2015] 3 WLR 683.

¹⁵ Draft Bill, sch 1 (new paras 1(2)(b) and 31(a) of sch AA1 to the Mental Capacity Act).

as where the person should live and with whom they should have contact.¹⁶ The Liberty Protection Safeguards also cannot be used to authorise the actual delivery of care or treatment to the person. Whilst the arrangements which can be authorised include that the person “is to receive care or treatment at one or more particular places”, the delivery of that care or treatment would continue to be governed by the statutory defence in section 5 of the Mental Capacity Act (which we discuss further from para 14.22).

- 7.17 Some consultees were concerned by the cost implications of our proposal. However, as noted above, the current system is far more expensive and inefficient, since it requires all deprivations of liberty outside hospitals and care homes to be taken to the Court of Protection. It is also relevant to note in this regard the evidence from consultation that cases outside hospitals and care homes are often not being addressed at all. A number of local authorities reported that, in the wake of *Cheshire West*, they do not have the resources to prioritise potential deprivations of liberty outside hospitals and care homes, and many such cases are being left unassessed and not being taken to court when they should be. This situation is not acceptable. Any “savings” currently being achieved are largely through non-compliance with the law, and in our view this does not provide a legitimate reason for maintaining the current position. It is vital that any new scheme must deliver practical and effective Article 5 rights.
- 7.18 We agree with the view expressed by many consultees that the Liberty Protection Safeguards must be implemented in a way that minimises intrusion into private and family life. In most cases arrangements could be authorised in an unobtrusive and straightforward manner through a care plan and without a perception of State intrusion in family matters. It is right that the State must not intrude unnecessarily. Only in more “serious” cases, where the arrangements are contrary to the person’s wishes, would more intervention be needed (in the form of an approval by an Approved Mental Capacity Professional as described from para 10.27). We think that this approach strikes an appropriate balance between the rights of the person to be protected, and rights to private and family life under Article 8.
- 7.19 We are aware that there is some ongoing debate over the reach of Article 5 when it comes to private and domestic settings. It has been argued that the State’s positive obligations will only be triggered in purely private arrangements when there are safeguarding concerns (for example, the deprivation of liberty is a reflection of an abusive relationship between the person and their family carer).¹⁷ In accordance with recommendation 2, the Liberty Protection Safeguards do not define deprivation of liberty; therefore any future case law developments could be absorbed by our scheme.

¹⁶ See, in particular, *Hillingdon LB v Neary* [2011] EWHC 1377 (COP), [2011] 4 All ER 584 at [33].

¹⁷ See, for example, the submissions of the Secretary of State for Justice in *SRK v Staffordshire CC* [2016] EWCOP 27, [2016] 3 WLR 867 at [58] and [148], and *Secretary of State for Justice v Staffordshire CC* [2016] EWCA Civ 1317 at [45]. In both cases, these submissions were unsuccessful.

Recommendation 4.

The Liberty Protection Safeguards should enable the authorisation of arrangements which are proposed (up to 28 days in advance), or are in place, to enable the care or treatment of a person which would give rise to a deprivation of that person's liberty. The arrangements that can be authorised should include:

- (1) arrangements that a person is to reside in one or more particular places;**
- (2) that a person is to receive care or treatment at one or more particular places; and**
- (3) arrangements about the means by which and the manner in which a person can be transported to a particular place or between particular places.**

This recommendation is given effect by schedule 1 to the draft Bill (new paragraph 1(1)(a) and (b), 2(1) and 34 of schedule AA1 to the Mental Capacity Act).

16 AND 17 YEAR OLDS

7.20 The remit of our review extends to considering the position of young people aged 16 and 17 (but not children aged 15 or younger). Most of the Mental Capacity Act applies to people aged 16 and over. However, the DoLS only apply to adults aged 18 and over.

7.21 There are several legal provisions that permit the deprivation of liberty of children and young people. Under section 25 of the Children Act 1989, a child who is being looked after by a local authority can be placed or kept in secure accommodation in England, provided for the purpose of restricting liberty. The Mental Health Act can be used to detain a person of any age suffering from mental disorder for the provision of medical treatment. Beyond these cases, the deprivation of liberty of a young person can be authorised by the Family Court or Family Division of the High Court under their respective inherent jurisdictions or by the Court of Protection.¹⁸

7.22 A complicating factor is that the Strasbourg court has recognised the right of parents – in certain cases – to consent to restrictions placed on their child which would otherwise amount to a deprivation of liberty.¹⁹ Applying this jurisprudence, Mr Justice Keehan in *Trust A v X* held that a child's parents can provide valid consent to what would otherwise be a deprivation of liberty where this is within the "zone of parental responsibility".²⁰ However, in *Birmingham City Council v D* (decided after the publication of the

¹⁸ See, for instance, *A Local Authority v A* [2010] EWHC 978 (Fam), (2010) 13 CCLR 404 at [47], *B v M* [2010] EWHC 2746, and *Barnsley MBC v GS* [2014] EWCOP 46.

¹⁹ *Nielsen v Denmark* (1988) 11 EHRR 175 (App No 10929/84), but note the many dissenting opinions. The decision was also doubted by Munby J in *A Local Authority v A* [2010] EWHC 978 (Fam), (2010) 13 CCLR 404 at [161].

²⁰ *Trust A v X* [2015] EWHC 922 (Fam), [2016] 1 FLR 142 at [55].

consultation paper), Mr Justice Keehan revisited X’s circumstances upon his turning 16, and limited this approach to children who are aged under 16.²¹

- 7.23 The consultation paper suggested that section 25 of the Children Act and detention under the Mental Health Act provide an inadequate basis for dealing with many young people who lack mental capacity and need to be deprived of their liberty.²² In addition, we argued that the legal framework for 16 and 17 year olds establishes unjustifiable inequalities amongst age groups, and potentially places young people at a distinct disadvantage compared to adults. We therefore provisionally proposed that the new scheme should apply to 16 and 17 year olds.
- 7.24 The consultation paper also raised concerns that judicial confidence was being placed in the “zone of parental responsibility”, which remains a poorly understood and ill-defined concept. The implication of the case law as it stood at the time of the consultation paper was that a young person who lacked capacity might be left without the protections guaranteed by Article 5 of the ECHR as a result of this concept. We asked for views on whether the concept was appropriate in practice when applied to 16 and 17 year olds who lack capacity.

Consultation responses

- 7.25 A majority at consultation supported our proposal to include 16 and 17 year olds in the new scheme.²³ Most argued this would provide consistency with the rest of the Mental Capacity Act, and that in many cases the use of the Mental Health Act and section 25 of the Children Act would be inappropriate.²⁴ We were also told that a court application is an unnecessary and costly way of dealing with such cases. It was reported that residential special schools make regular requests to the placing local authority asking them to apply to the Court of Protection for orders authorising deprivations of liberty, but the majority have had no response, leaving them in a “precarious legal position”, and the child without any Article 5 protections.²⁵ A number of NHS bodies and local authorities told us that, following *Cheshire West*, they were not even considering deprivation of liberty cases involving 16 and 17 year olds. Some suggested that the proposal would assist with the young person’s transition from children’s to adult services. Many pointed to the need to consider the interfaces with other legal provisions, such as the Children Act and Gillick competence. It was queried whether Ofsted and Estyn would be required to monitor and report on the new scheme in respect of 16 and 17 year olds.
- 7.26 Those who disagreed with the proposal felt that a young person’s rights were already adequately protected, for example, by the Children Act and Social Services and Well-being (Wales) Act and through the court system. Others argued that any potential benefits of extending the scheme to 16 and 17 year olds would be outweighed by the

²¹ *Birmingham CC v D* [2016] EWCOP 8. An appeal against his decision was heard by the Court of Appeal in February 2017 but the outcome was not known at the time of publishing this report.

²² Consultation paper, paras 15.2 to 15.12.

²³ Consultation analysis, PP 15-1, para 14.1.

²⁴ For example, the Association of National Specialist Colleges.

²⁵ As reported by, for example, the National SEND Forum and the National Association of Independent Schools and Non-Maintained Special Schools.

increased burdens on the child care system. Some suggested that care orders under the Children Act should be used to authorise deprivations of liberty. The Huntercombe Group and RadcliffesLeBrasseur felt that our review was a “missed opportunity” because it had failed to consider the position of children aged below 16.

7.27 We received a range of comments about the zone of parental responsibility.²⁶ Many felt that the concept was inappropriate when applied to potential deprivations of liberty involving 16 and 17 year olds, and prevented Article 5 safeguards from being provided to vulnerable young people. Others argued that it should be retained because 16 and 17 year olds are still maturing and require the “safety net” of parental consent, and that continuing parental responsibility enabled parents to assist their children in the transition to adult services.

Discussion

7.28 Our view remains that the current framework for the deprivation of liberty of 16 and 17 year olds is inadequate. We do not think it acceptable to require that, unless the use of the Mental Health Act is appropriate, a court application must be made in order to authorise a deprivation of liberty. This is unnecessarily onerous and expensive for the State (especially NHS bodies and local authorities, which are often expected to bring cases to court), and potentially distressing for the young person and family concerned.

7.29 Whilst section 25 of the Children Act could be used to deprive a young incapacitated person of liberty in a situation which is broadly analogous to a deprivation of liberty for the purpose of delivering care and treatment, in the vast majority of cases the use of section 25 would not be appropriate for this group. As Mr Justice Keehan noted in *A Local Authority v D*, a secure accommodation order has a “punitive quality to it” and is designed for looked-after children “who, by reasons of their actions, are likely to abscond and, thus, suffer significant harm or injure themselves or others”.²⁷

7.30 We were particularly concerned by the reports that public authorities are not currently taking cases to court when they should. Plainly, the legal framework is failing to deliver Article 5 safeguards to many young people who lack capacity to consent to their care and treatment arrangements. It is therefore fallacious to argue that extending the new scheme would increase the burdens placed on health and social care services. The current system is extremely costly and inefficient, since it requires NHS bodies and local authorities to initiate court proceedings, and is therefore not being implemented properly. Any “savings” are only being achieved through non-compliance with the law.

7.31 We have therefore concluded that the Liberty Protection Safeguards should extend to 16 and 17 year olds. This will allow deprivations of liberty to be authorised in a much more efficient and straightforward manner, and in a way that makes sense for the families and professionals concerned. It will also help to ensure that young people are provided with practical and effective Article 5 rights.

7.32 In extending the scheme we have deliberately sought to avoid making alterations or adjustments to provide for the circumstances of this group. For example, in line with recommendation 2, we have not attempted to give a specific definition of deprivation of

²⁶ Consultation analysis, Q 15-2, from para 14.17.

²⁷ *A Local Authority v D* [2015] EWHC 3125 (Fam), [2016] 3 WLR 1401 at [31].

liberty for the purposes of its application to young people. In *Cheshire West*, some of the judges considered the application of the “acid test” to children (MEG was 17), and implied that the test is more nuanced because children are compared with those of the same age and maturity.²⁸ To the extent that it may be appropriate to seek to outline how the “acid test” might apply in the context of 16 and 17 year olds (or even to those aged under 16), this is a matter better left to the new Code of Practice. Under the Liberty Protection Safeguards some differences do arise for 16 and 17 year olds, but these are mainly procedural, such as in relation to the consultation duties (see from para 10.6), the meaning of the responsible body (see from para 8.14) and potential regulatory arrangements (see from para 12.91).

- 7.33 In the consultation paper we expressed concern about the use of parental consent to authorise what would otherwise be a deprivation of liberty for 16 and 17 year olds. These concerns were not alleviated by consultation. We do not agree with the assertion made that 16 and 17 year olds often lack sufficient maturity; but even if this is so it does not provide an adequate reason for denying legal safeguards to young people. Similarly, we do not consider that transition difficulties between children and adult services provide a sufficient justification for denying access to Article 5 safeguards, and any such difficulties should be addressed through guidance and education.
- 7.34 We remain of the view that Article 5 safeguards should not be denied to young people on the basis of parental consent to the confinement. As we maintained in the consultation paper, it is important to respond to the increasing recognition in international law of the need to give greater weight to the views of young people.²⁹ The current legal position is that a parent cannot consent to what would otherwise amount to a deprivation of liberty of a 16 or 17 year old.³⁰ Despite our support for this position, we have decided not to expressly prohibit “substituted consent” in the draft Bill. It is possible that this position may alter in the future, either as a result of domestic or Strasbourg case law, and we want the Liberty Protection Safeguards to be able to accommodate the effect of any future judgments.
- 7.35 In some cases, 16 and 17 year olds who are being confined will be unable to give the requisite consent due to a lack of Gillick competence (rather than mental incapacity). In other words, they do not have sufficient maturity and intelligence to understand the nature and implications of the proposed decision.³¹ Under the existing legal framework, an application to either the Family Court or the Family Division of the High Court is required. Our scheme is based on lack of capacity in accordance with the Mental Capacity Act and therefore the position of such people would not be affected.
- 7.36 There will continue to be some degree of overlap between section 25 of the Children Act and the Liberty Protection Safeguards. The Children (Secure Accommodation) Regulations 1991 provide that that section 25 cannot apply to a child detained under

²⁸ *Cheshire West* at [79].

²⁹ Consultation paper, para 15.9. See also Articles 5 and 37 of the UN Convention on the Rights of the Child and Article 3(h) of the UN Convention on the Rights of Persons with Disabilities.

³⁰ *Birmingham CC v D* [2016] EWCOP 8 at [105] to [122]. An appeal against this decision was heard by the Court of Appeal in February 2017 but the outcome was not known at the time of publishing this report.

³¹ *Gillick v West Norfolk and Wisbech AHA* [1985] UKHL 7 [1986] 1 AC 112.

the Mental Health Act.³² We would expect a similar exclusion to apply when a young person is subject to the Liberty Protection Safeguards.

- 7.37 Whilst we consider that parents should not be able to consent on behalf of their 16 or 17 year old children to their confinement, we consider that it is important that parental rights in this regard are otherwise maintained and bolstered. The Liberty Protection Safeguards therefore provide, for example, that parents have rights to be consulted.³³ Also, if the parent of a 16 or 17 year old objected to the deprivation of liberty, they would continue to have the right to oppose it in a court.³⁴
- 7.38 We received some evidence from consultation of poor knowledge amongst health and social care professionals about how the Mental Capacity Act applies to young people. We hope that the reforms we recommend in this report will ensure a better understanding of the law in this respect and, in particular, the reforms we recommend in chapter 14 to the statutory defence under section 5 of the Mental Capacity Act and to best interests determinations. The reforms in chapter 14 should, amongst other matters, give prominence to the fact that where decisions are being taken on a best interests basis in respect of 16 and 17 year olds those decisions must be taken with a closer eye to the views of the person.
- 7.39 We do not agree that the Children Act should be amended to provide that when a court was considering making an interim or full care order it could also authorise the deprivation of liberty of the child in question.³⁵ This would only provide a solution potentially to a small number of cases involving children who need to be placed under the care of a local authority. But, more fundamentally, it would be reliant on a court authorisation which for the reasons set out above we do not think is proportionate or feasible given the numbers post *Cheshire West*. Moreover, there would need to be significant amendments made to the Children Act in order to deliver the safeguards required by Article 5, and it would not be sufficient, for example, to rely on child care reviews chaired by independent reviewing officers.³⁶ Such reforms would arguably alter the very nature of the care order regime.
- 7.40 Some consultees expressed dissatisfaction that the remit of our review did not extend to all children and young people aged under 18, and called for a “Children’s Capacity Act” which could codify and clarify the whole issue of capacity in relation to those under 18. We have some degree of sympathy with these concerns (which echo those previously expressed by others including members of the judiciary) and would urge the Government to consider a review of this area of law with a view to statutory codification.³⁷

³² The Children (Secure Accommodation) Regulations 1991, SI 1991 No 1505, reg 5(1).

³³ Draft Bill, sch 1 (new para 22(2) to sch AA1 of the Mental Capacity Act).

³⁴ Draft Bill, s 4(2).

³⁵ It has been confirmed that currently interim and full care orders do not provide authority for a deprivation of liberty, see *A Local Authority v D* [2015] EWHC 3125 (Fam), [2016] 3 WLR at [36].

³⁶ *A Local Authority v D* [2015] EWHC 3125 (Fam), [2016] 3 WLR 1401 at [31].

³⁷ See, for instance, McFarlane J, “Mental Capacity: One Standard for All Ages” (2011) 41 *Family Law* 5, 479.

7.41 The regulation and monitoring of our scheme in respect of 16 and 17 year olds is considered in para 12.93.

Recommendation 5.

The Liberty Protection Safeguards should apply to people aged 16 and above.

This recommendation is given effect by schedule 1 to the draft Bill (new paragraph 1(2)(a) of schedule AA1 to the Mental Capacity Act).

Recommendation 6.

The Government should consider reviewing mental capacity law relating to all children, with a view to statutory codification.

Chapter 8: The responsible body

- 8.1 This chapter considers the question of which bodies should be responsible for authorising arrangements that would give rise to a deprivation of liberty.
- 8.2 The DoLS provide that a supervisory body is responsible for considering requests for authorisations, commissioning the required assessments and, where the assessments are “positive”, authorising the deprivation of liberty. Where the DoLS are applied to a person in a care home, whether situated in England or Wales, the supervisory body will be the local authority for the area in which the person is ordinarily resident. If the person is not ordinarily resident in the area of any local authority (for example a person of no fixed abode), the supervisory body will be the local authority for the area in which the care home is situated.
- 8.3 When the application is being made by a hospital, the supervisory body in England is the local authority for the area in which the person is ordinarily resident. If the person is not ordinarily resident in the area of any local authority, the supervisory body will be the local authority for the area in which the hospital is situated. In Wales, the supervisory body is the local health board in the area where the person is (or is to be) situated.¹
- 8.4 The so called “deeming” rules, contained in the Care Act and Social Services and Well-being (Wales) Act, make provision for determining the ordinary residence of people whose needs can only be met through the provision of certain types of accommodation (such as care homes), including when the accommodation is being arranged in a different local authority area. The rules provide that a person’s ordinary residence remains with the local authority in which they were ordinarily resident immediately before moving into the accommodation.
- 8.5 Any disputes arising as to the ordinary residence of a person are determined by the Secretary of State or by the Welsh Ministers. In the event of a dispute, the local authority which receives the request for a standard authorisation must act as the supervisory body until the dispute is resolved, unless another local authority agrees to perform this role.²
- 8.6 The consultation paper provisionally proposed that, outside hospitals, local authorities should continue to be responsible for the new scheme.³ In hospitals we proposed a bespoke scheme which, in broad terms, would be the responsibility of the relevant hospital trust or local health board. We also asked whether difficulties arise in identifying the supervisory body for the purposes of the DoLS and if certain areas of the law could be usefully clarified under the new scheme. Finally, we asked whether a fast track

¹ Mental Capacity Act, sch A1, para 182(1) and (2). For hospitals in Wales, see also Mental Capacity (Deprivation of Liberty: Appointment of Relevant Person’s Representative) (Wales) Regulations 2009, SI 2009 No 266, reg 3.

² Mental Capacity Act, sch A1, para 183(4) and Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008, SI 2008 No 1858.

³ Consultation paper, PP 6-3 and 7-6.

determination scheme is needed for cases where a person is deprived of liberty and there is a dispute over the person's ordinary residence.⁴

Consultation responses

- 8.7 A majority agreed that local authorities should be responsible for the new scheme (outside hospitals).⁵ However, it was also argued that the NHS should be given greater responsibility, especially if the person's services are being managed and funded by the NHS. Local authorities told us that in practice they cannot compel the NHS to agree a care plan which it is unwilling to fund, and therefore – even in cases where the local authority (as the supervisory body) thinks that a less restrictive care plan would be more appropriate – they have little option but to grant a DoLS authorisation. It was also reported that NHS involvement in the DoLS has reduced significantly in England since 2013, when Primary Care Trusts ceased to be classified as supervisory bodies.
- 8.8 Many consultees reported current difficulties or areas that should be clarified.⁶ For example, some felt it was not clear whether the deeming rules applied in cases where a local authority has assisted the person to move, but has not made a formal placement. This was seen as a particular difficulty in cases involving self-funders. Others noted difficulties when the DoLS application relates to a person receiving NHS continuing health care, because NHS commissioning areas do not match local authority areas. There was also seen to be a conflict between the DoLS and adult safeguarding, since the latter is based on where the person is physically located rather than their ordinary residence.
- 8.9 Some local authorities described the difficulties that arise when a person has been placed in another local authority area some distance away: for example, an inability to monitor the DoLS authorisation effectively and assessors needing to travel long distances and being taken away from their day-to-day jobs for longer periods. Whilst ADASS published in 2009 a “protocol” which outlines the responsibilities of and actions to be taken by local authorities in these circumstances, we were told that this was under considerable pressure following *Cheshire West*, and that the big net receivers (mainly shire counties and seaside towns) had no spare best interests assessor capacity.⁷ Some argued that a simpler solution would be for the “host” authority to become responsible.
- 8.10 A majority of consultees supported a fast track determination scheme where there is a dispute over the person's ordinary residence.⁸ This was seen as being potentially useful in end-of-life cases. However, some local authorities felt it would impose significant costs, since they would be expected to pull together all the information in a short period of time. Others felt a fast track system was unnecessary provided there is clarity about who should be responsible pending resolution and the system of reimbursement.

⁴ As above, Q15-3 and 15-4.

⁵ Consultation analysis, PP 7-6, para 6.50.

⁶ As above, Q 15-3, from para 14.29.

⁷ ADASS, *Protocol for the Inter-Authority Management of Deprivation of Liberty Safeguards Applications* (2009).

⁸ Consultation analysis, Q 15-4, para 14.40.

Discussion

- 8.11 Consultation raised a number of complex issues about who should be responsible for authorisations. There was general agreement that the NHS should have greater responsibility, and had not been sufficiently engaged with the DoLS. This reinforces general feedback from consultees that there is often little awareness or understanding of deprivation of liberty within the NHS, since it is seen as a local authority matter.⁹ There was also much criticism of the language used by the DoLS in this area, especially the term “supervisory bodies”. In designing the Liberty Protection Safeguards we have deliberately moved away from this terminology; rather than a “supervisory body”, the draft Bill refers to the “responsible body” in relation to the authorisation of arrangements.
- 8.12 Identifying the responsible body in any given case is of vital importance. Consultation indicated the problems that can arise when, for example, a local authority is the supervisory body but the care or treatment is being delivered entirely by the NHS. Under the Liberty Protection Safeguards, our overarching intention is to establish a stronger link between the commissioning of the arrangements and responsibility for the authorisation. In other words, the body that is responsible for arranging the relevant care or treatment should (wherever possible) be responsible for considering requests for authorisations, for commissioning the required assessments and for the authorisation of arrangements. This would have the clear advantage that the commissioning body responsible for the proposed arrangements would be directly accountable for all stages of the process.
- 8.13 However, we also recognise the importance of legal certainty when it comes to identifying the responsible body. In some cases responsibility for the arrangements will not be clear cut: for instance, if there are joint funding arrangements in place, the person does not have a care plan or the person is a self-funder. Moreover, the Liberty Protection Safeguards would enable different health and social care arrangements to be authorised at the same time (such as an authorisation for the person to be deprived of their liberty in a care home and for a planned hospital admission). The identity of the responsible body needs to be sufficiently precise and should not produce disputes in a large number of cases.
- 8.14 The draft Bill aims to balance, on the one hand, the need for a stronger link between the commissioning of the arrangements and responsibility for the authorisation, with, on the other hand, the need for certainty. It therefore establishes a hierarchy of responsible bodies. In order to identify the responsible body, the following should be considered in order:
- (1) if the arrangements or proposed arrangements are being carried out primarily in a hospital, the responsible body is the “hospital manager”;
 - (2) otherwise, if the arrangements or proposed arrangements are being carried out primarily through the provision of NHS continuing health care, the responsible body is the relevant clinical commissioning group in England or the local health board in Wales; and

⁹ See, for example, consultation analysis, PP 7-34, 7-21, 8-1, 8-2 and general comments (from para 15.2).

- (3) otherwise the responsible body is the “responsible local authority”.¹⁰
- 8.15 The reason for establishing a hierarchy is to provide certainty in any case which potentially falls in more than one category (for example, it would be possible under the Liberty Protection Safeguards for a person in receipt of NHS continuing health care or social care to be deprived of liberty in a hospital). Under our approach, the first category (hospital arrangements) trumps the others, and the final category is residual and catches any case which does not fall within the first two categories. This is aimed at providing greater legal certainty.
- 8.16 The hierarchy also provides that the NHS would be responsible for authorisations of arrangements in hospitals and carried out through NHS continuing health care. This has the clear advantage of establishing a closer link between the commissioning of the arrangements, and responsibility for the arrangements. We hope that our recommendation in this respect would help to ensure that the NHS becomes an active partner in protecting people’s Article 5 rights.
- 8.17 The draft Bill uses the term “hospital manager” to describe the responsible body in a hospital. We are not by this identifying a specific individual (or set of individuals). Rather, in England this would be the Special Health Authority, NHS Trust or NHS Foundation Trust that manages the hospital. In Wales, it would be the local health board. In an independent hospital, the hospital manager is the person or persons in whose name the hospital is registered. In the small number of independent hospitals where there is no registered person (such as an armed services hospital) the responsible body would be the Secretary of State or Welsh Ministers.¹¹
- 8.18 Under the Liberty Protection Safeguards, a local authority would be the responsible body for cases that fall outside para 8.14(1) and (2) above, including self-funders and those in receipt of after-care under section 117 of the Mental Health Act. Whilst this approach is to some extent crude, it does give the advantage of certainty. Local authorities are currently responsible for many such cases under the DoLS, and will have at least part of their workload taken away when the arrangements are being carried out in hospitals or through the provision of NHS continuing health care. Moreover, authorising arrangements that give rise to a deprivation of liberty can be seen as an aspect of safeguarding duties which are allocated to local authorities by section 42 of the Care Act and section 126 of the Social Services and Well-being (Wales) Act.
- 8.19 It will be necessary to identify which local authority will be the “responsible local authority” for any given case which falls under para 8.14(3) above. The draft Bill establishes that the “responsible local authority” is the authority that is meeting the person’s needs under the Care Act or Social Services and Well-being (Wales) Act, or providing accommodation under section 20 of the Children Act or part 6 of the Social Services and Well-being (Wales) Act. If more than one local authority is meeting the person’s needs, the responsible local authority is the local authority in which the person is ordinarily resident under the Care Act, Children Act, or Social Services and Well-being (Wales) Act. In any other case (such as self-funders, those in receipt of section 117 after-care, or those who are placed in England and Wales by a statutory body in

¹⁰ Draft Bill, sch 1 (new para 7 of sch AA1 to the Mental Capacity Act).

¹¹ Draft Bill, sch 1 (new para 8 of sch AA1 to the Mental Capacity Act).

another jurisdiction) the responsible local authority is the authority for the place where the person resides, or in which the place of primary residence is situated, or in which the arrangements are or will be primarily carried out.¹²

- 8.20 The responsible body can change during the lifetime of an authorisation. It will be a matter of fact in each case which body at any particular time is the responsible body. For example, emergency admissions to a hospital are likely to alter the identity of the responsible body; this is a consequence of the requirement that authorisations must be specific. There may be cases of planned short-term hospital admissions where the identity of the responsible body would not change. This is because the question of where the arrangements are “primarily” to be carried out, for such admissions, can be determined prospectively over a period of time. Therefore in cases of planned short term admission, the arrangements as a whole can still be considered to be carried out “primarily” in the community. When a person’s needs change so as to move them between the categories in the hierarchy above – which will become apparent through reviews, assessments or procedures under other legislation (such as the Care Act and Social Services and Well-being (Wales) Act) – those involved will be aware that this will mean a change in responsible body. The new Code of Practice will play a very important role here.
- 8.21 Consultation identified a number of difficulties that arise under the current system. In particular, many pointed to the practical problems that arise in organising assessments and reviews at a distance, and some proposed that the local authority where the person was physically located should always become responsible for the authorisation. However, any reformed system based on physical location would run the risk of penalising areas that have a high proportion of care homes or specialist facilities and therefore would need to process a higher number of applications than neighbouring areas. It is not our intention to change the existing ordinary residence rules (including the deeming rules). We would expect the new Code of Practice to address the practical issues that sometimes arise when the person has been placed some distance away. In addition, it would continue to be possible under the Liberty Protection Safeguards for the responsible NHS body or local authority to arrange for the assessments or reviews to be carried out on its behalf by someone based in the home authority (such as an assessor employed by the host authority or an independent assessor), whilst making the final decision itself.
- 8.22 It is important to acknowledge that no system is failsafe, and difficulties will inevitably arise in identifying the responsible body in some cases. We think there would be merit in establishing a system, similar to that which applies under the DoLS, whereby determinations can be made by the Secretary of State or the Welsh Ministers, and the NHS body or local authority where the person is situated is responsible for the authorisation until the dispute is resolved. This system could also include a fast track determination system. However, this is ultimately a matter for the Department of Health and Welsh Government to decide (since there may need to be amendments to the ordinary residence regulations made under the Care Act and Social Services and Well-being (Wales) Act). But it could be included if the draft Bill were to be taken forward.

¹² Draft Bill, sch 1 (new para 11 of sch AA1 to the Mental Capacity Act).

Recommendation 7.

The responsible body, which can authorise arrangements, should be:

- (1) if the arrangements or proposed arrangements are being, or will be, carried out primarily in a hospital, the hospital manager;**
- (2) if paragraph (1) does not apply and the arrangements or proposed arrangements are being, or will be, carried out primarily through the provision of NHS continuing health care, the clinical commissioning group or local health board;**
- (3) if neither paragraph (1) nor paragraph (2) applies, the responsible local authority.**

This recommendation is given effect by schedule 1 to the draft Bill (new paragraph 7 of schedule AA1 to the Mental Capacity Act).

Chapter 9: The assessments

9.1 The following two chapters discuss the conditions that must be met before the responsible body can authorise arrangements which would give rise to a deprivation of liberty. This chapter considers the three assessments that must be carried out: the capacity assessment, the medical assessment, and the assessment of whether the arrangements are necessary and proportionate. Chapter 10 discusses the other procedural conditions.

THE CAPACITY ASSESSMENT

9.2 The mental capacity requirement under the DoLS requires that the person must lack capacity “in relation to the question whether [he or she] should be accommodated in the relevant hospital or care home for the purpose of being given the relevant care or treatment”.¹ This requirement reflects the “subjective element” of deprivation of liberty (see from para 2.27). In other words, if the person who is objectively confined lacks capacity to consent to those arrangements, they are unable to give the requisite “valid consent”, and hence (if the arrangements are imputable to the State) are deprived of their liberty for the purposes of Article 5.²

9.3 The courts have confirmed that the assessor must not only consider the person’s capacity to decide to be accommodated, but also their capacity to understand that they are being confined. In *A Primary Care Trust v LDV* Mr Justice Baker held that the information relevant to that question in the case of a person being deprived of their liberty in a private psychiatric hospital included:

- (1) that she was in hospital to receive care and treatment for a mental disorder;
- (2) that the care and treatment would include varying levels of supervision (including supervision in the community), use of physical restraint and the prescription and administration of medication to control their mood;
- (3) that staff at the hospital would be entitled to carry out property and personal searches;
- (4) that the person must seek permission of the nursing staff to leave the hospital and, until the staff at the hospital decide otherwise, would only be allowed to leave under supervision; and
- (5) that if she left the hospital without permission and without supervision, the staff would take steps to find and return her, including contacting the police.³

9.4 The consultation paper argued that the restrictive care and treatment scheme should retain a mental capacity requirement, but (because the scheme delivered safeguards on the basis of the care or treatment being provided, rather than just accommodation

¹ Mental Capacity Act, sch A1, para 15.

² *Storck v Germany* (2006) 43 EHRR 96 (App No 61603/00) at [74].

³ *A Primary Care Trust v LDV* [2013] EWHC 272 (Fam).

arrangements) we provisionally proposed that the relevant test should be that the person must “lack capacity to consent to the relevant care and treatment”.⁴

Consultation responses

9.5 A majority of consultees agreed with this proposal.⁵ But there was some concern that the test did not refer to capacity to consent to be “accommodated” to receive care and treatment and as to whether assessors would therefore be expected to assess areas of capacity which may be outside their field of expertise. A number of responses reported that, in practice, the DoLS mental capacity requirement is not properly understood and the quality of DoLS capacity assessments is often poor.

Discussion

9.6 Whilst the capacity requirement for restrictive care and treatment was supported at consultation, it was designed for the purposes of a scheme which delivered safeguards to a wider cohort of people than those deprived of liberty within the meaning of Article 5. The proposal would not be possible under the Liberty Protection Safeguards, which focus on deprivation of liberty, and it is therefore necessary to revise our approach.

9.7 We consider that the Liberty Protection Safeguards should continue to have a mental capacity requirement in order to translate into domestic terms the Article 5(1) requirement of an absence of valid consent. However, we are concerned by the evidence from consultation suggesting that the current requirement is poorly understood and implemented. In part, this confusion may be due to the existing wording (that the person must lack capacity in relation to whether they should be accommodated in the relevant hospital or care home for the purpose of being given the relevant care or treatment); this does not, in our view, get to the heart of the issue under Article 5. It is not the fact of a placement in itself, but the arrangements made for the person at the placement – including the elements of supervision, control and lack of freedom to leave identified by Lady Hale in *Cheshire West* – that give rise to the deprivation of liberty. We therefore consider it more accurate, and more closely aligned to Article 5, to provide that the person must lack capacity to consent to the care or treatment arrangements which would give rise to a deprivation of that person’s liberty.⁶

9.8 Importantly, this approach also enables authorisations to be granted for arrangements that cannot be described as requiring a person to live in a particular place (such as transport and day centre arrangements), and arrangements for care or treatment at more than one place (see para 7.12).

9.9 In order to determine the person’s capacity to consent to the arrangements, the assessor will continue to be required to apply the provisions of the Mental Capacity Act; particularly the principles in section 1, the diagnostic test in section 2 and the functional test in section 3 (see from para 3.3). The assessor must also state whether the capacity of the person is likely to fluctuate and, if so, the likely duration of any periods during which the person is likely to have capacity to consent to those arrangements.⁷ This will

⁴ Consultation paper, para 7.27.

⁵ Consultation analysis, PP 7-2, para 6.11.

⁶ Draft Bill, sch 1 (new para 1(2)(b) of sch AA1 to the Mental Capacity Act).

⁷ Draft Bill, sch 1 (new para 20 of sch AA1 to the Mental Capacity Act).

enable authorisations to apply on an ongoing basis to those whose capacity fluctuates. The position of those with fluctuating capacity is discussed from para 9.38.

- 9.10 The draft Bill confirms that the same assessor can provide the capacity and medical assessments (this point is discussed further at para 9.69).⁸ However, we do not want to encourage an automatic assumption that only a doctor can undertake the capacity assessment, and indeed there are many circumstances under which a professional of a different discipline would be better placed to conduct such an assessment. We would expect that the new Code of Practice emphasises this point.

Recommendation 8.

The responsible body may authorise arrangements if (amongst other requirements) a capacity assessment has been carried out which confirms that the person lacks capacity to consent to the arrangements which are proposed or in place and would give rise to a deprivation of that person's liberty.

This recommendation is given effect by schedule 1 to the draft Bill (new paragraph 1(2)(b) and 14(a) of schedule AA1 to the Mental Capacity Act).

THE MEDICAL ASSESSMENT

- 9.11 The mental health requirement under the DoLS is intended to ensure that the person's circumstances fall within the scope of Article 5(1)(e) of the ECHR, which allows for deprivation of liberty on the basis that the person is of "unsound mind". For the purposes of the DoLS, being of "unsound mind" is equated with suffering from "mental disorder" within the meaning of the Mental Health Act. This is, in turn, defined as "any disorder or disability of mind", apart from dependence on alcohol and drugs.⁹ For the purposes of the mental health requirement, the "learning disability exception" in the Mental Health Act does not apply. In broad terms, this exception means that a person cannot be made subject to certain provisions of the Mental Health Act solely for treatment of learning disability, unless that disability is associated with abnormally aggressive or seriously irresponsible conduct.¹⁰ A person with learning disability without these additional features may therefore be deprived of their liberty under the DoLS.¹¹
- 9.12 The remainder of the Mental Capacity Act applies to a broader range of people who lack decision-making capacity as a result of "an impairment of, or a disturbance in the functioning of the mind or brain".¹²
- 9.13 The consultation paper raised concerns that the DoLS mental health requirement excludes certain groups from protection, particularly those with "pure" brain disorders (for example, the after-effects of a stroke or brain haemorrhage) and those dependent on alcohol and drugs. We therefore provisionally proposed that the new scheme should be extended to match the wording of section 2 of the Mental Capacity Act, and apply to

⁸ Draft Bill, sch 1 (new para 19 of sch AA1 to the Mental Capacity Act).

⁹ Mental Capacity Act, sch A1, para 14, read together with Mental Health Act, s 1(2).

¹⁰ Mental Health Act, s 1(2A) and (2B).

¹¹ Mental Capacity Act, sch A1, para 14(2).

¹² Mental Capacity Act, s 2(1).

those who lack decision-making capacity as a result of “an impairment of, or a disturbance in the functioning of, the mind or brain”.¹³

Consultation responses

9.14 This proposal received majority support at consultation.¹⁴ Many agreed that it would bring consistency with the rest of the Mental Capacity Act and prevent needless arguments over whether a particular condition can be categorised as a “pure” brain disorder or a mental disorder. It was also argued that the mental health requirement means that patients who lack the requisite capacity, but who cannot reliably be determined as having a mental disorder, are being denied protections (the examples provided included patients who are unconscious due to intoxication, have “locked-in” syndrome or are in a persistent vegetative or minimally conscious state). Consultees reported that NHS trusts rarely seek court authorisations for people with a “brain disorder” who meet the “acid test”. Those who disagreed with the proposal felt there would be significant resource implications. Some also queried whether in practice there were any brain disorders which might cause a lack of decision-making capacity which would not be considered to be mental disorders.

Discussion

9.15 Following consultation we have decided not to use the test contained in section 2 of the Mental Capacity Act. In our view, incapacity under the Mental Capacity Act and unsoundness of mind are not necessarily coterminous. Examples of those who might lack capacity for purposes of the Mental Capacity Act, but would not be considered of “unsound mind” for the purposes of Article 5(1)(e), could include (but are not limited to) a person who is temporarily concussed or unconscious, or under the influence of alcohol or drugs. If we simply applied the section 2 test, we therefore risk widening the range of people who can be subject to a deprivation of liberty authorisation beyond the bounds permitted by Article 5(1)(e).

9.16 We have also considered whether the Liberty Protection Safeguards should retain the existing mental health requirement under the DoLS. However, we consider that this would make the scope of the scheme too narrow. The Court of Appeal has expressed the view that there exists “a class of incapacitated adults who are not mentally ill”, and could not be made subject to the Mental Health Act, but are nevertheless of unsound mind within the meaning of Article 5(1)(e).¹⁵ Moreover, consultees provided us with examples of patients who would not be considered mentally disordered for the purposes of the Mental Health Act, but arguably would be of unsound mind for the purposes of Article 5(1)(e).¹⁶ The practical question is, therefore, whether the Article 5 rights of such individuals should be delivered through a court authorisation or the Liberty Protection Safeguards. We remain of the view that court authorisations are too costly and a disproportionate approach to such cases. It is also relevant to note, in this regard, the evidence from consultation that cases are not being taken to court when they should be. To some degree this undermines any suggestion that extending the definition would have significant cost implications. Any “savings” currently being achieved are largely

¹³ Consultation paper, paras 6.6 to 6.15 and 7.3 to 7.13.

¹⁴ Consultation analysis, PP 6-2, para 5.17 and PP 7-1, para 6.1.

¹⁵ *G v E* [2010] EWCA Civ 822, [2012] Fam 78 at [60] referring to certain forms of learning difficulties. This case concerned an individual with tuberous-sclerosis which gave rise to severe learning disabilities.

¹⁶ See para 9.14 of this report.

through non-compliance with the law, and in our view this does not provide a legitimate reason for maintaining the narrow definition.

- 9.17 We have therefore concluded that the best approach would be to enable the new scheme to apply on the basis of unsoundness of mind.¹⁷ It is relevant to note that the Court of Protection currently requires evidence of unsoundness of mind, rather than of satisfaction of the DoLS mental health requirement, when considering deprivation of liberty cases outside hospitals and care homes; consultation provided no evidence that this was causing any difficulties in practice.¹⁸
- 9.18 The draft Bill confirms that the term “unsound mind” has the same meaning as in Article 5(1)(e) of the ECHR, but it is not further defined in the draft Bill.¹⁹ This is to allow the Liberty Protection Safeguards to accommodate future developments in Strasbourg jurisprudence over the meaning of unsoundness of mind. We anticipate that the new Code of Practice would give examples of what being of “unsound mind” will look like in practice.
- 9.19 In making this recommendation we acknowledge that the expression “unsound mind” is outdated and not in keeping with modern psychiatric terminology and social attitudes towards people with mental health problems. The term is being used purely as a matter of drafting in order to ensure that the Liberty Protection Safeguards have the same scope as the relevant provisions of Article 5. The new Code of Practice will have an important role to play by translating the concept into terms that are meaningful and clear.

Recommendation 9.

The responsible body may authorise arrangements if (amongst other requirements) a medical assessment has been carried out which confirms that the person is of “unsound mind” within the meaning of Article 5(1)(e) of the ECHR.

This recommendation is given effect by schedule 1 to the draft Bill (new paragraphs 1(2)(c), 4(1) and 14(b) of schedule AA1 to the Mental Capacity Act).

WHETHER THE ARRANGEMENTS ARE NECESSARY AND PROPORTIONATE

- 9.20 In order to comply with Article 5(1) the deprivation of liberty must be lawful. But the Strasbourg jurisprudence emphasises that in order to protect the individual from arbitrariness, it is not sufficient that the deprivation of liberty is in conformity with national law, it must be shown to be necessary in the circumstances, in the sense that less intrusive measures would not suffice and the measures are proportionate to the aim pursued.²⁰ A deprivation of liberty is therefore only justified if other, less severe measures have been considered and found to be insufficient to safeguard the individual

¹⁷ Draft Bill, sch 1 (new para 1(2)(c) of sch AA1 to the Mental Capacity Act).

¹⁸ COPDOL 10 form.

¹⁹ Draft Bill, sch 1 (new para 4(1) of sch AA1 to the Mental Capacity Act).

²⁰ *Witold Litwa v Poland* (2001) 33 EHRR 53 (App No 26629/95) at [78] and *Saadi v UK* (2008) 47 EHRR 17 (App No 13229/03) at [54].

or public interest”.²¹ The deprivation of liberty may be “necessary” not only where the person needs therapy, medication or other clinical treatment to cure or alleviate their condition, but also where the person needs control and supervision to prevent them, for example, causing harm to themselves or other persons.²²

9.21 The DoLS combine both the notion of best interests under the Mental Capacity Act (which is not recognised as a purpose of deprivation of liberty by Article 5(1)), and the concepts of necessity and proportionality (which as noted above, are a requirement of Article 5(1)). Under the DoLS, the best interests requirement provides that an assessor must consider whether all of the following conditions are met:

- (1) the person is, or is to be, a detained resident;
- (2) it is in the best interests of the person for them to be a detained resident;
- (3) in order to prevent harm to the person, it is necessary for them to be a detained resident; and
- (4) the deprivation of liberty is a proportionate response to:
 - (a) the likelihood of the person suffering harm; and
 - (b) the seriousness of that harm.²³

9.22 For the purposes of the rest of the Mental Capacity Act, a best interests decision need not focus only upon the direct benefits and detriments to a person which stem from a certain course of action. Wider consequential benefits may flow to the person from certain actions, such as providing or gaining emotional support from close relationships, and these should also be considered.²⁴ Case law has confirmed that, where such benefits are evident, such as a bone marrow donation and preventing harm to third parties, an act or decision can be in the person’s best interests.²⁵ However, as noted above, the DoLS specify that the deprivation of liberty must be necessary in order to prevent harm to the person. The consultation paper provisionally proposed that eligibility for the new scheme should be based on a best interests decision, and asked whether that best interests decision should take into account not just prevention of harm to the person, but also risk to others.²⁶

Consultation

9.23 A majority of consultees agreed that under the new scheme, eligibility should be based on a best interests decision.²⁷ The best interests requirement was described as the

²¹ *Witold Litwa v Poland* (2001) 33 EHRR 53 (App No 26629/95) at [78] and *Stanev v Bulgaria* (2012) 55 EHRR 22 (App No 36760/06) (Grand Chamber decision) at [143].

²² *Hutchison Reid v UK* (2003) 37 EHRR 9 App No 50272/99 at [52].

²³ Mental Capacity Act, sch A1, para 16.

²⁴ *Mental Capacity Act Code of Practice*, para 5.48.

²⁵ *Re Y* [1997] Fam 110, [1997] 2 WLR 556 and *J Council v GU* [2012] EWHC 3531 (COP), (2013) 16 CCLR 31.

²⁶ Consultation paper, paras 7.40 to 7.42.

²⁷ Consultation analysis, PP 7-6, para 6.50.

“cornerstone” of the current scheme²⁸, and seen as ensuring that the individual “does not get lost in the current complex and process driven assessment”.²⁹

- 9.24 Most consultees also agreed that the best interests decision should take into account risks to others.³⁰ Some recognised that in reality risk to others was already part of a best interests assessment and considered that this should be reflected in the law. Best interests assessors described cases where a deprivation of liberty was clearly necessary in order to prevent harm to others and had to be “shoe-horned” into the DoLS best interests requirement. However, some consultees were concerned about the development of a public protection detention mechanism outside (and potentially cutting across) that already provided for under the Mental Health Act, adult safeguarding and the criminal sphere.
- 9.25 More generally, consultees also reported widespread confusion over the legal basis for the underlying decision to place a person into residential accommodation.³¹ Families told us that placement decisions were often “dressed up” as being in the person’s best interests when really they were being taken on the basis of the cheapest available option. Others reported that in practice, people are offered no choice over their placements, thus leaving no room for a “real” best interests decision. At consultation meetings, best interests assessors provided examples of where deprivation of liberty had to be authorised because in reality the public authority was unwilling or unable to commission an alternative package of care.³²

Discussion

- 9.26 As a result of consultation – particularly responses from families and best interests assessors – we have decided to revise our approach to the best interests requirement. There appears to be some degree of confusion over the role of the best interests decision generally, and in particular when it comes to deprivations of liberty. In our view the law needs to be much clearer in this respect.
- 9.27 As set out at para 9.20, a deprivation of liberty for the purposes of Article 5(1)(e) must be both necessary and proportionate in terms of the risk of harm to the person or someone else. The problem with the DoLS best interests requirement is that the best interests element is included alongside, but adds nothing to, the consideration of whether the deprivation of liberty is necessary and proportionate. For example, the reason why a person has been placed in a care home may simply be that it would not be safe for them to be left unsupervised at home and the NHS body or local authority will not fund the necessary supervision at home.
- 9.28 The best interests decision in such cases is based on a purely notional “choice” between the person staying at home in an unsafe environment and the care home placement. If the local authority or NHS were prepared to fund supervision at home, the best interests decision would be a genuine choice between the available options. But, given that the DoLS assessor cannot compel the local authority or NHS to fund the domiciliary care,

²⁸ West Midlands Regional DoLS Leads Group, consultation analysis, PP 7-6, para 6.51.

²⁹ Swansea City and County Council, as above.

³⁰ Consultation analysis, Q 7-8, para 6.69.

³¹ As above, para 5.80.

³² For example, at seminars organised by Lancashire County Council, Carmarthenshire County Council, University of Sussex and Dorset County Council.

the prior decision of the local authority or NHS not to do so often leads inevitably to the conclusion that any resulting deprivation of liberty is necessary and proportionate (and, by exactly the same token, in the person's best interests). Many best interests assessors have told us that they are perplexed about being required to describe a deprivation of liberty resulting from a care package as being in a person's best interests when in reality no realistic alternative to the care package is being offered.

- 9.29 As well as adding nothing to the assessment in the vast majority of cases, the DoLS best interests requirement adds a complication in cases (admittedly a small number) where the deprivation of liberty is, in reality, only necessary to prevent the person causing harm to others. The Strasbourg case law is clear that a deprivation of liberty can be justified on those grounds, but the DoLS requirement (under which the deprivation of liberty must be both in the person's best interests and necessary in order to "prevent harm to the person" – see para 9.21(3) above), requires assessors to conclude, somewhat artificially, that the person's own interests include not harming someone else and thereby, for instance, themselves becoming subject to some form of "harm", such as civil or criminal proceedings.
- 9.30 We have therefore concluded that the authorisation of arrangements should be tied more directly to the requirement of Article 5(1)(e) that the deprivation of liberty must be necessary and proportionate. The draft Bill provides that an assessment must confirm that the arrangements are necessary and proportionate by having regard to either or both of the following matters:
- (1) the likelihood of harm to the person if the arrangements were not in place and the seriousness of that harm; and
 - (2) the likelihood of harm to other individuals if the arrangements were not in place and the seriousness of that harm.³³
- 9.31 This reform focuses the process of authorising arrangements upon the issues that are really at stake where a deprivation of liberty is being put forward for authorisation and removes the elements of artificiality that we have just described. It does not remove best interests from the process of formulating the arrangements as a whole. The person's move into arrangements giving rise to a deprivation of liberty will involve a decision, taken on their behalf under section 4 of the Mental Capacity Act, that they will make the move. Under the draft Bill that decision will be taken in the context of our recommended reforms to sections 4 and 5 of the Mental Capacity Act (see recommendations 40 and 41 in chapter 14). These reforms are intended to ensure that best interests considerations are fully addressed, before arrangements giving rise to a deprivation of liberty are put forward, and as part of a documented process. Our recommended amendments of section 4 would give greater prominence to the person's wishes and feelings, and our recommended further conditions for the immunity from legal liability in section 5 impose a sanction if the new requirements are not complied with.
- 9.32 Further, we consider that integral to the question of whether the deprivation of liberty is proportionate (as well as necessary) is consideration of whether there is a less intrusive alternative. This is particularly important where the particular arrangements (for example a care home placement) are contrary to the wishes and feelings of the person and will, for that reason, be more intrusive than arrangements to which the person does not object. Our draft Bill does not allow an authorisation to be refused on the grounds

³³ Draft Bill, sch 1 (new para 21(3) of sch AA1 to the Mental Capacity Act).

that additional funding ought to be provided to enable less intrusive arrangements; in this respect the position will be the same as under the current law. However, the requirement of proportionality means that a robust approach should be taken to challenging the assumptions upon which funding decisions have been taken.

- 9.33 To take an example which occurs regularly in practice, it may be considered that a person has a level of need which requires a very high level of care and that the cost of providing the care in their home means that placement in an institution is the only option. The principle of proportionality requires an assessment of whether those proposing the arrangements have sufficiently taken into account the importance to the person of remaining at home with a lower level of care, even if at the cost of some greater degree of risk. Authorisation could be refused on the basis that the person making the assessment was not satisfied that the deprivation of liberty to which the proposed arrangements would give rise is proportionate. Those proposing the arrangements could be invited to reconsider the matter. At that point, it may well be that the available funding could be allocated differently so as to provide a lower, but still acceptable, level of care enabling the person to remain at home.
- 9.34 Moreover, the draft Bill provides that cases where the person concerned objects to the proposed arrangements must be referred to an Approved Mental Capacity Professional (see from para 10.27).³⁴
- 9.35 In cases of risk of harm to others, our recommended approach would remove the element of artificiality currently involved in decisions which constitute justified (albeit serious) interferences with Article 5 and 8 rights, making the process more transparent. We recognise that it is not easy to reconcile concepts of public protection with the principles of the Mental Capacity Act, which are directed primarily at the empowerment of individuals and their protection from risks to themselves. It is nevertheless necessary in the public interest for it to be possible to authorise a deprivation of liberty where a person who lacks capacity is a source of risk to others. We consider it preferable for this to be done under our scheme rather than to set up separate legal machinery or to use other existing powers which may (for other reasons) be too blunt a tool.
- 9.36 The most obvious existing machinery in this regard is the Mental Health Act, which provides for the detention of people with a mental disorder on the basis of public protection. The draft Bill provides that the person making the necessary and proportionate determination in cases mainly involving risk of harm to others must consider whether it would be more appropriate for an application to be made under sections 2 or 3 of the Mental Health Act.³⁵ This is designed to ensure that the Liberty Protection Safeguards are not used in cases where detention under the Mental Health Act is more appropriate. Moreover, the draft Bill again provides that such cases must be referred to an Approved Mental Capacity Professional (see para 10.42).³⁶
- 9.37 The draft Bill requires that the assessor has the appropriate experience and knowledge to determine the likelihood and seriousness of harm to the person or others.³⁷ It sets out no further stipulations in this regard because appropriate levels of experience and knowledge will vary between different cases. However, the new Code of Practice could

³⁴ Draft Bill, sch 1 (new para 24(2) of sch AA1 to the Mental Capacity Act).

³⁵ Draft Bill, sch 1 (new para 21(4) of sch AA1 to the Mental Capacity Act).

³⁶ Draft Bill, sch 1 (new para 24(3) of sch AA1 to the Mental Capacity Act).

³⁷ Draft Bill, sch 1 (new para 21(2) of sch AA1 to the Mental Capacity Act).

be used to provide examples of cases where, for example, assessors from a specific professional background and / or with specialist knowledge might be needed.

Recommendation 10.

The responsible body may authorise arrangements if (amongst other requirements) those arrangements are necessary and proportionate, having regard to either or both of the following matters:

- (1) the likelihood of harm to the person if the arrangements were not in place and the seriousness of that harm; and**
- (2) the likelihood of harm to other individuals if the arrangements were not in place and the seriousness of that harm.**

This is given effect by schedule 1 to the draft Bill (new paragraphs 14(c) and 21 of schedule AA1 to the Mental Capacity Act).

FURTHER PROVISION ABOUT THE ASSESSMENTS

Fluctuating capacity

- 9.38 The legal framework for assessing capacity set out in sections 1 to 3 of the Mental Capacity Act (summarised from para 3.4) is relatively straightforward and easy to understand. These provisions reflect the principle that capacity is decision-specific and must be assessed in relation to the particular decision that needs to be taken, rather than any assessment being made of the person's ability to make decisions generally. It follows that a person may lack capacity in relation to one matter but not in relation to another. Capacity is also time-specific and must be assessed at the time the decision needs to be made.
- 9.39 However, in practice the capacity assessment can sometimes be extremely difficult, especially when the person's capacity fluctuates so that he or she has capacity at some times but not at others. A person with fluctuating capacity may be inconsistent and unreliable in their decision-making. There are different situations where fluctuating capacity may occur, for example as a result of mental illness, dementia or an acquired brain injury.
- 9.40 Fluctuating capacity is not a concept expressly addressed or provided for in the Mental Capacity Act (including the DoLS). The *Mental Capacity Act Code of Practice* recognises that steps that should be taken to support a person with fluctuating capacity to take their own decision by, for instance, choosing the time of day at which they are most alert.³⁸ However, it does not indicate what should happen where an assessment is required of a person's ability to make decisions on an ongoing basis as regards a particular matter.
- 9.41 The *DoLS Code of Practice* does provide guidance on how to deal with fluctuating capacity during a standard authorisation. It states that:

³⁸ *Mental Capacity Act Code of Practice*, para 4.26.

Where a relevant person's capacity to make decisions about the arrangements made for their care and treatment fluctuates on a short-term basis, a balance needs to be struck between:

- the need to review and terminate an authorisation if a person regains capacity; and
- spending time and resources constantly reviewing, terminating and then seeking fresh deprivation of liberty authorisations as the relevant person's capacity changes.

Each case must be treated on its merits. Managing authorities should keep all cases under review: where a person subject to an authorisation is deemed to have regained the capacity to decide about the arrangements made for their care and treatment, the managing authority must assess whether there is consistent evidence of the regaining of capacity on a longer-term basis. This is a clinical judgement that will need to be made by a suitably qualified person.

Where there is consistent evidence of regaining capacity on this longer term basis, deprivation of liberty should be lifted immediately, and a formal review and termination of the authorisation sought. However, it should be borne in mind that a deprivation of liberty authorisation carries with it certain safeguards that the relevant person will lose if the authorisation is terminated. Where the regaining of capacity is likely to be temporary, and the authorisation will be required again within a short period of time, the authorisation should be left in place, but with the situation kept under ongoing review.³⁹

9.42 Whilst the courts have given some limited consideration to issues arising out of fluctuating capacity, there have been no specific decisions relating to fluctuating capacity to consent to a deprivation of liberty.⁴⁰

Consultation responses

9.43 Whilst we did not consult directly on this issue, fluctuating capacity was mentioned in many consultation responses.⁴¹ It was clear that fluctuating capacity was a major concern for health and social care professionals. For example, a palliative care worker reported that fluctuating capacity often takes up a disproportionate amount of her time and resources due to the regular cycle of assessments and reviews. A psychiatrist told us that the "black and white" nature of the Mental Capacity Act's approach to capacity fails to reflect the reality and complexity of fluctuating capacity. It was notable that, at one care home we visited, staff reported that they would normally "deem" a person with fluctuating capacity as lacking capacity in order to ensure that the person received the benefit of the safeguards in the Mental Capacity Act. At a different care home we were told that people with fluctuating capacity were "deemed" as having the requisite capacity in order to protect their rights to autonomy and to make unwise decisions. Many responses called for greater clarity in the law and guidance on how to deal with fluctuating capacity.

³⁹ DoLS Code of Practice, paras 8.22 to 8.24.

⁴⁰ Prior to the Mental Capacity Act, fluctuating capacity was considered in *Re G* [2004] EWHC 2222 (Fam). After the introduction of the Mental Capacity Act, fluctuating capacity was considered in *A v X* [2012] EWHC 2400 (COP) and referred to in *Secretary of State for Justice v KC* [2015] UKUT 376 (AAC) at [134].

⁴¹ Consultation analysis, para 15.10.

Discussion

- 9.44 When it comes to fluctuating capacity there is a disconnection between legislation and practice. This applies generally in relation to the Mental Capacity Act, but raises specific issues when it comes to deprivation of liberty.
- 9.45 Under the DoLS, an authorisation must be terminated if an adult regains capacity.⁴² The managing authority or relevant person's representative is required to alert the supervisory body to any change in the person's circumstances which may mean the qualifying requirements are no longer met. Thus, if it appears that a person has regained capacity this should trigger a review of the standard authorisation and, if recovery of capacity is confirmed, the supervisory body must terminate the authorisation.⁴³
- 9.46 Strict application of these provisions would give rise to a number of unsatisfactory consequences. A person with fluctuating capacity would be subject to an ongoing cycle of DoLS re-assessments and discharges. Staff in hospitals and care homes would be required to assess on a continuous basis whether a person had capacity to consent to their confinement and, if so, whether they were giving or withholding consent. For example, in the case of older people with dementia whose condition fluctuates over the course of a day, such assessment might need to be hourly. Clearly, if decision-makers applied the legislation in this way, the DoLS would be impracticable and unworkable. Instead the *DoLS Code of Practice* tries to ensure a more pragmatic approach (set out in full above) by suggesting that an authorisation can remain in place where the regaining of capacity is likely to be temporary, and the authorisation will be required again within a short period of time.
- 9.47 In our view, it is not acceptable for the legislative framework simply to ignore fluctuating capacity. That exposes health and social care professionals and those authorising a deprivation of liberty to significant legal risk. It is therefore vital that the Liberty Protection Safeguards provide for fluctuating capacity expressly. The draft Bill achieves this in two different ways.
- 9.48 First, it allows a person to consent (whilst they have the capacity to do so) in advance to certain care or treatment arrangements that would otherwise amount to a deprivation of liberty. This would mean that Article 5 would not be engaged (see from para 2.27), and the case would fall outside the Liberty Protection Safeguards. Advance consent is considered further from para 15.2.
- 9.49 Secondly, in the case of those who have not given advance consent, the draft Bill builds on the position set out in the *DoLS Code of Practice*. We think that, save in the limited circumstances in which we have provided for advance consent to apply, the giving of consent should generally be regarded as an ongoing state of mind which is required in order for a confinement not to amount to a deprivation of liberty. There will be some who will lack capacity to give such consent for such a substantial proportion of the period covered by the proposed authorisation, and regain it for such brief periods, that it is right to regard them as, overall, lacking capacity to give or withhold consent to the arrangements.
- 9.50 We appreciate the sensitivity of creating a scheme that allows the deprivation of liberty of individuals during temporary periods of capacity to consent to the arrangements in

⁴² Mental Capacity Act, Sch A1, para 15.

⁴³ As above, paras 102 to 117.

question. However, it is important to bear in mind that, from the point of view of the ECHR, there is no obstacle to a deprivation of liberty, whether or not the person has capacity to consent to it, so long as the requirements of Article 5(1)(e) are met. These are that the person is of unsound mind (and in that regard a condition that causes capacity to fluctuate can amount to a continuous state of unsoundness of mind) and that deprivation of liberty is necessary and proportionate to a risk of harm. In many cases a risk of harm will derive from matters such as inability to orientate oneself or to recognise and avoid dangers. In cases of fluctuating ability to keep oneself safe, continuous deprivation of liberty may be necessary and proportionate if the person risks losing that ability whilst they are at large on their own.

- 9.51 Ability to keep oneself safe is logically a separate matter from capacity to give or withhold consent to a deprivation of liberty, which a person may lack continuously even if their ability to keep themselves safe fluctuates. But, for the reasons we have given, we consider that fluctuations in capacity to consent to the arrangements need not be an obstacle to a continuous authorisation of deprivation of liberty under the Liberty Protection Safeguards provided that the other criteria for a justified deprivation of liberty are fulfilled.
- 9.52 We are therefore of the view that it is legitimate to authorise arrangements that remain in place even during limited periods of capacity to consent or object to the arrangements, provided that:
- (1) the periods of capacity are likely to last only for a short period of time;
 - (2) the person remains at all times “of unsound mind” for the purposes of Article 5(1)(e); and
 - (3) the authorisation of arrangements remains necessary and proportionate.
- 9.53 In our view the inclusion of people with fluctuating capacity within the Liberty Protection Safeguards is better than their exclusion, in particular given that inclusion provides access to important legal rights, such as rights to representation and support by an advocate or an appropriate person (see from para 12.20). There also remains scope for professional discretion in such cases. An authorisation is not an order or injunction to detain the person, and professional discretion should be exercised (amplified by the Code of Practice) as to when to take or not take steps to, for example, ensure that the person is not allowed to leave and / or to bring about their return if they do leave.
- 9.54 The draft Bill therefore includes provisions that enable the authorisation of arrangements for people whose capacity is likely to fluctuate. However, it is important to emphasise that the Liberty Protection Safeguards only available where people lack capacity to consent to the arrangements. This applies equally to those who have fluctuating capacity; in other words, arrangements could only be authorised if the capacity assessment carried out for purposes of the initial authorisation concludes that, despite periods of capacity, the person is properly to be regarded overall as lacking capacity to consent to the arrangements.⁴⁴ In cases of fluctuating capacity, the assessor may need to visit the person on more than one occasion to determine the nature of the fluctuating capacity and the likely duration of any periods during which that person is likely to have capacity to consent to the arrangements. It is important to note that the

⁴⁴ Draft Bill, sch 1 (new paras 1(2)(b) and 14 (a) of sch AA1 to the Mental Capacity Act).

relevant time for these purposes is the point at which the capacity assessment is carried out, not the point at which the authorisation is granted.

- 9.55 At the point of initial authorisation, the draft Bill requires (in all cases) the mental capacity assessment to consider fluctuating capacity. The assessor must state whether the capacity of the person is likely to fluctuate and, if so, the likely duration of any periods during which the person is likely to have capacity to consent to those arrangements.⁴⁵ This will help to ensure that there are fewer cases where fluctuating capacity is missed, and that the assessment focuses on the time during which the person will lack capacity. The latter is particularly important because, in broad terms, arrangements should only ever be authorised if any periods of capacity, during the length of the authorisation, are short-term and temporary.
- 9.56 If the capacity assessment relied upon when authorising the arrangements states that the person's capacity to consent to arrangements will fluctuate, the arrangements will not cease automatically if the person gains capacity. Provided that the responsible body believes or can reasonably expect that the gaining of capacity will last for a short period only, the arrangements can continue. If a person is not identified in the initial capacity assessment as being a person whose capacity is likely to fluctuate then, if at any time the responsible body believes or ought reasonably to suspect that the person has capacity, the authorisation of the arrangements will cease to have effect.⁴⁶
- 9.57 There are several important safeguards provided in the draft Bill. The responsible body will have to demonstrate why its belief that the regaining of capacity will only last for a short period of time is reasonable. In many cases that will involve commissioning a fresh capacity assessment and evidencing the fluctuations in the person's capacity. So, for example, if for the past month the person seems to have capacity for a few hours in the morning but by the afternoon they have deteriorated it will be reasonable for the responsible body to believe that the same will happen in the future. Of course if there is a change and the person seems to have capacity in the afternoon for a few days in a row then that may well indicate that it is no longer reasonable to believe that the period of capacity is short-lived. There is no statutory definition of "short period", nor can there be. The new Code of Practice will need to deal with this in detail.
- 9.58 The draft Bill also provides to the same effect at the renewal stage.⁴⁷

Recommendation 11.

If the capacity assessment which was relied on for the purpose of authorising arrangements stated that the person's capacity to consent to the arrangements is likely to fluctuate, the authorisation should not automatically cease to have effect provided that the responsible body reasonably believes that the gaining or regaining of capacity will last for a short period only.

This recommendation is given effect by schedule 1 to the draft Bill (new paragraphs 20, 35(3) and 37(7) and (8) of schedule AA1 to the Mental Capacity Act).

⁴⁵ Draft Bill, sch 1 (new para 20 of sch AA1 to the Mental Capacity Act).

⁴⁶ Draft Bill, sch 1 (new para 35(2)(a) and (3) of sch AA1 to the Mental Capacity Act).

⁴⁷ Draft Bill, sch 1 (new para 37(7) and (8) of sch AA1 to the Mental Capacity Act).

Objective medical expertise

9.59 Under the DoLS, the “mental health assessment” must be carried out by a registered medical practitioner, who must also be approved under section 12 of the Mental Health Act as having special experience of diagnosis or treatment of mental disorder or have at least three years’ post-registration experience in the diagnosis or treatment of mental disorder. In addition, he or she must have completed the training for the DoLS mental health assessors.⁴⁸ This aspect of the DoLS reflects the Strasbourg jurisprudence which establishes that individuals cannot lawfully be deprived of liberty in accordance with Article 5(1)(e) without first seeking “objective medical expertise”.⁴⁹

9.60 The consultation paper criticised this jurisprudence for being “rooted in outmoded assumptions about professional roles and hierarchies” and, in particular, a line of cases suggesting that the medical expert must always be a psychiatrist.⁵⁰ We also noted encouraging developments, both in Strasbourg and domestic case law, suggesting that in some cases general practitioners, psychologists and psychotherapists could provide the necessary medical evidence. But overall, we considered that:

The case law appears out of kilter with modern mental health practice, where expertise is based on competencies rather than qualifications. Moreover, it fails to take into account the individual needs of the person being assessed, which may not always call for a doctor’s assessment.⁵¹

9.61 We provisionally proposed that the new scheme should allow for a range of practitioners to provide the medical expertise, including psychiatrists, psychologists and general practitioners.

Consultation responses

9.62 The majority agreed with our proposal.⁵² Some argued that for some conditions (such as acquired brain injury, autism or dementia) a psychologist’s assessment could be more appropriate than medical evidence from a doctor, and could provide greater insight into whether restrictions could be reduced. A benefit of our proposal was seen to be that the person would be more likely to be assessed by someone who knew them.

9.63 Many DoLS professionals also criticised the utility of the DoLS mental health assessment. It was claimed that in practice assessments were often too brief, doing little more than confirming a life-long diagnosis, and failing to engage with the person. Some consultees argued that our proposals should go further and enable medical assessments to be undertaken by advanced practitioner nurses and community psychiatric nurses, or remove the requirement for a doctor’s assessment where the diagnosis was not in dispute and the situation is unchanged.

9.64 However, a number of consultees were doubtful that the Strasbourg court would recognise non-psychiatrists as being medical experts for the purpose of Article 5. Others

⁴⁸ Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008, SI 2008 No 1858, reg 4.

⁴⁹ See, for example, *Winterwerp v Netherlands* (1979-80) 2 EHRR 387 (App No 6301/73) at [39] and *Varbanov v Bulgaria* App No 31365/96 at [47].

⁵⁰ Consultation paper, paras 7.172 to 7.194.

⁵¹ As above, para 7.186.

⁵² Consultation analysis, PP 7-31, para 6.329.

felt that, irrespective of the legal position, a medical doctor should always provide the required medical assessment, and that as an additional safeguard more than one doctor should be required and assessing doctors should always be registered with a current licence to practise.

Discussion

- 9.65 Consultation broadly confirmed our approach to objective medical expertise. There was widespread agreement that the requirement of an assessment by a psychiatrist in every case was unnecessary and costly, and frequently failed to benefit the person being assessed.
- 9.66 Some consultees argued that Article 5 requires the provision of an assessment by a psychiatrist. We consider it would be highly unlikely that any court today would interpret Article 5 as laying down a general rule that objective medical expertise can only be provided by a psychiatrist, or even a doctor, although it is possible to conceive of individual cases where evidence from a psychiatrist would be necessary. As noted in the consultation paper, the Strasbourg court requires “substance over form” and would be unlikely to hold that a medical qualification, as opposed to a demonstration of medical competence, was a pre-requisite to objective medical expertise.⁵³ Indeed, existing case law supports the notion that objective medical expertise can be provided by general practitioners, psychotherapists and psychologists.⁵⁴ We also consider there are sound arguments that some specialist nurses could lawfully take on this role, although we concede that the courts have yet to consider this particular issue.
- 9.67 In order to comply with the Strasbourg jurisprudence, the Liberty Protection Safeguards provides that arrangements can only be authorised if a medical assessment has confirmed that the person is of unsound mind.⁵⁵ However, the draft Bill does not limit the range of medical professionals who could potentially provide this evidence. Instead, the medical assessment must in all cases have been prepared by someone who meets the requirements set out in regulations.⁵⁶ This would allow the Secretary of State and Welsh Ministers to prescribe matters such as the experience, specialisms or qualifications of the assessor. It would be possible, for example, for the regulations to provide that certain types of psychologists, or doctors holding a licence to practise, could provide the assessment. The regulations could also be used to specify circumstances in which a “specialist” medical assessment must be carried out; for example, requiring that that people with autism should only be assessed by practitioners with qualifications or experience in the treatment of autism. The regulations could also enable specialist nurses to undertake the medical assessment, for instance, if case law confirmed that such professionals could lawfully undertake this role.
- 9.68 We have also applied the same approach to the mental capacity assessment. In other words, the capacity assessments must have been prepared by someone who meets the requirements set out in regulations. In doing so, it is important to empathise that this does not mean necessarily that only specific professionals should be able to undertake

⁵³ Consultation paper, para 7.177 (quoting Richard Gordon QC in support of the Government’s interpretation of *Varbanov v Bulgaria* App No 31365/96 during the passage of the Mental Health Bill 2006-07).

⁵⁴ See *Rivera v Switzerland* App No 8300/06 at [59], *G v E and others* [2010] EWCA Civ 822, [2012] Fam 78 at [60], *Re X* [2014] EWCOP 25, [2015] 1 WLR 2454 at [15], and *Re NRA* [2015] EWCOP 59 at [224].

⁵⁵ Draft Bill, sch 1 (new paras 1(2)(c) and 14(b) of sch AA1 to the Mental Capacity Act).

⁵⁶ Draft Bill, sch 1 (new para 17(1) of sch AA1 to the Mental Capacity Act).

this assessment. The regulations could be used, for example, to specify that people from a non-professional background could undertake the assessment, and to enable an assessor who already knows the person to undertake the assessment. The regulations could also be used to require a specialist capacity assessment in certain cases.

- 9.69 We were concerned by the criticism of the quality of many mental health assessments under the DoLS. We intend that the new legal framework should encourage a more expansive use of the medical assessor, beyond merely confirming the existence of unsoundness of mind. The draft Bill therefore confirms that the same assessor can provide the capacity and medical assessments.⁵⁷ Moreover, the medical assessor could undertake the assessment of whether the arrangements are necessary and proportionate (see discussion at para 9.74). Whilst it would not be right (and would add to costs unnecessarily) to require this in every case, the Liberty Protection Safeguards establish no unnecessary barriers in this respect. However, as noted at para 9.10, it is not our intention to encourage an automatic assumption that only a doctor can undertake the capacity assessment, and indeed there are many circumstances under which a professional of a different discipline would be better placed to conduct such an assessment.

Recommendation 12.

A capacity assessment and a medical assessment must in all cases have been prepared by someone who meets the requirements set out in regulations made by the Secretary of State and Welsh Ministers.

This recommendation is given effect by schedule 1 to the draft Bill (new paragraph 17 of schedule AA1 to the Mental Capacity Act).

The number and independence of assessors

- 9.70 In the majority of cases, detention under the Mental Health Act is founded on the provision of two medical recommendations and an application by the Approved Mental Capacity Professional. At least one of the doctors must be approved under section 12 of the Act as having special experience of diagnosis or treatment of mental disorder, and (if practicable) at least one doctor should have previous acquaintance with the patient.⁵⁸ The DoLS require six assessments to have been carried out by a minimum of two assessors – the best interests assessor and a mental health assessor. As noted earlier, the best interests assessor cannot be someone who is involved in the person's care or in making decisions about the person's care.⁵⁹
- 9.71 The consultation paper proposed that the new scheme should establish a greater degree of flexibility on these matters. The Approved Mental Capacity Professional would have wide discretion to select assessors based on the individual circumstances

⁵⁷ Draft Bill, sch 1 (new para 17(1) of sch AA1 to the Mental Capacity Act).

⁵⁸ Mental Health Act, s 12(2).

⁵⁹ Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008, SI 2008 No 1858, reg 12(1) and Mental Capacity (Deprivation of Liberty: Assessments, Standard Authorisations, and Disputes about Residence (Wales) Regulations 2009, SI 2009 No 783 (W 69), reg 8.

of the case. For example, it might be that the person would benefit from an assessment by a professional who already knows them, or they may require an assessment by a professional with specialist knowledge and skills. In other cases, the Approved Mental Capacity Professional could undertake the assessment themselves and thereby ensure that an independent assessment takes place.⁶⁰

Consultation responses

9.72 A majority of consultees agreed with this proposal.⁶¹ Consultees agreed that it would ensure more flexibility and make the assessment process less resource intensive. Some argued that the delegation of assessment to other workers would ensure that the health and social care workforce remained engaged with the DoLS replacement scheme. Those who disagreed felt that in practice it would be difficult to require other professionals to undertake assessments and the quality of the assessments would often be poor due to the widespread poor knowledge of the Mental Capacity Act (including the DoLS).

Discussion

9.73 We remain of the view that the legal framework for assessments needs to ensure a greater degree of flexibility. Whilst the Liberty Protection Safeguards identifies which assessments must be carried out before arrangements can be authorised, it ensures that a wide range of professionals and practitioners could complete the assessments. The main exception is the medical assessment, which is discussed from para 9.11.

9.74 The draft Bill sets out that in all cases there must be at least two assessors. This serves as a check against arbitrariness for the purposes of Article 5. But the draft Bill places no restrictions on how the three assessments are divided up between assessors.⁶² So, for instance:

- (1) a social worker involved in the person's care could undertake the capacity assessment and the assessment of whether the arrangements are necessary and proportionate (and a doctor could provide the medical assessment);
- (2) in a hospital setting, a doctor could carry out the medical assessment and the assessment of whether the arrangements are necessary and proportionate (and an occupational therapist could provide the capacity assessment); or
- (3) all three assessments could be carried out by different professionals.

9.75 The Liberty Protection Safeguards also provide that if the assessments are carried out by two assessors, they must be independent of each other – or if there are more than two assessors at least two must be independent of each other.⁶³ We have deliberately left the meaning of independence to be fleshed out in the new Code of Practice. We envisage that the Code would emphasise that where possible the assessors would be from different professional backgrounds or disciplines (even though they may work in the same multi-disciplinary team), and should not be involved in a line management relationship.

⁶⁰ Consultation paper, paras 7.63 to 7.67.

⁶¹ Consultation analysis, PP 7-11, para 6.103.

⁶² Draft Bill, sch 1 (new paras 17 and 21(5) of sch AA1 to the Mental Capacity Act).

⁶³ Draft Bill, sch 1 (new para 29 of sch AA1 to the Mental Capacity Act).

- 9.76 As discussed at para 9.69, the draft Bill confirms that the same assessor can provide the capacity and medical assessments. However, it is not our intention to establish an automatic assumption that only a doctor can undertake the capacity assessment.
- 9.77 As described earlier, an element of independence would be introduced into the process and, as a whole, would also be secured by the role of the independent reviewer, and in certain cases the Approved Mental Capacity Professional.

Recommendation 13.

The capacity assessment, the medical assessment and the assessment of whether the arrangements are necessary and proportionate must be provided by at least two assessors. If the assessments are carried out by two assessors, they must be independent of each other – or if there are more than two assessors at least two must be independent of each other.

This recommendation is given effect by schedule 1 to the draft Bill (new paragraphs 17, 21(5) and 29 of schedule AA1 to the Mental Capacity Act).

Equivalent assessments

- 9.78 The DoLS provide that where an “equivalent assessment” to any of the required qualifying assessments has already been obtained, the supervisory body may rely upon that instead of obtaining a fresh assessment. An equivalent assessment may, for example, have been carried out as part of the relevant person’s care plan. Such an assessment may only be used if:
- (1) it is in writing;
 - (2) it complies with the requirements of the assessment for which it is standing;
 - (3) it has been carried out within the previous 12 months (unless it is an age assessment); and
 - (4) the supervisory body is satisfied that it remains accurate and up-to-date.⁶⁴
- 9.79 The consultation paper provisionally proposed that the new legal framework should continue to enable the use of equivalent assessments.⁶⁵

Consultation responses

- 9.80 A majority of consultees agreed with this proposal.⁶⁶ It was argued that greater use of equivalent assessments, where appropriate, would reduce costs. Many consultees expressed their frustration at having to arrange (and pay for) new mental health assessments every 12-months even when the person’s diagnosis was permanent and long-standing (such as a life-long learning disability). The figures quoted for costs per assessment ranged from £175 to £600, and one local authority reported spending around £135,000 per year on medical assessments for the purposes of the DoLS. Some consultees suggested that the NHS should pay for mental health assessments rather

⁶⁴ Mental Capacity Act, sch A1, para 49(1) to (5).

⁶⁵ Consultation paper, paras 7.87 and 7.187.

⁶⁶ Consultation analysis, PP 7-15, para 6.151, and PP 7-31, para 6.329.

than local authorities. Others argued that equivalent assessments should be available for an unlimited time, as long as they remained valid. Those who disagreed with the proposal argued that the need for a fresh assessment at the point of a proposed deprivation of liberty was a key safeguard.

Discussion

9.81 Consultation has confirmed our view that the new legal framework should enable the use of equivalent assessments. In some cases it will be entirely unnecessary for a new assessment to be commissioned, For example, the person may have a lifelong severe learning disability and their previous mental health and capacity assessments could be relied on since there could have been no change in their condition. Therefore, the Liberty Protection Safeguards do not always require new capacity and medical assessments to be carried out in every case. It would be open to the responsible body to rely on equivalent assessments provided it is reasonable to do so, which might include:

- (1) a previous assessment carried out under the Liberty Protection Safeguards; or
- (2) a similar assessment which has been carried out for different purposes, such as a needs assessment under the Care Act or the Social Services and Well-being (Wales) Act.⁶⁷

9.82 Indeed, we think that the law could do more in this respect. The DoLS require that a new assessment must be generated (at least) every 12 months. The draft Bill does not set a time-limit on the use of capacity and medical assessments, and instead provides that equivalent assessments can be used where they remain a reliable indicator of the person's current condition. The use of equivalent assessments for the capacity assessment could include those which confirm fluctuating capacity. The new Code of Practice might usefully be used to clarify cases where the use of equivalent assessments might be appropriate or not.

9.83 The Liberty Protection Safeguards do not provide for the use of equivalent assessments when it comes to the the assessment of whether the arrangements are necessary and proportionate. This is because, in our view, it would be extremely rare that a fresh determination of whether the arrangements are necessary and proportionate would not be appropriate. A new assessment is therefore always required as an additional safeguard for the person.

9.84 We were interested by the suggestion that local authorities should not in all cases be expected to fund medical assessments. The underlying concern should be addressed, at least in part, by the requirement that the "responsible body" (which can mean an NHS body – see para 8.14) must commission the necessary assessments (including the medical assessment). This would mean that for hospital patients, and those in receipt of NHS continuing health care, the NHS would be responsible for securing (and paying for) the medical assessment. Otherwise, this would fall to the responsible local authority.

⁶⁷ Draft Bill, sch 1 (new para 18 of sch AA1 to the Mental Capacity Act).

Recommendation 14.

The responsible body should be able to rely on a capacity or medical assessment carried out under the Liberty Protection Safeguards on a previous occasion or for any other purpose, provided it is reasonable to do so. In doing so, it must have regard to the length of time that has elapsed since the assessment was carried out, the purpose of the assessment and whether there has been any significant change in the person's condition.

This is given effect by schedule 1 to the draft Bill (new paragraph 18 of schedule AA1 to the Mental Capacity Act).

Chapter 10: The procedural conditions

10.1 Chapter 9 discussed the assessments that must be carried out before an authorisation can be given. This chapter discusses the other conditions that must be met before the responsible body can authorise arrangements which would give rise to a deprivation of liberty. These conditions can in general terms be described as “procedural” in nature, and address the following areas: the required consultation, the conflicting decision of a donee or deputy, the independent review, and approval by an Approved Mental Capacity Professional.

THE REQUIRED CONSULTATION

10.2 Under the DoLS, the best interests assessor is required to determine whether it is in the best interests of the relevant person for them to be a detained resident.¹ This determination is made by reference to section 4 of the Mental Capacity Act, which (amongst other matters) includes a duty to consult. The individual making the best interests determination is required to take into account the views of:

- (1) anyone named by the person as someone to consult;
- (2) anyone engaged in caring for the person or interested in their welfare;
- (3) any donee of a lasting power of attorney; and
- (4) any court-appointed deputy.²

10.3 This duty applies to the extent that it is “practical and appropriate” to consult the person in question. The purpose of the consultation is to ascertain what would be in the person’s best interests and, in particular, the person’s past and present wishes and feelings, beliefs and values and other factors that the person would be likely to consider if they had capacity.³

10.4 The consultation paper provisionally proposed retaining this general approach; entitlement to the restrictive care and treatment scheme would be based on a best interests decision which would, accordingly, include the duty to consult contained in section 4.⁴

Consultation

10.5 We received few comments specifically on the duty to consult, but more generally consultees emphasised the importance of ensuring that family members and other unpaid carers are fully involved in the decision-making.⁵ Specific issues were raised in relation to 16 and 17 year olds, in particular the importance of ensuring the involvement

¹ Mental Capacity Act, sch A1, para 16(3).

² As above, s 4(6).

³ As above, s 4(7).

⁴ Consultation paper, para 7.29.

⁵ Consultation analysis, PP 7-6, from para 6.50.

of parents and the local authority when it is acting as the “corporate parent” for the purposes of the Children Act 1989 or the Social Services and Well-being (Wales) Act.

Discussion

- 10.6 We remain committed to ensuring that full consultation takes place before arrangements can be authorised. Whereas in the consultation paper we relied upon the best interests decision-making framework in section 4 of the Mental Capacity Act to ensure this outcome, under the Liberty Protection Safeguards the equivalent decision is made by reference to whether the arrangements are necessary and proportionate (see recommendation 10). It is therefore necessary to establish an express duty to consult for the purposes of the Liberty Protection Safeguards. This duty is intended to mirror the consultation requirement contained in section 4(6) of the Mental Capacity Act – which is now well-established and does not appear to cause any significant difficulties in practice. In addition, the new consultation duty seeks to put beyond doubt that an advocate, the appropriate person (see from para 12.43) and the donee of an enduring power to attorney should be consulted, and in the case of 16 and 17 year olds, that anyone with parental responsibility and (if the young person is being “looked after” by a local authority) the local authority must be consulted.⁶ The main purpose of the consultation is to try to ascertain the person’s wishes or feelings in relation to the arrangements which are proposed or in place.
- 10.7 The consultation duty applies if it is practical and appropriate to do so. These terms are not defined in the draft Bill, since their meaning is too case-specific. However, we would expect the new Code of Practice to provide guidance on how they should be applied to individual cases and circumstances in practice.

Recommendation 15.

The responsible body may authorise arrangements if (amongst other requirements) it has consulted, unless it is not practical or appropriate to do so:

- (1) anyone named by the person as someone to be consulted;**
- (2) anyone engaged in caring for the person or interested in their welfare;**
- (3) any donee of a lasting power of attorney or enduring power of attorney, and any court appointed deputy;**
- (4) any appropriate person or independent mental capacity advocate;**
- (5) in the case of a person aged 16 or 17, anyone with parental responsibility; and**
- (6) in the case of a person aged 16 or 17 who is being looked after by a local authority, the authority concerned.**

This recommendation is given effect by schedule 1 to the draft Bill (new paragraphs 14(d) and 22 of schedule AA1 to the Mental Capacity Act).

⁶ Children Act 1989, s 22 and Social Services and Well-being (Wales) Act, s 74.

CONFLICTING DECISION OF A DONEE OR DEPUTY

10.8 The “no refusals requirement” under the DoLS provides that a standard authorisation cannot be given in the following situations:

- (1) if it would conflict with a valid decision of a donee of a lasting power of attorney or a court-appointed deputy; or
- (2) where the person has made a valid advance decision to refuse all or part of the treatment which it is proposed to give them at the hospital or care home.⁷

10.9 The consultation paper provisionally proposed that this provision should be maintained.⁸

Consultation responses

10.10 A majority of consultees agreed with this proposal.⁹ Many did so because it would not alter the current legal position, although some felt that the no refusals requirement was misunderstood or not applied in practice. Some consultees were concerned that the proposal might give donees “too great a power” and questioned how local authorities would deal with a situation where a donee does not agree to a care home placement when this may clearly be the only appropriate option to meet needs.

Discussion

10.11 Consultation has confirmed our view that provision is necessary in this respect, but also uncovered some confusion about the meaning of the current no refusals requirement. This confusion may, in part, arise due to a lack of clarity in the law. A standard authorisation cannot be given if “for the person to be accommodated at the relevant hospital or care home for the purpose of receiving some or all of the relevant care or treatment” would clash with a valid decision of a donee or deputy.¹⁰ On a plain reading, this appears to be limited to a decision as to whether or not the person should be accommodated there, and is not about, for instance, treatment decisions (not least because the DoLS do not provide authority for treatment). However, the *DoLS Code of Practice* suggests a wider interpretation when it states the following:

If any part of the proposal to deprive the person of their liberty (including any element of the care plan) would be in conflict with a valid decision of a donee or deputy made within the scope of their authority, then the standard authorisation cannot be given. For example, if a donee or deputy decides that it would not be in the best interests of the relevant person to be in a particular care home, and that decision is within the scope of their authority, then the care plan will need to be reviewed with the donee or deputy.¹¹

10.12 Similarly, the *DoLS Code of Practice* suggests that where an advance decision to refuse treatment has been made which covers some or all of the treatment that is the purpose

⁷ Mental Capacity Act, sch A1, paras 18 to 20.

⁸ Consultation paper, para 13.36.

⁹ Consultation analysis, PP 13-2, para 12.20.

¹⁰ Mental Capacity Act, sch A1, para 20(1).

¹¹ *DoLS Code of Practice*, para 4.26.

for which the authorisation has been requested, then the standard authorisation cannot be given.¹²

- 10.13 The draft Bill sets out with more precision which decisions of a donee, a deputy, or the person themselves (using an advance decision) should operate as a bar to the granting of an authorisation. Importantly, it establishes that arrangements cannot be authorised which would conflict with a valid decision of either a donee or a deputy as to where the person should reside or receive care or treatment.¹³ This would confirm our understanding of the current legal position. However, the draft Bill does not automatically prevent the authorisation of arrangements in circumstances where a donee, a deputy or the person themselves (through an advance decision) is refusing all or part of the care or treatment which is to be delivered to them. Rather, the question of whether they should be authorised is to be resolved by application of the necessary and proportionate condition (discussed from para 9.20). The assessor would need to consider whether – given that refusal and the terms of that refusal – it could be said to be necessary and proportionate to authorise the arrangements. We would expect the new Code of Practice to give guidance on this matter.
- 10.14 We have drawn a distinction between these two positions because we consider it important that the Liberty Protection Safeguards delineate the bright-line distinction between a decision to deprive someone of their liberty and a decision about treatment. A deprivation of liberty authorisation does not, in itself, authorise treatment (either under the DoLS or the Liberty Protection Safeguards). It therefore follows that whether or not a donee or deputy agrees with treatment to be given to the person should not stand as an automatic bar to the authorisation. In many cases, if it is clear that a donee or deputy will not consent on the person's behalf to treatment, it is unlikely to be necessary and proportionate to authorise the proposed arrangements. But there may be some cases where it would be; for example, if the donee or deputy objects to a particular form of treatment – but not treatment in general – it still may be necessary and proportionate for the arrangements to be authorised in order for the person to receive other forms of care or treatment. Similarly, an advance decision may have been used to bar the administration of particular medical treatment or treatments. This would make it difficult to justify authorising arrangements that are based on the provision of that treatment. However, again, we do not rule that there may be circumstances in which the arrangements could still be authorised (for instance pending consideration of whether alternative medical treatment could be offered). Any disputes may ultimately need to be decided by the Court of Protection.
- 10.15 Similarly, if the donee or deputy did not consent to transport arrangements (and these arrangements fell within their decision-making powers), this would not be an automatic bar to an authorisation; we would expect the issue to be resolved through consideration of the necessary and proportionate condition.
- 10.16 The draft Bill also confirms the current position that is implied, rather than express, in the Mental Capacity Act that a donee or deputy cannot consent on behalf of the person to what would otherwise be a deprivation of their liberty.¹⁴ Whilst a donee or deputy may have a power (circumscribed as above) to accept or refuse treatment, their approval of

¹² *DoLS Code of Practice*, para 4.26.

¹³ Draft Bill, sch 1 (new para 15 of sch AA1 to the Mental Capacity Act).

¹⁴ Draft Bill, cl 3.

the arrangements does not obviate the need for them to be authorised through our scheme if the arrangements give rise to a deprivation of the person's liberty.

10.17 We took the decision not to allow either a donee or deputy to consent on behalf of the person for three key reasons. The first reason is that there is only very limited support in the Strasbourg case law for any concept of proxy or substituted consent. Mr Justice Keehan has noted that the reference to substituted consent in one case had the character of a "chance passing comment".¹⁵ The second reason is that it appears to us problematic, as a matter of principle, for a person to be able to remove themselves from the scope of Article 5(1) by giving a power of attorney without themselves having considered the specific circumstances which might engage the Article. We therefore consider that there is a qualitative difference between the giving of advance consent and the action of a proxy decision-maker. The third reason is that we think that, as a matter of practice, it is better to err on the side of caution here given that there is sufficient evidence from the case law that not all donees and deputies act in compliance with the spirit or the letter of the Mental Capacity Act.¹⁶ We therefore think that codifying the current position is the right approach.

10.18 We also received responses from individual deputies who argued that an administrative authorisation is otiose in cases where the court has already appointed a deputy and is therefore aware of the case and better placed to authorise and review any deprivation of liberty. The Liberty Protection Safeguards do not rule out the responsible body seeking a court order in such cases, but clearly this would need to be balanced against other considerations (including the costs incurred to the public purse compared to an administrative authorisation). In some cases there may be disputes between the deputy and the responsible body over the proposed arrangements. Under the Liberty Protection Safeguards the current position would be maintained whereby an authorisation could not conflict with a valid decision by a deputy to decide where the person should reside or receive treatment. Where a deputy does not agree with other aspects of the care plan, this must be considered by the NHS body or local authority. We would also expect that the responsible body should always consider taking the matter to court if a deputy does not agree that the person is, in fact, deprived of liberty. In our view, the new Code of Practice should address cases of dispute between the responsible body and a deputy.

Recommendation 16.

The responsible body should not be able to authorise arrangements which provide for a person to reside in, or to receive care or treatment at, a particular place, which conflict with a valid decision of a donee of a lasting power of attorney or a deputy appointed by the court.

This recommendation is given effect by schedule 1 to the draft Bill (new paragraph 15 to schedule AA1 to the Mental Capacity Act).

¹⁵ *Birmingham CC v D* [2016] EWCOP 8 at [118], commenting upon *Stanev v Bulgaria* (2012) 55 EHRR 22 (App No 36760/06) (Grand Chamber Decision).

¹⁶ See, for example, *Re GM* [2013] EWHC 2966 (COP) and *Re OB* [2014] EWCOP 28.

Recommendation 17.

The Mental Capacity Act should be amended to confirm that a donee of a lasting power of attorney or a court appointed deputy cannot consent on a person's behalf to arrangements which give rise to a deprivation of that person's liberty.

This recommendation is given effect by clause 3 of the draft Bill.

INDEPENDENT REVIEW

10.19 The role of the supervisory body is central to the operation of the DoLS. For example, it is responsible for appointing assessors, signing off authorisations, and determining the length of the authorisation and whether the authorisation will be given subject to conditions. In England, the supervisory body is the relevant local authority, and in Wales the role is performed by the relevant local authority or, in respect of hospitals, the relevant local health board.¹⁷ The role of the supervisory body is set out in para 4.4 and the identity of the supervisory body is discussed in para 8.3.

10.20 The consultation paper criticised the supervisory body role for generating procedural complexity and costs, with some bodies creating layers of bureaucracy in order to sign off DoLS authorisations. We also argued that in practice the supervisory body was unable to conduct the forensic examination of assessments that the courts expect, and that internal responsibility for signing off DoLS authorisations is often obscured (an issue specifically mentioned by Mr Justice Peter Jackson in *London Borough of Hillingdon v Neary*).¹⁸ We therefore provisionally proposed that the role of the supervisory body should be reduced to the receipt and scrutiny of the documents, and that there should instead be a commensurate increase in decision-making responsibility given to best interests assessors (whose role would be revised, and renamed "Approved Mental Capacity Professionals").¹⁹

Consultation responses

10.21 This proposal was supported by a majority at consultation.²⁰ It also generated some debate about the current role of the supervisory body. We were told that in some areas, those responsible for granting standard authorisations were not adequately scrutinising the assessments and recommendations of best interests assessors, and that the signing-off procedures being adopted were over-elaborate and time-consuming. Others reported that the supervisory body was an important safeguard which provides direct oversight over assessors, helps to enforce conditions, and plays a wider role than we had suggested in the consultation paper (including training and advice).²¹ Alternative

¹⁷ Mental Capacity Act, Sch A1, paras 178 to 182.

¹⁸ *Hillingdon LB v Neary* [2011] EWHC 1377 (COP), [2011] 4 All ER 584 at [33] (see summary of this case at para 1.26)

¹⁹ Consultation paper, paras 7.91 to 7.112.

²⁰ Consultation analysis, PP 7-16, para 6.161.

²¹ For example, Derek Boothby (MCA lead).

regulatory structures were suggested, such as the establishment of internal panels,²² and requiring a neighbouring local authority to sign off decisions.²³

Discussion

10.22 Under the Liberty Protection Safeguards, the role of the supervisory body would be undertaken by the “responsible body” (see para 8.14). Following consultation, we remain of the view that the signing-off process should be streamlined and freed of procedural complexity, and that there should be an increase in decision-making responsibility given to assessors. But we also consider that further reforms are necessary, particularly to the signing-off process, in order to identify clearly the individual who is responsible for granting the authorisation on behalf of the NHS body or local authority and to reinforce the need for operational independence.

10.23 The need for operational independence is particularly great given that in many cases the relevant assessments will be undertaken by members of the team that is responsible for the person’s care or treatment.²⁴ The Strasbourg court has emphasised that in cases where the same clinicians are responsible for depriving the person of liberty and in charge of their treatment during that period, there must be “guarantees of independence” and counterbalancing procedures aimed at preventing “indiscriminate involuntary” admissions (in this case a breach of Article 5(1) occurred in circumstances where a patient was involuntarily detained following an examination by a panel of four psychiatrists, two of whom had been initially involved in admitting the patient to hospital).²⁵

10.24 The Liberty Protection Safeguards require that an “independent review” of the assessments must be carried out in all cases.²⁶ The purpose of the review is to confirm that it is reasonable for the responsible body to conclude that the conditions for an authorisation are met, or (if certain criteria are met) to refer the case to an Approved Mental Capacity Professional (see further from para 10.34).²⁷ The reviewer cannot be someone who is involved in the day-to-day care of, or providing any treatment to, the person.²⁸ They could be someone employed by the responsible body, but equally they could be from outside. We would expect the new Code of Practice to provide guidance on the qualities and background of those who should be appointed to this role and ensure that this should be someone of sufficient seniority and experience.

10.25 In cases which are not being referred to the Approved Mental Capacity Professional, the reviewer would be required to certify personally that it reasonable to conclude that the conditions for an authorisation are met. This would mean that the reviewer could not simply rubber stamp decisions and would be expected to scrutinise the assessments. In making this decision, they must review the information available to the responsible body and determine whether or not the responsible body’s decision to

²² The Law Society.

²³ Belinda Schwehr.

²⁴ The number and independence of the assessors is discussed at para 9.67 of this report.

²⁵ *IN v Ukraine* App No 28472/08 at [81].

²⁶ Draft Bill, sch 1 (new para 14(e) of sch AA1 to the Mental Capacity Act).

²⁷ Draft Bill, sch 1 (new para 14(e) of sch AA1 to the Mental Capacity Act).

²⁸ Draft Bill, sch 1 (new para 23(1) of sch AA1 to the Mental Capacity Act).

authorise arrangements is a reasonable one to come to on the basis of that information. The reviewer cannot make additional enquiries or obtain new assessments. It is essentially a review “on the papers”. The responsible body must be informed in writing of the result of the review (or if the case has been referred to an Approved Mental Capacity Professional).²⁹

10.26 Once the reviewer has confirmed that it is reasonable to conclude that the conditions for an authorisation are met, the responsible body can authorise the proposed arrangements.

Recommendation 18.

The responsible body may authorise arrangements if (amongst other requirements) an independent review has been carried out and the person carrying it out has confirmed that:

- (1) it is reasonable for the responsible body to conclude the relevant conditions for an authorisation are met, or**
- (2) the case has been referred to an Approved Mental Capacity Professional and their approval has been obtained.**
- (3) The independent review may not be carried out by a person who is involved in the day-to-day care of, or providing any treatment to, the person.**

This recommendation is given effect by schedule 1 to the draft Bill (new paragraphs 14(e) and 23 of schedule AA1 To the Mental Capacity Act).

APPROVAL BY AN APPROVED MENTAL CAPACITY PROFESSIONAL

10.27 Under the DoLS, the role of the best interests assessor is a particularly important one. They must decide whether a deprivation of liberty is occurring, or is likely to occur, and, if so, whether it is in the person’s best interests. They must also decide whether the deprivation of liberty is necessary in order to prevent harm to the person and is a proportionate response to the likelihood of the person suffering harm and the seriousness of that harm.³⁰ The role also ensures an independent element to the assessment process; the best interests assessor cannot be involved in the person’s care, or in making decisions about the person’s care.³¹ The best interests assessor can be an Approved Mental Health Professional, a social worker, a nurse, an occupational therapist or a psychologist.³²

²⁹ Draft Bill, sch 1 (new para 23(5) of sch AA1 to the Mental Capacity Act).

³⁰ Mental Capacity Act, sch A1, para 16.

³¹ Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008, SI 2008 No 1858, reg 12(1) and Mental Capacity (Deprivation of Liberty: Assessments, Standard Authorisations, and Disputes about Residence) (Wales) Regulations 2009, SI 2009 No 783 (W 69), reg 8.

³² Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008, SI 2008 No 1858, reg 5(2) and Mental Capacity (Deprivation of Liberty: Standard Authorisations and Disputes about Residence) (Wales) Regulations 2009, SI 2009 No 783 (W 69), reg 5(1).

10.28 The consultation paper argued that the restrictive care and treatment scheme should be designed around a revised role for the best interests assessor (which we re-named the “Approved Mental Capacity Professional”). We provisionally proposed that Approved Mental Capacity Professionals – acting as independent decision-makers on behalf of the local authority – would be responsible for overseeing the assessment process, keeping cases under review, setting conditions for authorisations and discharging people from the scheme. As well as providing for a flexible and person-centred approach to decision-making, we argued that this would lead to greater efficiencies through the dismantling of the layers of bureaucracy that had been developed by supervisory bodies to sign off DoLS assessments.³³

Consultation responses

10.29 The new Approved Mental Capacity Professional role was supported by a majority at consultation.³⁴ Many argued that it recognised and built upon the existing role and expertise of the best interests assessor, and provided for equivalent status to Approved Mental Health Act Professionals who operate under the Mental Health Act. Social care practitioners argued that the Approved Mental Capacity Professional role reflected social work values and principles. In particular, they felt it would give social work a leadership role, by holding other professionals to account across the health and care system to ensure compliance with the Mental Capacity Act.

10.30 However, a number of responses raised concerns about the resource implications. It was argued that the new role was too broad, and too much responsibility was being given to a single professional. Some felt that the Approved Mental Capacity Professional role would need to be a full-time position in order to cope with the new levels of responsibilities (whereas currently best interests assessors typically work on a rota basis and in addition to their main professional role, for example as a social worker).

Discussion

10.31 The responses disagreeing with our proposal, albeit from a minority of consultees, provided a challenging critique. On reflection, the monitoring-and-review role envisaged for the Approved Mental Capacity Professional was too broad and might have led to the creation of a new full-time role, which had not been our intention. Even if such changes were desirable (and many consultees were strongly of this view), it would not be practicable in view of the number of cases post *Cheshire West*. We have therefore revised the role of the Approved Mental Capacity Professional to focus on the approval of arrangements amounting to deprivation of liberty.

10.32 However, it is also clear that the existing requirement of a best interests assessment in every case is simply no longer sustainable. As we discussed in para 4.24, the DoLS are currently failing to deliver this assessment to a significant number of people confined in hospitals and care homes. Owing to the vast number of people now considered to be deprived of their liberty following *Cheshire West* – and taking into account that the Liberty Protection Safeguards would in addition extend to 16 and 17 year olds and those deprived of liberty outside hospitals and care homes – it would not be proportionate or affordable to provide an Approved Mental Capacity Professional in every case where a

³³ Consultation paper, paras 7.50 to 7.163.

³⁴ Consultation analysis, PP 7-11, para 6.103.

responsible body proposes to authorise arrangements. We have therefore concluded that the only practical alternative is to focus this role on certain defined cases.

10.33 In adopting this approach, it is crucial to emphasise that all those deprived of liberty (irrespective of whether they meet the criteria for a referral to an Approved Mental Capacity Professional) would be eligible for the safeguards provided under the Liberty Protection Safeguards, including rights to seek a review of the care or treatment arrangements, rights to advocacy or an appropriate person and access to the court (as set out in chapter 12). Moreover, the draft Bill contains a range of reforms aimed at securing Article 8 rights for any person who lacks capacity in relation to a matter (not just those who are deprived of liberty). For example it provides that a professional decision-maker cannot rely on the section 5 defence in respect of certain key decisions unless there is a written record which must include (amongst other matters) confirmation that a formal capacity assessment has been undertaken and any rights to advocacy have been implemented. These reforms are set out in chapter 14.

The duty to refer a case

10.34 There are various ways in which the law could structure access to an Approved Mental Capacity Professional. Perhaps the most straightforward method would be to simply list cases or situations that must be referred (such as those involving one-to-one care during the day or night, where medication is used to control behaviour, and new and unstable placements).³⁵ This approach has the advantages of being transparent and easily understood, but gives rise to problems of inclusivity; for example, it is not difficult to think of individual cases of one-to-one care or the use of medication which are not contentious and where a referral would add very little benefit.

10.35 In our view the most important factor that makes cases particularly acute and in need of additional oversight is where there is an indication that the arrangements are contrary to the person's wishes. The draft Bill therefore provides that a referral must be made to an Approved Mental Capacity Professional where the arrangements that are proposed, or in place, provide for the person to reside in, or receive care or treatment at, a particular place, and it is reasonable to believe that the person does not wish to reside at that place, or receive the care or treatment at that place.³⁶ This approach also has the benefit that it aligns the Liberty Protection Safeguards, to a greater degree, with the UN Convention on the Rights of Persons with Disabilities, and in particular Article 12, which indicates that national laws should provide support to the person to ensure that their will and preferences are respected. The compatibility of our scheme overall with the Convention is considered in appendix B.

10.36 In determining whether or not the duty arises, the independent reviewer must consider "all the circumstances so far as they are reasonably ascertainable, including the person's behaviour, wishes, feelings, views, beliefs and values".³⁷ Past circumstances can be relevant, as long as it is still appropriate to consider them.³⁸ The focus should be on the person's current wishes and past circumstances must be relevant to the

³⁵ To some extent, this is the approach adopted in the screening tool issued by ADASS following *Cheshire West* (see also para 4.19 of this report): ADASS, *Advice Note November 2014: Guidance for Local Authorities in the light of the Supreme Court decisions on Deprivation of Liberty Safeguards* (2014).

³⁶ Draft Bill, sch 1 (new para 24(2) of sch AA1 to the Mental Capacity Act).

³⁷ Draft Bill, sch 1 (new para 25(1) of sch AA1 to the Mental Capacity Act).

³⁸ Draft Bill, sch 1 (new para 25(2) of sch AA1 to the Mental Capacity Act).

person's current wishes. Therefore the duty to refer would apply if the person was actively trying to leave a care home - even if in the past (when they had capacity) they had indicated that they would be content to live there. Alternatively, the duty to refer would arise if the person (since losing capacity) was not objecting to the arrangements, but had been vociferous in objecting previously. These aspects of the duty to refer are materially similar to those which already apply in the context of deciding whether community patients object to treatment under the Mental Health Act, or whether the relevant person objects to being a mental health patient for purposes of DoLS.³⁹ They therefore have the advantage of familiarity. In determining whether the person's wishes are ascertainable, the independent reviewer can take into account any relevant views expressed by those who have been consulted by the responsible body (see discussion at para 10.6).⁴⁰

- 10.37 The draft Bill requires the independent reviewer to refer the case to an Approved Mental Capacity Professional if it is "reasonable to believe" that the person does not wish to reside at a particular place, or receive the care or treatment at that place.⁴¹ Therefore, the independent reviewer would not have to be certain of these matters in order for the duty to refer to be triggered.
- 10.38 In some cases the person's wishes will be clear. It might be, for example, that the person is actively trying to leave the premises, and being prevented from doing so – or is not physically capable of leaving but nevertheless expressing a desire to leave. It may be that family members are raising concerns on the person's behalf, arguing that the proposed arrangements are not what their loved one would have wanted.
- 10.39 But not all cases will be clear-cut. The person may be unable to express their wishes (for example as a result of a stroke), in which case the independent reviewer might need to consider their ascertainable past wishes and feelings (as far as it is still appropriate to consider them), or look towards interpreting the person's behaviour and / or communication in present or previous situations as the expression of the person's wishes. Under the Liberty Protection Safeguards, it would be left to professionals on the ground to make these determinations (assisted by the new Code of Practice) and make the position clear in their assessments which are given to the independent reviewer. However, it is important to emphasise that mere acquiescence, in itself, should never be indicative of the person's wishes. In other words, it should never be assumed that because a person is compliant with the care regime, he or she therefore wishes to reside in, or receive care or treatment, at the particular place. We would expect this point to be emphasised in the new Code of Practice.
- 10.40 In some cases – despite the best efforts of the assessor – it will not be possible to discern the person's wishes. We have considered whether there should be a default position that such cases should always be referred to an Approved Mental Capacity Professional. On balance we have decided not to recommend legislating for this position. We are concerned that this would apply to a significant number of people and have major resource implications. Instead, there would be a power to refer such cases (see from para 10.43 below).

³⁹ Mental Health Act, s 64J and Mental Capacity Act, sch 1A, para 5.

⁴⁰ Draft Bill, sch 1 (new para 25(3) of sch AA1 to the Mental Capacity Act).

⁴¹ Draft Bill, sch 1 (new para 24(2)(b) of sch AA1 to the Mental Capacity Act).

10.41 We have also decided that the duty to refer should not apply purely on the grounds that there is a reason to believe that a person would object to transport arrangements. This may be impractical to implement, particularly since transport arrangements may need to be put in place in a relatively short period of time. Instead, we consider that, on balance, a power to refer the case would be more proportionate.

10.42 As discussed from para 9.20, the Liberty Protection Safeguards allow arrangements to be authorised which are considered to be necessary and proportionate wholly or mainly by reference to the likelihood of harm to others if the arrangements were not in place and the seriousness of that harm. Such cases will often give rise to serious interferences with the Article 8 rights of those deprived of their liberty on this basis and an awkward overlap with the powers in the Mental Health Act. As we noted, our intention is to provide that the Liberty Protection Safeguards are not used if it would be more appropriate for an application to be made under section 2 or 3 of the Mental Health Act. For these reasons, the draft Bill provides that all such cases should also be referred to an Approved Mental Capacity Professional.⁴²

The power to refer a case

10.43 If the duty to refer the case to an Approved Mental Capacity Professional does not arise, the independent reviewer still has a power to make the referral if the case is one which is appropriate to be considered by an Approved Mental Capacity Professional and the Approved Mental Capacity Professional agrees to accept the referral.⁴³

10.44 Examples of cases which may be appropriate for consideration by an Approved Mental Capacity Professional might include those where:

- (1) the person's wishes are particularly difficult to discern, or fluctuate;
- (2) the restrictions being placed on the person are particularly intense or intrusive (for example, one-to-one care throughout the day and night), even though the care regime is not obviously against their wishes; or
- (3) the family object to the care and treatment (but not necessarily on the basis that the arrangements are contrary to the person's wishes).

10.45 The power to make a referral only arises if the Approved Mental Capacity Professional agrees to accept the referral.⁴⁴ It may be that an individual referral cannot be accepted because it is felt that the case could be dealt with adequately by the responsible body (for instance, if the independent reviewer is being overly cautious in making a referral). We anticipate that in practice the numbers of refused referrals would be low due to informal discussions taking place with the Approved Mental Capacity Professional before the referral is made. We would expect the new Code of Practice to give examples of individual cases which might, or might not, be appropriate to refer under the power, and to emphasise that a decision not to accept the referral should only be taken after a review of the papers, and the reasons must be documented.

10.46 There may be cases where the independent reviewer has a reasonable belief that the person does not wish to reside in, or receive care or treatment at, the particular place (and therefore makes a referral to the Approved Mental Capacity Professional) but upon

⁴² Draft Bill, sch 1 (new para 24(3) of sch AA1 to the Mental Capacity Act).

⁴³ Draft Bill, sch 1 (new para 23(3) of sch AA1 to the Mental Capacity Act).

⁴⁴ Draft Bill, sch 1 (new para 23(3)(b) of sch AA1 to the Mental Capacity Act).

closer inspection by the Approved Mental Capacity Professional it appears that this is not the case. In such cases we would expect the Approved Mental Capacity Professional and independent reviewer to decide between them on the best course of action. It could be agreed, for example, that the approval of the Approved Mental Capacity Professional would be helpful.

The determination by the Approved Mental Capacity Professional

10.47 Where a referral is made, the Approved Mental Capacity Professional's role is to determine whether or not they must approve the arrangements. The responsible body would be arranging everything up to that point. Before then, the Approved Mental Capacity Professional could be involved (if at all) only in a purely advisory capacity, for example to advise on what would constitute a deprivation of liberty or how to interpret the referral criteria.

10.48 The Approved Mental Capacity Professional must approve the arrangements if he or she determines that the conditions for the authorisation of arrangements are met. In order to make this determination, the Approved Mental Capacity Professional must review the information on which the responsible body has relied in concluding that the conditions are met.⁴⁵ For example, it may be that a local authority is proposing to place a person in a care home on the basis of a decision about resource allocation, or that the local authority has identified a range of options and is justifying their proposed placement on the basis of the person's best interests. In both cases, the Approved Mental Capacity Professional would be required to reconsider the assessment which has determined that the arrangements are necessary and proportionate. The Approved Mental Capacity Professional would be expected to consider matters using their own professional judgment rather than simply to consider whether those conducting the assessments could reasonably reach the conclusions that they did. The obligations upon them are therefore more onerous than upon the independent reviewer.

10.49 In order to discharge their obligations (and unlike the independent reviewer), the Approved Mental Capacity Professional is required to meet with the person, unless it is not practicable or appropriate to do so.⁴⁶ We envisage that it would be rare for the Approved Mental Capacity Professional not to meet the person, but there may be some cases where a meeting will not be practicable or appropriate, for instance where it is clear that even sensitive further consultation with the person would cause them psychiatric harm. The Approved Mental Capacity Professional also has the power to consult other key individuals in the person's life (by reference to the list referred to in recommendation 15 (see para 10.7)).⁴⁷ The inclusion of a power (rather than a duty) here is intended to give some flexibility. Consultation will already have been carried out by the responsible body (see recommendation 15). In some cases, given the importance of the cases being considered, it will be important to "double check" the views of key individuals. In other cases this will be unnecessary (for example in some end of life cases). We would expect the new Code of Practice to explain further how and when consultation should take place.

⁴⁵ Draft Bill, sch 1 (new para 28(1)(a) of sch AA1 to the Mental Capacity Act).

⁴⁶ Draft Bill, sch 1 (new para 28(1)(b) of sch AA1 to the Mental Capacity Act).

⁴⁷ Draft Bill, sch 1 (new para 28(2)(a) of sch AA1 to the Mental Capacity Act).

- 10.50 The draft Bill also confirms that the Approved Mental Capacity Professional can take such further steps (including obtaining information or making further enquiries) as are appropriate in order to determine whether the conditions for the authorisation of arrangements are met.⁴⁸
- 10.51 The Approved Mental Capacity Professional should not, we consider, have authority to instruct professionals, from the responsible body or elsewhere, to carry out assessments. Such a power would, in our view, blur the responsibilities of those responsible for commissioning the arrangements and the Approved Mental Capacity Professional. The assessments should be included in the referral, and if they are missing or inadequate, the Approved Mental Capacity Professional should simply refuse to approve the arrangements. If the Approved Mental Capacity Professional does not approve the arrangements, he or she must give reasons in writing to the responsible body and describe any steps the responsible body could take in order to obtain approval.⁴⁹ To avoid delays, the Approved Mental Capacity Professional could indicate informally that he or she intends not to approve the arrangements and make recommendations for how the issues may be resolved. The responsible body could then simply respond to these recommendations, avoiding the need for an application to be resubmitted. Further details on how this might work in practice should be included in the new Code of Practice.
- 10.52 The approval must be notified in writing to the responsible body.⁵⁰ The written approval of the Approved Mental Capacity Professional would, upon acceptance by the responsible body (and scrutiny for any obvious errors on the face of the approval), enable the authorisation of arrangements by the responsible body of the arrangements. The effect of authorisation is discussed further from para 11.11.

⁴⁸ Draft Bill, sch 1 (new para 28(2)(b) of sch AA1 to the Mental Capacity Act).

⁴⁹ Draft Bill, sch 1 (new para 27 of sch AA1 to the Mental Capacity Act).

⁵⁰ Draft Bill, sch 1 (new para 26(2) of sch AA1 to the Mental Capacity Act).

Recommendation 19.

There should be a duty to refer a case to an Approved Mental Capacity Professional if:

- (1) the arrangements that are proposed, or in place, provide for the person to reside in, or receive care or treatment at, a particular place, and it is reasonable to believe that the person does not wish to reside at that place, or receive the care or treatment at that place; or**
- (2) an assessor has determined that the arrangements are necessary and proportionate wholly or mainly by reference to the likelihood of harm to other individuals if the arrangements were not in place and the seriousness of that harm.**

Otherwise, there should also be a power to refer a case to the Approved Mental Capacity Professional if the case is one which is appropriate to be considered by an Approved Mental Capacity Professional and the Approved Mental Capacity Professional agrees to accept the referral.

This recommendation is given effect by schedule 1 to the draft Bill (new paragraphs 23(3) and 24 of schedule AA1 to the Mental Capacity Act).

Recommendation 20.

The Approved Mental Capacity Professional should be required to approve the arrangements if he or she determines that the conditions for the authorisation of arrangements are met. In doing so, he or she must meet with the person (unless it is not practicable or appropriate to do so), and may consult others and take further steps (including obtaining information or making further enquiries).

This recommendation is given effect by schedule 1 to the draft Bill (new paragraphs 26 and 28 of schedule AA1 to the Mental Capacity Act).

The Approved Mental Capacity Professional role

10.53 The consultation paper suggested that local authorities should be responsible for the approval of Approved Mental Capacity Professionals and that Approved Mental Capacity Professionals should be in the same position legally as Approved Mental Health Professionals under the Mental Health Act. We provisionally proposed that the Approved Mental Capacity Professional should be acting as an independent decision-maker on behalf of the local authority. This would mean the local authority would be vicariously liable for their actions, although the Approved Mental Capacity Professional could not be directed by the local authority to make a particular decision, or have their decision overturned by a local authority. In order to reflect further the importance of the new role, we proposed that the Health and Care Professions Council and the Care Council for Wales would be required to set the standards for, and approve, the education, training and experience of Approved Mental Capacity Professionals. A

person's entitlement to practise as an Approved Mental Capacity Professional would be indicated on the relevant professional register.⁵¹

10.54 The consultation paper also proposed that the following professionals should be able to undertake the new Approved Mental Capacity Professional role (thus retaining the list of professionals who are currently able to undertake the best interests assessor role):

- (1) an approved mental health professional (this is a person approved under section 114(1) of the Mental Health Act);
- (2) a social worker registered with the Health and Care Professions Council or Care Council for Wales;
- (3) a first-level nurse (this is a nurse who is registered in sub-part 1 of the register maintained by the Nursing and Midwifery Council and is not limited to a nurse who is trained in mental health or learning disabilities);
- (4) an occupational therapist registered with the Health and Care Professions Council; or
- (5) a chartered psychologist listed in the British Psychological Society's register and holding a practising certificate issued by the Society.

10.55 The consultation paper also asked for views on whether the new scheme should allow doctors to become Approved Mental Capacity Professionals.⁵²

Consultation responses

10.56 A majority supported the proposal that the Approved Mental Capacity Professional should act on behalf of the local authority as an independent decision-maker.⁵³ Many argued it would enhance the status of the new role and provide a clearer delineation between the role of the Approved Mental Capacity Professional and that of the local authority. However some consultees questioned our analogy between best interests assessors and Approved Mental Health Professionals. For example, it was argued that the latter role has over 30 years' history and culture behind it, whereas the best interests assessor role had not had time to "bed-down". Some argued that currently best interests assessors sometimes lack the professional confidence to challenge other decision-makers, especially doctors.

10.57 A majority supported our proposals for the oversight of the education and training of Approved Mental Capacity Professionals.⁵⁴ It was argued that our proposals would "gold plate" the Approved Mental Capacity Professional's independence.⁵⁵ However, the Health and Care Professions Council had reservations about adding annotations on the relevant professional register because ultimately the approval of Approved Mental Capacity Professionals would be a matter for local authorities, and therefore a professional register could not confirm entitlement to practise.

⁵¹ Consultation paper, paras 7.103 to 7.105.

⁵² As above, paras 7.69 and 7.190.

⁵³ Consultation analysis, PP 7-16, para 6.161.

⁵⁴ As above, PP 7-17, para 6.176 and PP 7-18, para 6.197.

⁵⁵ Consultation event with best interests assessors organised by Hounslow social services.

10.58 There were mixed responses to the question of whether doctors could become Approved Mental Capacity Professionals.⁵⁶ Many felt that a social care perspective was required and the new role would be beyond a doctor's range of expertise. Others argued that enabling doctors to perform this role would enhance their skills and would make sense where the deprivation of liberty is linked (directly or indirectly) to the provision of medication. A number of responses commented on which professionals could be permitted to perform the Approved Mental Capacity Professional role. Some felt the role should be limited to social workers, while others suggested it should be widened to include – for example – speech therapists, advocates and medical staff.

Discussion

10.59 We remain of the view that local authorities should be responsible for the approval of Approved Mental Capacity Professionals. The local authority already undertakes this role in respect of Approved Mental Health Professionals and therefore would be familiar with what is required. The draft Bill also requires local authorities to ensure that there are sufficient numbers of persons approved as Approved Mental Capacity Professionals.⁵⁷

Who can be approved to act as an Approved Mental Capacity Professional?

10.60 A local authority can only approve a person to act as an Approved Mental Capacity Professional if the person meets the requirements prescribed in regulations by the Secretary of State or Welsh Ministers.⁵⁸ A wide range of matters can be prescribed by the regulations. For example, the regulations could provide for a prescribed body (such as the Health and Care Professions Council and Care Council for Wales) to approve courses for Approved Mental Capacity Professionals.⁵⁹ This would put Approved Mental Capacity Professionals on a similar footing to Approved Mental Health Professionals. However, we accept that to require annotation in the relevant professional register might be misleading for members of the public. This is because the regulators would only set standards for education providers; a local authority would be responsible for approving the professional (after completion of their education) and the relevant regulations could set extra criteria – such as the completion of a practice placement. Therefore, whilst a regulator might be able to confirm that the professional has passed the relevant course, it could not confirm whether he or she is entitled to practise.

10.61 The Liberty Protection Safeguards do not specify which professions could undertake the new Approved Mental Capacity Professional role, or expressly rule out any professions. This would be a matter for the Secretary of State and Welsh Ministers to decide and implement through the regulations.⁶⁰ This would, amongst other matters, allow for a greater degree of flexibility. For example, it would allow the Government to

⁵⁶ Consultation analysis, Q 7-34, from para 6.360.

⁵⁷ Draft Bill, sch 1 (new para 42(a) and (c) of sch AA1 to the Mental Capacity Act). The equivalent provisions in relation to Approved Mental Health Professionals are contained in s 114(1) of the Mental Health Act and Department of Health, *Mental Health Act 1983: Code of Practice* (2015) para 14.35 and Welsh Government, *Mental Health Act 1983: Code of Practice for Wales Review* (2016) para 14.25.

⁵⁸ Draft Bill, sch 1 (new paras 44 and 45 of sch AA1 to the Mental Capacity Act).

⁵⁹ Draft Bill, sch 1 (new para 45(1)(c) of sch AA1 to the Mental Capacity Act). The regulations could also prescribe that this role be undertaken by the new regulatory body for the social work profession in England which is proposed by the Children and Social Work Bill 2016-17.

⁶⁰ Draft Bill, sch 1 (new para 45(1) of sch AA1 to the Mental Capacity Act).

retain the existing professional categories of people who may become a best interests assessor, establish a more restrictive list (for instance allowing registered social workers only to undertake this role), or prescribe a broader list (allowing additional professions or practitioners to undertake this role such as advocates, speech therapists and psychotherapists). The regulation-making power would also allow the Government to specify that an Approved Mental Capacity Professional must have certain qualifications or be of a particular profession for the purpose of considering certain types of referrals. For example, in cases where the person has difficulties with their sight or hearing the regulations may specify that the Approved Mental Capacity Professional role be undertaken by a professional with specified communication qualifications.

Independence of the Approved Mental Capacity Professional role

- 10.62 Under the Liberty Protection Safeguards, it is important that the Approved Mental Capacity Professional is seen to be independent and of sufficient professional standing that their decisions will be respected by the responsible body and the courts will be reluctant to interfere with their determinations. This will not be the case if there is any suspicion that their decision, whether or not to approve the arrangements, might be subject to influence by the responsible body (as the body seeking the authorisation of arrangements) or by a local authority (as the body responsible for approving the Approved Mental Capacity Professional).
- 10.63 The draft Bill provides that Approved Mental Capacity Professionals are as far as possible in the same position legally as Approved Mental Health Professionals. In particular, they are not employees of the local authority, and are independent decision-makers who cannot be directed by a public authority to make a particular decision. However, they also act “on behalf” of the local authority.⁶¹ It is likely that a local authority will remain ultimately responsible for the Approved Mental Capacity Professional’s actions, depending on the facts of the case.⁶²
- 10.64 Like the independent reviewer, the Approved Mental Capacity Professionals cannot be involved in the day-to-day care of, or providing any treatment to, the person.⁶³ This reflects the need for operational independence which is required for the purposes of Article 5(1)(e) (see para 10.23).
- 10.65 Although this is not set out expressly in the draft Bill, we consider that Approved Mental Capacity Professionals would be “public authorities” for the purposes of the Human Rights Act 1998. They could not approve a set of arrangements based upon obviously flawed public law decision-making because they cannot, themselves, act incompatibly with the ECHR. To this extent, they will have a similar ability to a Court of Protection judge to undertake “rigorous probing, searching questions and persuasion” in respect of the proposed arrangements, but their ultimate sanction is simply to refuse to approve the arrangements, rather than to dictate what arrangements are to be made.⁶⁴

Management structure for Approved Mental Capacity Professionals

- 10.66 A key issue arising from consultation was the need to ensure that the independence of the Approved Mental Capacity Professional, within a local authority, is put beyond

⁶¹ Draft Bill, sch 1 (new para 42(a) of sch AA1 to the Mental Capacity Act).

⁶² See, for example, *TTM v Hackney LB* [2011] EWCA Civ 4, [2011] 1 WLR 2873.

⁶³ Draft Bill, sch 1 (new para 26(3) of sch AA1 to the Mental Capacity Act).

⁶⁴ *Re MN* [2015] EWCA Civ 411 at [81].

doubt. Under the Liberty Protection Safeguards, the Approved Mental Capacity Professional function is established with a clear management structure. A head of service must be appointed with overall responsibility for matters such as the conduct, performance and allocation of Approved Mental Capacity Professionals. To underline its actual and perceived independence, the draft Bill makes the service accountable directly to the director of social services (or the director of adult social services), and therefore managed at arm's length from the operational functions of the social services departments.⁶⁵ We would also expect the new Code of Practice to rule out any dual role for the head of the team in respect of safeguarding / commissioning to mitigate further against conflicts of interests.

- 10.67 We intend that this structure would have the additional benefit of fostering a team ethos, rather than leaving Approved Mental Capacity Professionals to work in isolation. Their location within a separate service, headed by a senior manager, would buttress their position considerably, minimise the risk of professional isolation and help to develop greater professional confidence. Approved Mental Capacity Professionals would not need to be permanent or full time team members. They could undertake this role on a rota basis, or on a freelance basis (similar to independent best interests assessors currently) – but when undertaking their Approved Mental Capacity Professional role, they would be seen as working for the service.
- 10.68 Despite the concerns raised by many consultees, the draft Bill does not expressly rule out a continuing role for freelance professionals. We anticipate that local authorities will wish to take the opportunity presented by the introduction of the Liberty Protection Safeguards to take stock of their arrangements with freelance best interests assessors in determining whether to make similar arrangements for Approved Mental Capacity Professionals. In any event, the workload of Approved Mental Capacity Professionals should be more manageable than that of best interests assessors under the DoLS, since Approved Mental Capacity Professionals will only be involved in a proportion of cases and therefore the use of freelance professionals should no longer be a necessity.⁶⁶
- 10.69 Not least because the local authority could be vicariously liable for the actions and omissions of the Approved Mental Capacity Professionals discharging these functions on its behalf, some form of oversight process will be needed. This oversight might involve (for instance) regular auditing of the paperwork in order to check for omissions, errors and other defects, as well as for broader quality-monitoring purposes. Under the Liberty Protection Safeguards this role could be performed by the head of service, or delegated to others by the head of service, thus helping to ensure that the independent element of the role is not undermined. We do think this is a matter that should be addressed in the draft Bill, owing to the importance of encouraging flexibility and innovation. But we would expect the new Code of Practice to expand on the oversight process.

⁶⁵ Draft Bill, sch 1 (new para 42(a) and (b) of sch AA1 to the Mental Capacity Act).

⁶⁶ We estimate that 25% of all authorisations under the Liberty Protection Safeguards would require an Approved Mental Capacity Professional. This is approximately 57,000 applications each year. Whilst the DoLS fully operationalised requires over 6,000 best interests assessors, the Liberty Protection Safeguards would require around 700 Approved Mental Capacity Professionals. See impact assessment, pp 17, 22 and 33.

The responsible local authority for Approved Mental Capacity Professionals

10.70 In any given case, the referral must be made to an Approved Mental Capacity Professional approved by the “responsible local authority”.⁶⁷ The meaning of the responsible local authority is set out in para 8.14. In most cases the responsible local authority will be the local authority in whose area the person is ordinarily resident (including by virtue of the “deeming rules” – see para 8.21). By recommending this, we aim to encourage referrals to follow seamlessly from the (provisional) care or treatment decision that has made the authorisation necessary, and before that decision has been implemented (and using one set of documentation). This would, of course, mean that in many cases the local authority may be both the responsible body and providing the Approved Mental Capacity Professional. We think that concerns about independence can be addressed by the proposed internal structure (in particular the management structure), described above, around the role of the Approved Mental Capacity Professional. The draft Bill also provides sufficient flexibility to enable an assessor based in the placing authority to commission (from an independent assessor or the host authority) whatever work needs to be done at a distance, whilst making the final decision themselves.

Recommendation 21.

Each local authority should be required to make arrangements for the approval of persons to act on its behalf as Approved Mental Capacity Professionals, and ensure there are sufficient numbers of persons approved as Approved Mental Capacity Professionals for the purposes of the Liberty Protection Safeguards.

This is given effect by schedule 1 to the draft Bill (new paragraph 42(a) and (c) of schedule AA1 to the Mental Capacity Act).

Recommendation 22.

The Secretary of State and Welsh Ministers should be given regulation making powers to prescribe, amongst other matters, criteria which must be met in order for a person to become an Approved Mental Capacity Professional and a body to approve courses.

This is given effect by schedule 1 to the draft Bill (new paragraphs 44 and 45 of schedule AA1 to the Mental Capacity Act).

⁶⁷ Draft Bill, sch 1 (new para 46 of sch AA1 to the Mental Capacity Act).

Recommendation 23.

Each local authority should be required to appoint a manager who is responsible for the conduct and performance of Approved Mental Capacity Professionals and is accountable directly to the director of social services.

This is given effect by paragraphs 42(b) and 43 of schedule AA1 to the Mental Capacity Act).

AUTHORISING ARRANGEMENTS

10.71 If all the conditions set out in chapters 9 and 10 are met, and the procedural matters set out in this chapter are complied with, the responsible body then has a power, rather than a duty, to authorise the arrangements.⁶⁸ This is a deliberate change to the current position under the DoLS where a duty to grant a standard authorisation arises if the six qualifying requirements are met.⁶⁹ Our intention is that responsible bodies do not feel obliged to authorise arrangements in all cases where the conditions are met. For instance, the responsible body may want to explore further the possibility of alternative arrangements which do not give rise to deprivation of liberty, or which may still give rise to a deprivation of liberty but which are perceived as less coercive by the person and their family. By giving the responsible body the discretion not to authorise the arrangements, we intend to make clear that the process of considering the person's circumstances should not end upon the completion of the various assessments and the procedural steps set down in this chapter.

10.72 The draft Bill does not specify by whom the responsible body will exercise the power to authorise the arrangements. This means that there is no reason why the independent reviewer cannot also be the person to whom the responsible body gives authority to authorise the arrangements on its behalf, and there may well be administrative and practical reasons why such would be appropriate. However, as this is primarily a matter for the implementation of the Liberty Protection Safeguards by any given responsible body, this is not a matter for statute but rather something we would expect to see addressed in the new Code of Practice.

10.73 The details of what must be in the authorisation record, and the effect of an authorisation, are discussed in chapter 11.

⁶⁸ Draft Bill, sch 1 (new para 14 of sch AA1 to the Mental Capacity Act).

⁶⁹ Mental Capacity Act, sch A1, para 50.

Chapter 11: Authorisations

11.1 This chapter discusses the authorisation itself, and how it would operate in practice. Specifically it considers the effect of an authorisation, the authorisation record, and the duration, review and suspension of authorisations.

AUTHORISATION RECORD

11.2 The DoLS provide that a standard authorisation must be in writing and include specified information, such as the name of the person, the name of the hospital or care home, and the duration for which the authorisation is to be in force. The supervisory body must keep a written record of the standard authorisations it has given, the requests for standard authorisation where an authorisation was not given and the matters stated in the authorisations they have given.¹

11.3 The consultation paper provisionally proposed that an authorisation should be part of the person's overall care plan. We argued that a deprivation of liberty should not be seen as separate from the rest of the person's care and treatment arrangements, and that much more use could be made of existing care plans that have been constructed under, for example, the Care Act or the Social Services and Well-being (Wales) Act.²

Consultation responses

11.4 This proposal was supported by a majority of consultees.³ Many welcomed the "mainstreaming" of the authorisation process, and argued that the proposal would ensure stronger links with social care legislation and the rest of the Mental Capacity Act. However, some consultees wanted a "statutory form" to be prescribed by the new legislation, and others raised concerns about the poor quality of existing care plans.

Discussion

11.5 It remains our intention to allow any pre-existing care plans to include the details of the authorisation. However, we were concerned by the evidence at consultation that existing care plans are often vague and poorly constructed, and sometimes not drawn up at all. As we explained in para 7.15, the Liberty Protection Safeguards require decision-makers to be clear and precise about the particular arrangements that are being authorised. Arrangements cannot be authorised which are vague and broad. This is, not least, because Article 5 requires that the law governing deprivation of liberty be sufficiently precise to enable a person to foresee, to a degree that is reasonable in the circumstances, the consequences which a given action may entail.⁴

¹ Mental Capacity Act, sch A1, paras 54 and 60.

² Consultation paper, paras 7.166 to 7.170.

³ Consultation analysis, PP 7-29, para 6.307.

⁴ *Medvedyev v France* (2010) 51 EHRR 39 (App No 3394/03) (Grand Chamber decision) at [80] and *Creangă v Romania* (2013) 56 EHRR 11 (App No 29226/03) (Grand Chamber decision) at [120].

- 11.6 The Liberty Protection Safeguards therefore include a duty to produce an “authorisation record” and prescribe the information that must be included, such as detail about the precise nature of the arrangements that have been authorised, the date that the authorisation will start, and why the conditions for an authorisation have been met.⁵ The draft Bill also provides that copies of the record must be given as soon as reasonably practicable to the person and other individuals who would need to be given a copy of the authorisation record to ensure that they were equipped to carry out their role (most obviously advocates and the appropriate person). Also, donees and deputies are required to be given a copy so that, for example, they could be alerted to the possibility of their making a “conflicting decision” about where a person should live.⁶
- 11.7 As noted from para 7.11, the Liberty Protection Safeguards enable the authorisation of arrangements in different settings. So, for example, if it is known in advance that a person will reside in a care home but will need to be transported to a community hospital once a week for treatment, then (in so far as arrangements to achieve all that will give rise to a deprivation of that person’s liberty) all these arrangements can be included in the record. But if the person’s circumstances change and they need to reside in a different place or be admitted to hospital, it is likely that the responsible body (the identity of which may have changed) may well need to authorise additional or different arrangements. Importantly, however, any new responsible body will be able to add to the authorisation record, as authorisation records are not “tied” to the responsible body which generated them.⁷ In the case of a planned hospital admission, where (although it will depend upon the facts) it is likely that the responsible body will have changed, the arrangements could therefore be authorised in advance by the hospital and added to the person’s authorisation record. The record could therefore travel with them as a form of “passport”.
- 11.8 In any situation where the responsible body has changed temporarily, it will be a question of fact whether the original authorisation remains in place insofar as it relates to the original arrangements. If it does – for instance if the person has been discharged from hospital after a brief admission and their circumstances have not otherwise changed – the original arrangements would remain authorised, and the first responsible body could then review the authorisation record to delete the arrangements relating to the hospital. This situation is most likely to arise in the context of short admissions to hospital, but it is not in principle limited to such situations.
- 11.9 Under the DoLS the supervisory body may attach conditions to a standard authorisation; the managing authority is required to ensure that any such conditions are complied with.⁸ The Liberty Protection Safeguards do not include conditions. The scheme instead focuses on particular arrangements and what will be authorised are very specific arrangements. Further, it is only arrangements which result in the minimum amount of deprivation of liberty possible that will be authorised, otherwise the necessary and

⁵ Draft Bill, sch 1 (new paras 30 and 31 of sch AA1 to the Mental Capacity Act).

⁶ Draft Bill, sch 1 (new para 33 of sch AA1 to the Mental Capacity Act).

⁷ Draft Bill, sch 1 (new para 30 of sch AA1 to the Mental Capacity Act), which refers to “a,” rather than “the” responsible body.

⁸ Mental Capacity Act, sch A1, para 53.

proportionate condition will not be met. So the arrangements will need to be described in a way which builds in any conditions.

11.10 The draft Bill does not prescribe a statutory form of authorisation record; so long as the record contains the necessary information, it can take the form appropriate to the setting in which it is generated. In practice, we anticipate that the record will be combined (administratively) with any statutory care plan maintained in relation to the person (for example, under the Care Act or the Social Services and Well-being (Wales) Act). But in law, the authorisation record is separate.

Recommendation 24.

The responsible body should be required to produce or revise an authorisation record if it authorises arrangements. This must, amongst other matters, specify in detail the arrangements which are authorised and date(s) from which they are authorised. Copies of the authorisation record must be given to the person and certain other key individuals.

This recommendation is given effect by schedule 1 to the draft Bill (new paragraphs 30 to 33 of schedule AA1 to the Mental Capacity Act).

EFFECT OF AUTHORISATIONS

11.11 A DoLS authorisation has two different effects. The first is to give an express statutory authority to the managing authority of the hospital or care home to deprive a person of their liberty by detaining them in the hospital or care home.⁹ The second is to afford a statutory defence to the individual members of staff who are doing the actual acts of detaining.¹⁰ That protection from liability does not extend to negligent or criminal acts, nor to acts done other than for the purpose of the standard or urgent authorisation in force (nor to ones which do not comply with any conditions attached to a standard authorisation).¹¹

11.12 A DoLS authorisation, and hence an individual's defence to any claim, only extends to acts connected to the deprivation of liberty. It does not serve as authority, for instance, to administer medical treatment to the person – that must be sanctioned either by the person's valid consent or other legal provisions such as section 5 of the Mental Capacity Act.

11.13 The position under the DoLS can also be contrasted to the two other situations provided for by the Mental Capacity Act:

- (1) where an individual is giving effect to a welfare order made by the Court of Protection under section 4A of the Mental Capacity Act;¹² and

⁹ As above, sch A1, para 2.

¹⁰ As above, s 4A(5) read alongside sch A1, paras 1 to 3.

¹¹ As above, sch A1, para 4.

¹² As above, s 4A(3).

- (2) where a question has arisen over whether a person can be lawfully deprived of liberty under section 4A, which is pending resolution by the court, and a deprivation of liberty is necessary to prevent the person from coming to serious harm.¹³

11.14 In both of these situations, the individual has direct statutory authority to deprive the person of their liberty, so the need for a defence does not arise.

11.15 The effect of authorisation under the DoLS can also be contrasted with that of detention under the Mental Health Act. A duly completed application for admission under Part 2 of the Mental Health Act constitutes authority for the Approved Mental Health Professional who has completed the application, or any person they have authorised, to take the patient and convey him or her (by the use of reasonable force if required) to the hospital named in the application.¹⁴ That application then constitutes authority to the relevant hospital managers to detain the person in the hospital.¹⁵ Any member of the hospital staff then acting to detain the patient in the hospital would then be protected from either civil or criminal proceedings (unless they acted in bad faith or without reasonable care).¹⁶

11.16 The DoLS system is essentially a responsive regime recognising that specific care arrangements in place at a particular hospital or care home give rise (or will give rise) to a deprivation of the person's liberty. This is achieved by giving immunity from civil or criminal liability to those who will actually be doing the acts to detain the person under those arrangements.

Consultation responses

11.17 We did not consult specifically on the effect of an authorisation. However it was evident that there was some confusion on this subject. Some responses described the effect of a DoLS authorisation in similar terms to detention under the Mental Health Act, suggesting that the DoLS provided authority to detain the person in a hospital or care home for the purpose of administering specific care or treatment. It was also not uncommon for consultation responses to refer to the stigma attached to being "detained under the DoLS", rather than perceiving the DoLS as confirming the underlying care arrangements as being in the person's best interests.

Discussion

11.18 It is important that the new legal framework establishes clearly the effect of the authorisation. Some of the confusion identified at consultation may, at least in part, arise from the lack of clarity under the current legislation which provides for two different effects of a DoLS authorisation (referred to at para 11.11). The draft Bill, therefore, does not preserve the first effect of a DoLS authorisation, namely to provide an express statutory authority to deprive a person of their liberty. Instead it retains the second effect

¹³ As above, s 4B.

¹⁴ Mental Health Act, s 6(1), read together with s 137.

¹⁵ As above, s 6(2). Applications can also be completed by the patient's nearest relative, and the same principles apply.

¹⁶ As above, s 139(1).

of DoLS authorisations, by providing a defence against civil or criminal liability in relation to acts done for the purposes of the authorisation.¹⁷

11.19 The provisions in the draft Bill are based loosely on paragraphs 3 and 4 of schedule A1 to the Mental Capacity Act. They provide that if the arrangements have been authorised under the Liberty Protection Safeguards, an individual gains protection from liability when carrying out those arrangements. If an individual does something which is not within the scope of the arrangements, they cannot rely on the statutory defence. The draft Bill does not provide any protection for the provision of medical treatment or restricting contact with third parties, since “arrangements” cannot extend to these matters (see para 7.16).

11.20 The draft Bill also confirms that the defence does not exclude civil or criminal liability resulting from the negligence of the individual in carrying out the arrangements.¹⁸ It also provides that the defence remains available where the authorisation has come to an end before a fixed expiry date but those who are implementing arrangements are unaware of that fact.¹⁹ Conversely, those carrying out the arrangements will not be protected where they either knew or ought to have known of that fact.

11.21 It should be noted that a “person” will include a body of persons (corporate and unincorporated) and so will not just be a natural person.²⁰ This will ensure that the defence could apply to, for example, bodies and institutions, as well as their employees or agents.

Recommendation 25.

Where arrangements have been authorised under the Liberty Protection Safeguards, no liability should arise in relation to the carrying out of the arrangements if no liability would have arisen if the person had had capacity to consent to the arrangements, and had consented.

This recommendation is given effect by clause 1 of the draft Bill.

DURATION, CESSATION AND RENEWAL

11.22 The Strasbourg case law confirms that a lawful deprivation of liberty for the purposes of Article 5(1)(e) of the ECHR must include both “limits in terms of time” and “continuing clinical assessment of the persistence of a disorder warranting detention”.²¹ Therefore, in order to comply with Article 5, any scheme must contain:

- (1) a provision for the termination of the authorisation after the maximum time limit has expired; and

¹⁷ Draft Bill, cl 1.

¹⁸ Draft Bill, cl 1 (new s 4A(3) of the Mental Capacity Act).

¹⁹ Draft Bill, cl 1 (new s 4A(4) of the Mental Capacity Act)..

²⁰ Interpretation Act 1978, sch 1.

²¹ *HL v UK* (2005) 40 EHRR 32 (App No 45508/99) at [120].

- (2) the ability to terminate an authorisation before the time limit has expired if the deprivation of liberty is no longer necessary.

11.23 The safeguards this provides to the individual are twofold. First, that the person can foresee, to a degree that is reasonable in the circumstances, the consequences of the decision to deprive them of liberty. This is in accordance with the principle of legal certainty guaranteed under Article 5.²² Secondly, it protects the person from arbitrariness; such protection is guaranteed under Article 5 which requires, amongst other factors, that there is a connection between the grounds for the detention and the ongoing detention in question.²³

11.24 Under the DoLS, the maximum time limit for a standard authorisation is 12 months. The supervisory body must decide the period during which an authorisation is in force, but this period must not exceed the “maximum authorisation period” stated in the best interests assessment.²⁴ According to the *DoLS Code of Practice*:

The underlying principle is that deprivation of liberty should be for the minimum period necessary so, for the maximum 12-month period to apply, the assessor will need to be confident that there is unlikely to be a change in the person’s circumstances that would affect the authorisation within that timescale.²⁵

11.25 If the managing authority considers that a person will still need to be deprived of liberty after the authorisation ends, it must request a further standard authorisation to begin immediately after the expiry of the existing authorisation.²⁶ There is no ability to extend a standard authorisation. The process for a new authorisation is the same as that for obtaining an original authorisation, and the same assessment process must take place.

11.26 A standard authorisation can also be terminated following a formal review. When a supervisory body receives a request for a review of a standard authorisation, it must decide if any of the qualifying requirements need to be reviewed. If so, the supervisory body must arrange for a separate review of each of these requirements. The authorisation must be terminated if one or more of the assessments carried out comes to a “negative conclusion”.²⁷ The review process under the DoLS is discussed from para 12.3.

11.27 A standard authorisation is also terminated when a new standard authorisation is made, either due to a change in place of the detention or due to a review.²⁸

11.28 The consultation paper provisionally proposed that under the new scheme authorisations should be given for a period which may not exceed 12 months.²⁹ We also

²² See, for example, *Sunday Times v UK* (1979) 2 EHRR 245 (App No 6538/74) at [49].

²³ See, for example, *Winterwerp v Netherlands* (1979-80) 2 EHRR 387 (App No 6301/73) at [39].

²⁴ Mental Capacity Act, sch A1, paras 42 and 51.

²⁵ *DoLS Code of Practice*, para 4.71.

²⁶ Mental Capacity Act, sch A1, para 29.

²⁷ As above, para 117.

²⁸ Mental Capacity Act, sch A1, para 62.

²⁹ Consultation paper, para 7.76.

expressed concern that all standard authorisations that are no longer necessary must be formally terminated through the review process by the supervisory body. There is no ability to discharge outside this process. We contrasted this to the Mental Health Act, which gives managers and clinicians general discretion to discharge patients at any time (and requires responsible clinicians to discharge the patient if the renewal criteria are no longer met).³⁰ We therefore provisionally proposed the responsible local authority and the Approved Mental Capacity Professional should be given general discretion to discharge the person from the scheme.³¹

11.29 It is also of importance to note in this context that the Mental Health Act provides for renewals of authority to detain, where a full re-assessment is not required, if it “appears” that the conditions continue to be met: the initial authority to detain will last six months, a second renewed period of authority for a further six months and then for periods of a year at a time.³² There is no limit to the number of times that authority to detain for a year can be renewed.

Consultation responses

11.30 The majority of consultees agreed with the proposal that authorisations should be for a period of up to 12 months.³³ However, some felt that longer authorisations would be appropriate, particularly if the person has a life-long and stable diagnosis such as a learning disability or a long-term diagnosis such as dementia. The significant costs associated with repeating the formal DoLS authorisation process, in such cases, every 12 months were also brought to our attention. We were told that this process can become a “rubber stamping exercise” and of little benefit to the person. Alternative suggestions ranged from two to five year authorisations (sometimes following an initial one year authorisation), and some argued for an “open authorisation” with no end unless circumstances changed (and on the basis that regular reviews were taking place). Others felt that an authorisation should be more in line with the approach under the Mental Health Act and operate for a shorter period (such as 28 days or six months), at least initially.

11.31 Opinion was divided on the proposal that Approved Mental Capacity Professionals should be given general discretion to discharge the person, but a majority agreed with the proposal that local authorities should be given this power.³⁴ Some care providers provided evidence of the difficulties they face under the DoLS when they know that, for example, a person has regained capacity but they have to wait for an assessor to see the person before the authorisation can be terminated. A number of responses suggested that decisions to discharge should in all cases be referred to a tribunal or management panel.

³⁰ See, Mental Health Act, s 23 and Department of Health, *Mental Health Act 1983: Code of Practice* (2015) para 32.18.

³¹ Consultation paper, para 7.160.

³² Mental Health Act, s 20(2).

³³ Consultation analysis, PP 7-12, para 6.133.

³⁴ As above, PP 7-25, from para 6.272 and PP 7-27, from para 6.290.

Discussion

- 11.32 On balance, we remain of the view that the authorisation should last for an initial period of up to 12 months.³⁵ Any time limit of this nature is arbitrary, but 12 months seems to strike an appropriate balance, and matches the minimum recommended timescales for reviews under the Care Act and the Social Services and Well-being (Wales) Act, and would therefore help to minimise the duplication of assessments.³⁶ We do not consider that open-ended authorisations would be justifiable, nor provide the protection against arbitrary deprivations of liberty required by Article 5 of the ECHR.³⁷
- 11.33 The draft Bill provides that the duration of the authorisation must be stated in the authorisation record.³⁸ The period during which the authorisation has effect can be shortened or lengthened on a review (but not extended beyond 12 months).³⁹ So, for example, the responsible body could not initially provide that an authorisation should last for 12 months, then shorten that to six months but then provide for it to last for a further eight months.
- 11.34 Consultation provided some useful information about what happens in practice when authorisations need to be renewed. It was not uncommon for consultees to refer to the “annual DoLS review”, even though in law this is a fresh application. This perhaps indicates how the renewal process can become a “rubber stamping exercise”. This view was reinforced by arguments that to start the assessment process from scratch is often of little benefit to the person, a waste of resources and likely to generate emotional distress for the person and their family.
- 11.35 We think that two reforms may assist in this respect. First, the draft Bill provides that an authorisation can be renewed for a second period of again up to 12 months and then for an indefinite number of periods of up to three years.⁴⁰ We recognise that three years is decidedly longer than 12 months. However, in all cases the responsible body may renew an authorisation only where it reasonably believes that it is unlikely that there will be any significant change in the person’s condition during the renewal period that would affect their incapacity, their unsoundness of mind or whether the arrangements continue to be necessary and proportionate.⁴¹ Therefore, the responsible body would have to be satisfied that a person’s situation was stable in the long-term before an authorisation could be renewed for a period of three years. We think that the approach taken in the draft Bill strikes the right balance between providing a robust system to ensure the lawfulness of detention and ensuring that the operation of that system provides actual benefit to the person rather than simply generating paperwork for the sake of it. It is important to emphasise that – irrespective of the length of the authorisation – the person would always remain subject to a robust system of reviews, have access to advocacy

³⁵ Draft Bill, sch 1 (new para 35(1)(a) and (b) of schedule AA1 to the Mental Capacity Act).

³⁶ Department of Health, *Care and Support Statutory Guidance* (2016) para 13.32 and Welsh Government, *Social Services and Well-being (Wales) Act 2014: Part 4 Code of Practice (Meeting Needs)* (2015) para 88.

³⁷ See, for example, *HL v UK* (2005) 40 EHRR 32 (App No 45508/99) at [119] to [120].

³⁸ Draft Bill, sch 1 (new para 31(e) of schedule AA1 to the Mental Capacity Act).

³⁹ Draft Bill, sch 1 (new para 35(1)(c) of schedule AA1 to the Mental Capacity Act).

⁴⁰ Draft Bill, sch 1 (new para 37(1) of schedule AA1 to the Mental Capacity Act).

⁴¹ Draft Bill, sch 1 (new para 37(1)(d) of schedule AA1 to the Mental Capacity Act).

or an appropriate person, and have a right to apply to the court to challenge the authorisation. We consider that our reforms to the review process (see from para 12.3), and the role of the advocate / appropriate person (see from para 12.20), are particularly important in ensuring that the person's circumstances are kept under review on an ongoing basis, rather than solely at the fixed end point of a period of authorisation.

11.36 Secondly, the draft Bill introduces an express system of renewal, rather than fresh authorisation.⁴² The concept of renewal is one provided for in the Mental Health Act (as discussed above), and we think that it is one that is equally applicable in the context of the Liberty Protection Safeguards. The system of renewals allows the responsible body to renew an authorisation by simply confirming that certain conditions continue to be met; only in cases where this cannot be confirmed would any new assessments be required. Specifically, the draft Bill provides that the responsible body can renew an authorisation if it "reasonably believes" that:

- (1) the person continues to lack capacity to consent to the arrangements;
- (2) the person continues to be of unsound mind; and
- (3) the arrangements continue to be necessary and proportionate.⁴³

11.37 For example, in the case of a person with a lifelong and stable learning disability, who is likely to lack capacity to consent to arrangements for the rest of their life, it might be reasonable for the responsible body to believe that the conditions continue to be met. That would not be the case if the responsible body had been notified of a change in the person's condition. In such a case it would not be reasonable to believe that the conditions continue to be met without further investigation, and probably fresh evidence. In addition, the more time which elapses the less reasonable it would be for the responsible body to believe that the conditions continue to be met (even if not notified of changes). But much would depend on the circumstances and nature of the person's condition. In our view a time will come where fresh evidence will need to be obtained in order for the responsible body to be able to renew an authorisation. We would expect the new Code of Practice to provide case studies to illustrate when it might be reasonable for the responsible body to believe that the conditions continue to be met, and to emphasise that fresh assessments should always be sought in cases of doubt.

11.38 The draft Bill also provides that a renewal must be referred to an Approved Mental Capacity Professional if the responsible body believes the arrangements continue to be necessary and proportionate wholly or mainly because of the likelihood of harm to other individuals, but this was not the original reason why the arrangements were considered to be necessary and proportionate.⁴⁴

11.39 The draft Bill does not set a statutory time limit on how far in advance of the expiry of an authorisation a renewal can be sought. This would depend on the circumstances of the case. We would expect the new Code of Practice to emphasise that renewals should be sought far enough in advance for the process to be completed before the existing

⁴² Draft Bill, sch 1 (new para 37 of schedule AA1 to the Mental Capacity Act).

⁴³ Draft Bill, sch 1 (new para 37(3) of schedule AA1 to the Mental Capacity Act).

⁴⁴ Draft Bill, sch 1 (new para 37(5) of schedule AA1 to the Mental Capacity Act).

authorisation ends. But the Code will also need to remind decision-makers that an authorisation should not be renewed too far in advance as this may prevent an assessor from making an accurate assessment of what the person's circumstances will be at the time the authorisation will come into force.

11.40 We remain of the view that there should be provision to ensure an authorisation can cease or be terminated before the end of the authorisation, and outside the formal review process. The draft Bill provides that authorisation ceases to have effect, at any time, if the responsible body knows or ought reasonably to suspect that:

- (1) the person has, or has regained, capacity to consent to the arrangements (except in fluctuating capacity cases – see from para 9.38); or
- (2) the person is no longer of unsound mind; or
- (3) the arrangements are no longer necessary and proportionate.⁴⁵

11.41 The authorisation also ceases to have effect if there is a conflicting decision of a lasting power of attorney or a court appointed deputy (in relation to where the person should reside or receive care or treatment), or if it conflicts with requirements arising under legislation relating to mental health. But in all these cases the authorisation would cease to have effect in so far as it relates to those arrangements.⁴⁶ It may therefore continue to have effect in respect of other parts of the arrangements.

11.42 This means that the authorisation can be terminated automatically, rather than the termination continuing until it is terminated by the responsible body. This is a more logical approach, especially given that the defence in section 4AA will fall away automatically if the conditions for authorisation cease to be met. The responsible body must notify any person who is likely to be doing any act in carrying out the arrangements that the authorisation has ceased.⁴⁷ This might be implemented, for example, by the responsible body contacting a care home and expecting the care home to relay the message to the individual care workers. This only applies where an authorisation comes to an end earlier than expected.

11.43 If the capacity assessment relied upon when authorising the arrangements states that the person's capacity to consent to the arrangements fluctuates, and that the periods when the person has capacity are likely to last for a short period only, the authorisation will not cease automatically, provided that the responsible body reasonably believes that the regaining of capacity will last for a short period only.⁴⁸ The draft Bill also provides for the same effect at the renewal stage.⁴⁹

11.44 It is crucial that individuals are not penalised for acting in accordance with an authorisation when, unknown to them, the authorisation no longer has effect. The draft Bill provides that in such cases the individual is protected under section 4AA unless

⁴⁵ Draft Bill, sch 1 (new para 35(2) of schedule AA1 to the Mental Capacity Act).

⁴⁶ Draft Bill, sch 1 (new paras 35(4) to (6) of schedule AA1 to the Mental Capacity Act).

⁴⁷ Draft Bill, sch 1 (new para 36 of schedule AA1 to the Mental Capacity Act).

⁴⁸ Draft Bill, sch 1 (new para 35(3) of schedule AA1 to the Mental Capacity Act).

⁴⁹ Draft Bill, sch 1 (new para 37(7) and (8) of sch AA1 to the Mental Capacity Act).

they ought to have known this.⁵⁰ But they may not be protected if, for example, they were not notified that the authorisation had ceased to have effect but it was nevertheless clear that the person had regained capacity or was no longer of unsound mind (depending on the circumstances of the case).

Recommendation 26.

An authorisation should last for an initial period of up to 12 months, and be renewed for a further period of up to 12 months and then for further periods of up to three years.

This recommendation is given effect by schedule 1 to the draft Bill (new paragraphs 35(1)(a) and 37(1) of schedule AA1 to the Mental Capacity Act).

Recommendation 27.

The responsible body should be able to renew an authorisation if it reasonably believes that:

- (1) the person continues to lack capacity to consent to the arrangements;**
- (2) the person continues to be of unsound mind;**
- (3) the arrangements continue to be necessary and proportionate; and**
- (4) it is unlikely that there will be any significant change in the person's condition during the renewal period which would affect any of the matters in (1), (2) and (3).**

This recommendation is given effect by schedule 1 to the draft Bill (new paragraph 37(3) of schedule AA1 to the Mental Capacity Act).

Recommendation 28.

An authorisation should cease to have effect if the responsible body knows or ought reasonably to suspect that:

- (1) the person has, or has regained capacity, to consent to the arrangements (except in fluctuating capacity cases); or**
- (2) the person is no longer of unsound mind; or**
- (3) the arrangements are no longer necessary and proportionate.**

The authorisation should also cease to have effect if there is a conflicting decision of a lasting power of attorney or a court appointed deputy, or if the authorisation conflicts with requirements arising under legislation relating to mental health (in so far as it relates to those arrangements).

This recommendation is given effect by schedule 1 to the draft Bill (new paragraph 35(2) and (4) to (6) of schedule AA1 to the Mental Capacity Act).

⁵⁰ Draft Bill, sch 1 (new para 40(2) of schedule AA1 to the Mental Capacity Act).

Chapter 12: Safeguards

- 12.1 This chapter considers the safeguards that must be delivered when a responsible body has authorised arrangements under the Liberty Protection Safeguards in respect of a person. There are four key safeguards discussed: reviews, independent advocacy, rights of legal challenge, and monitoring and reporting. It is vital that the new scheme not only recognises a person's rights under Article 5 of the ECHR, but is also capable of delivering practical and effective Article 5 rights.
- 12.2 These safeguards must be seen alongside the reforms set out in chapter 14. The changes proposed there to sections 4 and 5 of the Mental Capacity Act would strengthen the Article 8 rights of all those lacking capacity (including those deprived of liberty) by ensuring that decision-makers must seek to minimise interference with the right to respect for autonomy.

REVIEWS

- 12.3 Article 5 provides that the lawfulness of continued confinement depends upon the persistence of the mental disorder warranting compulsory confinement.¹ It follows that any scheme which authorises deprivation of liberty must include a mechanism to ensure that the persistence of such disorder is kept under appropriate review by the detaining authority.
- 12.4 Under the DoLS, the managing authority is required to keep the person's case under review and must request a review if one or more of the qualifying requirements appear to them to be reviewable.² The qualifying requirements are reviewable if:
- (1) the person no longer meets the age, mental health, mental capacity, best interests or no refusals requirements; or
 - (2) the person no longer meets the eligibility requirement because he or she now objects to receiving treatment for his or her mental health in hospital and he or she meets the criteria for detention under section 2 or 3 of the Mental Health Act; or
 - (3) the reason why the person meets a qualifying requirement is not the reason stated in the authorisation; or
 - (4) there has been a change in the person's case and, because of that change, it would be appropriate to vary the conditions of the authorisation (this ground only applies to the best interests requirement).³

¹ *Winterwerp v Netherlands* (1979-80) 2 EHRR 387 (App No 6301/73) at [39].

² Mental Capacity Act, sch A1, para 103.

³ As above, paras 104 to 107.

- 12.5 The supervisory body is not required to take any action if none of the qualifying requirements appear to be reviewable.⁴
- 12.6 In addition, the supervisory body may carry out a review of a standard authorisation at any time.⁵ It is required to review the person's case if a request is made by the relevant person, the relevant person's representative or the managing authority.⁶ Much of the detail of how reviews should be carried out is contained in the *DoLS Code of Practice*.⁷
- 12.7 In contrast to the DoLS, the Mental Health Act gives hospital managers and clinicians general discretion to discharge patients at any time (and requires responsible clinicians to discharge the patient if the renewal criteria are no longer met).⁸ In effect, this requires the patient's care and treatment to be kept under ongoing review.
- 12.8 The consultation paper raised concerns that the DoLS require a review to be held before a person can be discharged, and that there is no ability to discharge outside this process. We also raised concerns about the low numbers of DoLS reviews overall, and that few of these were initiated by the relevant person or their representative.⁹ We therefore provisionally proposed that local authorities and Approved Mental Capacity Professionals should have a general discretion to discharge people at any time and the Approved Mental Capacity Professional would be requested to keep under review generally the person's care and treatment. We also proposed a duty to carry out a review following a reasonable request by the person (including someone making the request on their behalf) and certain others (including an advocate).¹⁰

Consultation responses

- 12.9 Our proposals were supported by a majority at consultation.¹¹ There was widespread agreement that the review process should be joined up with other reviews being carried out for the person, and duplication and paperwork should be kept to a minimum. A number of care providers reported that post-*Cheshire West* supervisory bodies are unable to respond to their requests for reviews, and that too often reviews are perfunctory or not carried out at all.
- 12.10 Some consultees suggested that reviews should be the responsibility of care providers or the relevant community or hospital team. Others suggested introducing an internal panel and / or tribunal to carry out reviews (with powers to discharge). Some felt that reviews should be held at regularly defined intervals; for instance, after three months and then six months in the first year.

⁴ As above, para 110.

⁵ As above, para 102.

⁶ As above, para 103.

⁷ *DoLS Code of Practice*, paras 8.6 to 8.16.

⁸ See, Mental Health Act, s 23 and Department of Health, *Mental Health Act 1983: Code of Practice* (2015) para 32.18.

⁹ Consultation paper, para 7.149 to 7.148.

¹⁰ As above, paras 7.150 to 7.163.

¹¹ Consultation analysis, PP 7-25, para 6.272, PP 7-27, para 6.290 and PP 7-28, para 6.298.

Discussion

- 12.11 The right to a review of an authorisation is a vital safeguard. Without a system of regular reviews, the authorised arrangements could become quickly out of date and no longer necessary and proportionate. Following consultation, we remain of the view that the cessation of authorised arrangements should be possible outside the review process, and that the person (or someone on their behalf) should be given greater opportunities to initiate a review within the structure of a planned review process. It is also our view that the review process should be simple and straightforward, and allow some degree of flexibility.
- 12.12 In line with our approach set out in para 8.12, the responsible body would be required to keep authorisations under review. The Liberty Protection Safeguards do not require the responsible body to undertake planned reviews of an authorisation at set minimum intervals, such as at least every three months or yearly. Instead the responsible body is required to set out in the authorisation record its proposals for reviewing the authorisation of arrangements.¹² This would enable the responsible body to set out fixed dates or say that it will review at certain intervals. Our intention is to provide sufficient flexibility to enable the frequency of reviews to match the individual circumstances of the case. We would expect the new Code of Practice to provide examples of cases where, for example, more frequent reviews would be appropriate and list factors relevant in making this decision.
- 12.13 It should also be noted that the role of the independent reviewer and the Approved Mental Capacity Professional will be important in this respect (see from para 10.19 and para 10.27). The independent reviewer – in determining whether it is reasonable for the responsible body to conclude that the conditions are met – would be required to consider the proposed review arrangements as part of the assessment of whether the authorisation of arrangements would be necessary and proportionate. In cases that are referred to an Approved Mental Capacity Professional, he or she must take into account the adequacy of the review arrangements in making the decision whether or not to approve the arrangements.
- 12.14 A DoLS authorisation can only be reviewed following a change in one or more of the qualifying requirements. In our view this is unduly restrictive. The Liberty Protection Safeguards provide that a responsible body must keep an authorisation under review generally.¹³ This means that responsible bodies would be expected to establish systems that allow the proportionate monitoring of authorisations to ensure they continue to be necessary and proportionate. In most cases this will involve cooperation with care providers who may be able to inform the responsible authority of any changes to the person's condition or circumstances. The responsible body is therefore in a position to undertake a review at any time in between any planned review dates set out in the authorisation record, if circumstances change.
- 12.15 In addition, the responsible body is required to review an authorisation in a number of specific cases. First, there must be a review following a "reasonable request by a person

¹² Draft Bill, sch 1 (new para 31(f) of sch AA1 to the Mental Capacity Act).

¹³ Draft Bill, sch 1 (new para 38(1) of sch AA1 to the Mental Capacity Act).

with an interest in the arrangements”.¹⁴ The draft Bill also does not define precisely who can make the request. A person with “an interest in the arrangements” would clearly include the person to whom the arrangements relate and other key individuals such as family members, carers and advocates. Our intention is that a broad interpretation should be adopted. But the duty is limited by the fact that the request must be “reasonable”. The meaning of reasonable is left to the new Code of Practice to flesh out with examples; we consider that it would be too case specific to define in the legislation.

12.16 Secondly, there must also be a review if the person becomes subject to mental health arrangements, or becomes subject to different requirements arising under legislation relating to mental health.¹⁵ These terms are explained further in paras 13.22 and 13.27, but broadly speaking the intention is to ensure that a review must take place if a person’s circumstances change to the extent that the use of the Mental Health Act becomes necessary (or changes are needed to existing powers under the Act which the person may be subject to, such as guardianship or a community treatment order). In addition, there must be a review if the responsible body becomes aware of a significant change in the person’s condition or circumstances.¹⁶ This last requirement will be of particular relevance where a person’s circumstances have changed such that (as described in para 8.20) a new body has become the responsible body. The new responsible body would be required to review the authorisation record and, in all likelihood, add to that record specific authorisation for the new arrangements. Whether it needs to remove the authorisation relating to the previous arrangements will depend upon whether it is likely that the person will return within a suitably short space of time to those arrangements such that they may become relevant again for purposes of discharge of the previous responsible body’s review and authorisation duties.

12.17 There may be cases where an authorisation has not been approved by an Approved Mental Capacity Professional but the request for a review indicates (or the responsible body, otherwise becomes aware) that the person objects to residing at the particular place or receiving care or treatment at the particular place. The Liberty Protection Safeguards require the responsible body to refer these cases to an Approved Mental Capacity Professional who must review the authorisation and determine if the conditions for an authorisation are met.¹⁷

12.18 Wherever possible, we would anticipate that reviews of the authorisation would be undertaken alongside reviews of the person’s care plan produced, for example, under the Care Act, the Social Services and Well-being (Wales) Act and NHS continuing health care. We would expect that the new Code of Practice would encourage a joined-up approach to reviews wherever possible and appropriate.

12.19 The draft Bill does not prescribe how reviews must be conducted. Matters such as ensuring the full participation of the person and their family, which professionals should be invited and who should chair the review are better dealt with in the new Code of Practice. But the draft Bill provides that the authorisation record must be revised

¹⁴ Draft Bill, sch 1 (new para 38(2)(a) of sch AA1 to the Mental Capacity Act).

¹⁵ Draft Bill, sch 1 (new para 38(2)(b) and (c) of sch AA1 to the Mental Capacity Act).

¹⁶ Draft Bill, sch 1 (new para 38(2)(d) of sch AA1 to the Mental Capacity Act).

¹⁷ Draft Bill, sch 1 (new paras 38(3) to (6) and 40 of sch AA1 to the Mental Capacity Act).

following a review if any of the required elements of the record need to be changed; for example if the authorisation is renewed or if there is a change in the appointment of an appropriate person or advocate.¹⁸

Recommendation 29.

The responsible body should be required to specify in the authorisation record when it proposes to review the authorisation of arrangements, to keep an authorisation under review, and to review an authorisation:

- (1) on a reasonable request by a person with an interest in the arrangements which are authorised;**
- (2) if the person to whom it relates becomes subject to mental health arrangements;**
- (3) if the person to whom it relates becomes subject to different requirements arising under legislation relating to mental health; and**
- (4) if it becomes aware of a significant change in the person's condition or circumstances.**

This recommendation is given effect by schedule 1 to the draft Bill (new paragraph 38 of schedule AA1 to the Mental Capacity Act).

INDEPENDENT ADVOCACY

12.20 In broad terms, the role of an advocate is to represent and support a person, to assist them to speak up for themselves or, if the person is unable to do so, to communicate and represent their views, wishes and feelings. Many advocacy organisations are small local schemes and often user-led, whilst others are run and managed by larger charities such as Mind, Age UK and the Richmond Fellowship. Funding for advocacy comes primarily from statutory bodies, notably the NHS and local authorities. This is often supplemented by charitable funding from grant making trusts such as the Community Fund and Comic Relief.

12.21 The DoLS provide that local authorities must instruct an Independent Mental Capacity Advocate in the following circumstances:

- (1) A person “becomes subject” to the DoLS and there is no person (other than a professional or paid carer) to consult in determining the person's best interests (section 39A advocate);¹⁹
- (2) when the appointment of a relevant person's representative comes to an end under the DoLS, and there is no one (other than a professional or paid carer) to consult in determining the person's best interests (section 39C advocate);²⁰ and

¹⁸ Draft Bill, sch 1 (new para 32 of sch AA1 to the Mental Capacity Act).

¹⁹ Mental Capacity Act, s 39A.

²⁰ As above, s 39C.

- (3) if an authorisation is in force and a relevant person's representative has been appointed (but who is not being paid to act as such), and:
- (a) a request is made by the person subject to the authorisation or representative to instruct an advocate; or
 - (b) it appears to the supervisory body that without an advocate, the person and their representative would be unable, or unable to exercise a relevant right, or that they have failed to exercise one (section 39D advocate).²¹

12.22 The role of an Independent Mental Capacity Advocate under the DoLS is to represent and support the person in challenging the DoLS authorisation, and to support the person during any court hearing. An Independent Mental Capacity Advocate appointed under section 39D of the Mental Capacity Act has the additional function of supporting the relevant person's representative.

12.23 In addition to instructing an advocate, the supervisory body must appoint a relevant person's representative when a person is made subject to a standard authorisation. The duties of the representative include representing, supporting and maintaining contact with the person.²² The representative is chosen by the person themselves (if they have capacity to do so) or by a donee of a lasting power of attorney, a deputy appointed by the Court of Protection or the best interests assessor. If there is no suitable person to act as the person's representative, the supervisory body must appoint someone to perform this role in a professional capacity (a "paid representative").²³ The representative is entitled to support from an advocate to assist them to fulfil their role.

12.24 Outside the DoLS, there are several other legal duties to provide advocacy. The Mental Capacity Act requires local authorities to appoint an Independent Mental Capacity Advocate if it is proposed that a person should receive "serious medical treatment" or be provided with long-term accommodation in a hospital or care home by the NHS or residential care by a local authority.²⁴ Their statutory role is to provide reports on the best interests of the person. There is also a power to appoint an advocate where a review of accommodation is taking place (and there is no other person to consult) and in adult protection cases.²⁵

12.25 Under the Care Act, the right to an advocate is triggered if a local authority in England considers that, were an independent advocate not to be available, the individual would experience "substantial difficulty" in understanding relevant information, retaining that information, using or weighing that information, or communicating their views, wishes

²¹ As above, s 39D.

²² As above, sch A1, paras 140 and 132.

²³ Mental Capacity (Deprivation of Liberty: Appointment of Relevant Person's Representative) Regulations 2008, SI 2008 No 1315, regs 8(5) and 9.

²⁴ Mental Capacity Act, ss 37 to 39.

²⁵ Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Expansion of Role) Regulations 2006, SI 2006 No 2883 and Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Wales) Regulations 2007, WSI 2007 No 852.

or feelings.²⁶ The circumstances in which this duty applies include needs assessments, carer's assessments, care and support planning and safeguarding enquiries.²⁷

12.26 The duty to provide an advocate under the Care Act does not apply if the local authority is satisfied there is an appropriate person (who is not a professional or paid carer) to represent an adult. The adult must consent to being represented by that person or, where the adult lacks capacity to consent, the local authority must be satisfied that it would be in their best interests to be represented by that person.²⁸

12.27 In Wales section 181 of the Social Services and Well-being (Wales) Act gives power to make regulations governing rights to advocacy. However, the Welsh Government has not exercised this power. Instead the provision of advocacy is governed by a Code of Practice issued under section 145 of the Act.²⁹ The relevant provisions of the Code are similar to those set out above in respect of Care Act advocacy and discuss the role of the appropriate person.³⁰

12.28 The Mental Health Act requires local authorities to make arrangements for Independent Mental Health Advocates to be made available to help most mental health patients.³¹ The Mental Health (Wales) Measure 2010 places a duty on Welsh Ministers to make arrangements for help to be provided by Independent Mental Health Advocates to qualifying compulsory and informal patients.

12.29 The consultation paper argued that it was vital that independent advocacy should play a central role in the proposed scheme. We therefore provisionally proposed that everyone subject to the protective care scheme should be provided with a right to advocacy (or an appropriate person). We also proposed to maintain the role of the relevant person's representative.³²

12.30 The consultation paper also suggested that there might be benefits in streamlining and consolidating advocacy provision across the Mental Capacity Act and social care legislation. In particular we suggested that the statutory provisions for Care Act advocacy are far more advanced than those for Mental Capacity Act advocacy (including DoLS advocacy), especially in terms of the express duties to support the person in making a decision and participating in the relevant decision-making process. Therefore we proposed that a system based on Care Act advocacy (and the role of the appropriate person) could replace Mental Capacity Act advocacy. We also asked whether Independent Mental Health Advocacy should be replaced by a Care Act advocacy system.³³

²⁶ Care Act, ss 67(4) and 68(3).

²⁷ As above, ss 67(3) and 68(1).

²⁸ As above, ss 67(5) and (6) and 68(4) and (5).

²⁹ Welsh Government: *Social Services and Well-Being (Wales) Act 2014: Part 10 Code of Practice (Advocacy)* (2015).

³⁰ As above.

³¹ Mental Health Act, ss 130A and 130C.

³² Consultation paper, paras 9.2 to 9.68.

³³ Consultation paper, paras 9.2 to 9.43.

Consultation responses

- 12.31 A majority agreed that an independent advocate (or appropriate person) should be appointed for all those subject to the new scheme.³⁴ There was general consensus that the provision of advocacy could be a vital safeguard. However, many reported that, following *Cheshire West*, advocacy organisations are overstretched, there are long waiting lists for advocacy support, and sometimes advocates cannot be provided. Sarah Rochira (Older People’s Commissioner for Wales) stated that the “lack of referrals to Independent Mental Capacity Advocacy services by professionals is an issue my casework and scrutiny team has identified too often”.³⁵ Voiceability argued that local authorities are not instructing advocates when they are legally obliged to do so, due to the “opt-in” nature of the right to section 39D advocacy (in most cases the relevant person must request an advocate themselves or it is left to the supervisory body to identify the risk of a relevant right not being exercised).
- 12.32 The provisional proposal to streamline and consolidate the role of independent advocates was supported by a majority.³⁶ The Older People’s Advocacy Alliance argued that this would lead to greater consistency and cost efficiencies. Some consultees reported that, at present, a person may have to deal with any number of advocates in a short period of time, depending on the types of advocacy required. A number of consultees (including those supporting and those who disagreed with our proposal) argued that in practice Mental Capacity Act advocates already went beyond the legislative provisions and performed roles closer to those envisaged in the Care Act. Those who did not support the proposal frequently argued that advocates’ specialist knowledge of a specific area of law would become diluted if they had to work across different legislation.
- 12.33 Some consultees raised general concerns about how the role of appropriate person is being performed in practice. Voiceability told us that many local authority staff are unaware of this role and some local authorities are appointing people who are not willing or able to undertake the role.
- 12.34 No overall majority view was reached on the question of whether Independent Mental Health Advocacy should be replaced by a system of Care Act advocacy.³⁷ Those who disagreed felt that Independent Mental Health Advocacy was too specialist and distinct a role to be capable of being consolidated with Care Act advocacy. Empowerment Matters suggested an extension of rights to advocacy in England along the lines introduced by the Mental Health (Wales) Measure 2010.
- 12.35 There were mixed responses to our proposal to retain the role of the relevant person’s representative.³⁸ Some pointed to the positive effects that the involvement of a representative can have on the person’s situation. But many argued that representatives are often reluctant to challenge decision-makers, and that family

³⁴ Consultation analysis, PP 9-1, para 8.1.

³⁵ Consultation analysis, PP 9-1, para 8.4.

³⁶ As above, PP 9-2, para 8.10.

³⁷ As above, Q 9-4, para 8.34.

³⁸ As above, PP 9-5, from para 8.43.

members are involved in best interests decisions in any case, and so do not need to be formally appointed as a relevant person's representative.

Discussion

- 12.36 Consultation has confirmed our view that independent advocacy must continue to play a central role in the new scheme. The provision of advocacy can have a transformative effect and be the first time that the person's views, and those of their family, are forcefully represented to decision-makers. We received several case studies and responses from individual service users and family members attesting to the key role played by advocates in their lives. The provision of advocacy is also an important element in ensuring that a person's right to bring proceedings under Article 5(4) are effective (a core requirement of Strasbourg case law), since it is the advocate who may need to initiate court proceedings on the person's behalf.³⁹
- 12.37 We therefore remain strongly committed to ensuring that an advocate is available for every person when arrangements are being proposed or authorised under the Liberty Protection Safeguards. It is, therefore, of serious concern that currently legal rights to advocacy are not being fully implemented, and long waiting lists for advocacy support are not uncommon. In our view, it is essential to the success of the new scheme that legal rights to advocacy are delivered in practice. We urge the Government to review the current levels of advocacy provision, not just under the Mental Capacity Act but also under the Care Act, the Social Services and Well-being (Wales) Act, and mental health legislation.
- 12.38 This is particularly important because under the Liberty Protection Safeguards rights to advocacy would expand. Existing rights to advocacy support do not extend to many people who are deprived of their liberty outside hospitals or care homes. We believe that advocacy support must be available to all people who are being deprived of their liberty – irrespective of settings – in order to deliver practical and effective Article 5(4) rights.
- 12.39 Under the Liberty Protection Safeguards, advocacy support must be provided at the earliest possible stage. The draft Bill provides that an advocate must be appointed if a responsible body “proposes to authorise arrangements”.⁴⁰ Therefore, the duty to appoint an advocate is triggered when the responsible body has a clear proposal to approve arrangements and is about to arrange for the necessary assessments to be carried out, and not when an authorisation is put in place. Importantly the advocacy duty is an ongoing one, which continues throughout the period of the authorisation.⁴¹ In other words, it is not limited to the assessment period or review process, or any specific tasks during the authorisation.
- 12.40 A number of consultees raised an important point that advocacy should not be provided on an opt-in basis to those who lack capacity. Currently DoLS advocacy under section 39D is available only when a request is made or if the supervisory body considers that

³⁹ See *AJ v A Local Authority* [2015] EWCOP 5, [2015] 3 WLR 683 for a review of the Strasbourg case law and also for an example of the problems that arise when this is not delivered in practice.

⁴⁰ Draft Bill, cl 10(3) (new s 38A(1)(a) of the Mental Capacity Act).

⁴¹ Draft Bill, cl 10(3) (new s 38A(1)(b) of the Mental Capacity Act).

that person is unable to exercise a relevant right.⁴² The draft Bill alters this position; the responsible body must appoint an advocate unless the person does not consent, or if the person lacks capacity to consent, unless being represented by an advocate would not be in the person's best interests. This might be the case if, for example, the person's ascertained wishes and feelings clearly show that they do not wish to be supported by an advocate. Our intention is to ensure that advocacy is provided automatically and on an opt-out basis. It is also intended to ensure that the circumstances in which an advocate is not appointed for a person lacking capacity to consent to being represented are rare; the absence of advocacy support in such circumstances would only be lawful if the responsible body is satisfied that appointing an advocate was not in the person's best interests.

12.41 The role of the advocate is to "represent and support" the person⁴³ or to support the appropriate person.⁴⁴ In addition, the Secretary of State and Welsh Ministers are given powers to make regulations about how advocates are to discharge their functions, including as to challenging decisions and facilitating the person's involvement in any decisions.⁴⁵ The latter, which is modelled on the Care Act approach, is particularly important to make the Mental Capacity Act more compliant with Article 12 of the UN Convention on the Rights of Persons with Disabilities in supporting the person to exercise their legal capacity both to take their own decisions and make sure their voice is heard in decisions being taken about them.

12.42 The regulation-making power granted to the Secretary of State and Welsh Ministers also extends, in the case of an advocate appointed under the Liberty Protection Safeguards, to making provision as to how that advocate is to support both the person and, where relevant, the appropriate person in exercising both the right to make an application to court and to request a review.⁴⁶ This provision is necessary to secure the effective enjoyment of rights under Article 5(4).

The appropriate person

12.43 We have also imported into the Liberty Protection Safeguards the role of the appropriate person from the Care Act. The draft Bill provides that the duty to appoint an advocate applies unless there is an appropriate person appointed for the person.⁴⁷ If the responsible body proposes to authorise arrangements under the Liberty Protection Safeguards, it must determine whether there is someone who would be an "appropriate person" who is not engaged in providing care or treatment to the person in a professional capacity or for remuneration.⁴⁸

⁴² Mental Capacity Act, s 39D(1).

⁴³ Draft Bill, cl 10(3) (new s 38A(2) of the Mental Capacity Act).

⁴⁴ Draft Bill, cl 10(3) (new s 38A(3) of the Mental Capacity Act).

⁴⁵ Draft Bill, cl 11 (new s 36 of the Mental Capacity Act).

⁴⁶ Draft Bill, cl 11 (new ss 36(4) and (5) of the Mental Capacity Act).

⁴⁷ Draft Bill, cl 10(3) (new s 38A(2) of the Mental Capacity Act).

⁴⁸ Draft Bill, sch 1 (new para 47(1) of sch AA1 to the Mental Capacity Act).

- 12.44 The function of the appropriate person is to represent and support the person on matters arising under the Liberty Protection Safeguards.⁴⁹ Regulations can make further provision about how that function is to be discharged including on challenging decisions, facilitating the person's involvement in any decisions and enabling them to apply to court or to request a review.⁵⁰ Like the advocacy duty, the duty to provide an appropriate person is an ongoing one, which continues throughout the period of the authorisation.⁵¹
- 12.45 The draft Bill refers to the "appointment" of an appropriate person, and sets out how the responsible body should go about this task.⁵² In contrast, sections 67 and 68 of the Care Act do not refer to the appointment of an appropriate person, but instead provides that the duty to arrange an advocate does not apply if there is an appropriate person. This move towards a more formalised role is deliberate on our part. We want to ensure that the responsible body takes this role very seriously. In effect, the appropriate person is performing the same role as an independent advocate, and therefore should be recognised as a vital safeguard for the purposes of Article 5.
- 12.46 When determining whether to appoint an appropriate person, the responsible body would be required to consider a number of matters. First, it must make sure that the appropriate person is able and willing to take on this role. It is important that family members and other unpaid carers do not feel forced or pressured into undertaking this role. Under the Liberty Protection Safeguards an appropriate person must consent to being appointed.⁵³ Secondly, the responsible body must consider the views, wishes and feelings of the person who is being assessed or subject to an authorisation. That person must consent, provided that they have capacity to do so, to the appointment of the appropriate person.⁵⁴ If the person lacks capacity to consent to the appointment, the responsible body must consider if the appointment would not be in the person's best interests.⁵⁵ This is particularly important because advocacy stakeholders brought to our attention that local authorities sometimes exclude relatives from being the appropriate adult under the Care Act when they are too "difficult" or assertive and may challenge too much. We have therefore not imported directly the equivalent Care Act provision (which requires local authorities to consider if being represented by an appropriate person would be in the adult's best interests), but instead included the narrower test that the appointment of an appropriate person must be made unless the appointment is not in the person's best interests.⁵⁶

⁴⁹ Draft Bill, sch 1 (new para 49(1) of sch AA1 to the Mental Capacity Act).

⁵⁰ Draft Bill, sch 1 (new para 49(2) of sch AA1 to the Mental Capacity Act).

⁵¹ Draft Bill, sch 1 (new para 49(1) of sch AA1 to the Mental Capacity Act). The duty is to support and represent the person in matters arising under schedule AA1 and not just for any one-off purpose (such as the initial assessment).

⁵² Draft Bill, cl 10(3) (new s 38A(2) of the Mental Capacity Act) and sch 1 (new para 47(2) of schedule AA1 to the Mental Capacity Act).

⁵³ Draft Bill, sch 1 (new para 47(2)(a) of sch AA1 to the Mental Capacity Act).

⁵⁴ Draft Bill, sch 1 (new para 47(2)(b) of sch AA1 to the Mental Capacity Act).

⁵⁵ Draft Bill, sch 1 (new para 47(2)(c) of sch AA1 to the Mental Capacity Act).

⁵⁶ Care Act, s 67(6)(b).

12.47 The Liberty Protection Safeguards provide that the responsible body must keep under review whether the appropriate person is, in fact, undertaking their functions. If not it may be that he or she no longer meets the criteria for the appointment of an appropriate person, and could no longer be considered as such for purposes of the advocacy provisions. There would thus be a duty to appoint another appropriate person or an advocate might be triggered.⁵⁷ But it should be noted in this respect that an appropriate person is entitled to support from an advocate to assist them to fulfil their role (a duty to appoint an advocate for an appropriate person applies unless the appropriate person does not consent).⁵⁸

The relevant person's representative

12.48 Following consultation, we have decided not to retain the relevant person's representative role. In our view, the role of the appropriate person and that of the relevant person's representative are essentially identical. They both should be concerned with representing and supporting the person, and ensuring that the person remains at the heart of the decision-making process at all stages. Where there is somebody who is able and willing to act as the appropriate person, in most cases the same person would also be the most suitable person to be appointed as the relevant person's representative. It is therefore unnecessary and would be confusing for a person to be supported by both an appropriate person and a representative.

12.49 In cases where there is no person suitable to act as the appropriate person (and therefore an advocate has been appointed), it follows that there would be no suitable person who could act as the representative. We think that the provision of advocacy in such cases would be sufficient to represent and support the person, and that the additional appointment of a paid representative is unnecessary.

12.50 The consultation paper suggested that the role of the representative would help to give proper recognition to the role of family members and carers. We now consider that there are other more effective ways of recognising this role. In particular, the role of the appropriate person is crucial in this respect and we have also recommended rights for family members and other unpaid carers to be consulted before arrangements can be authorised (see from para 10.2). Additionally, if the parent of a 16 or 17 year old objected to the deprivation of liberty, they would continue to have the right to oppose it in a court.⁵⁹

Consolidation of advocacy

12.51 There was no strong appetite at consultation for wholesale consolidation of advocacy across the mental capacity, mental health and social care legislation. Instead we have sought to tidy up some aspects of the various legislative provisions to ensure greater consistency between those provisions and the Liberty Protection Safeguards. In particular, the draft Bill would amend rights to advocacy under sections 37 to 39 of the Mental Capacity Act (see para 12.24) to provide that the role of advocacy under these

⁵⁷ Draft Bill, cl 10(3) (new s 38A(2) of the Mental Capacity Act) and sch 1 (new para 47(1)(a) of schedule AA1 to the Mental Capacity Act).

⁵⁸ Draft Bill, cl 10(3) (new s 38A(3) of the Mental Capacity Act)

⁵⁹ Draft Bill, s 4(2).

provisions is to represent and support the person.⁶⁰ This would provide consistency between the role of advocacy under the Liberty Protection Safeguards and under the rest of the Mental Capacity Act. The draft Bill also introduces a new regulation-making power to provide how an advocate is to discharge the functions of representing or supporting a person, including by way of facilitating their involvement in relevant decisions, along the lines of the approach taken under the Care Act.⁶¹ In a small number of cases the role of the advocate will be limited to that of supporting alone, where an advocate has been appointed to support an appropriate person, as in that case it is not appropriate to talk of “representation”.⁶²

12.52 The draft Bill also amends section 39 of the Mental Capacity Act (the duty to provide an advocate for the provision of long-term accommodation) in order to streamline the provision of advocacy with social care legislation. The amendment provides that section 39 does not apply when the accommodation is being provided under the Care Act or the Social Services and Well-being (Wales) Act; this is because the adult will already be eligible – potentially – for an advocate under this legislation. Instead, the duty under section 39 would only apply if the accommodation is being provided under section 117 of the Mental Health Act.⁶³

12.53 As noted above, the Mental Capacity Act provides a power to appoint an advocate where a review of accommodation is taking place (and there is no other person to consult) and in adult protection cases, applying to both local authorities and the NHS.⁶⁴ There is some doubt in adult protection cases whether the power contained in the regulations still applies in England.⁶⁵ This power overlaps with situations in which independent advocates are appointed by local authorities under the Care Act and the Social Services and Well-being (Wales) Act.⁶⁶ Whilst the draft Bill does not amend the relevant regulations or guidance, we would expect the UK Government and Welsh Government to make the necessary changes if the Bill is taken forward.

⁶⁰ Draft Bill, sch 2, paras 4 to 6.

⁶¹ Draft Bill, cl 11 (2) (new s 36 of the Mental Capacity Act). See also Care Act, s 67(2).

⁶² Draft Bill, cl 11(3) (new s 36 of the Mental Capacity Act).

⁶³ Draft Bill, sch 2, para 5.

⁶⁴ Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Expansion of Role) Regulations 2006, SI 2006 No 2883 and Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Wales) Regulations 2007, WSI 2007 No 852.

⁶⁵ It may be that the power in reg 4 of the Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Expansion of Role) Regulations 2006, SI 2006 No 2883 is now obsolete as it ties the power back to arrangements made under previous statutory guidance (which has now been repealed under the Care Act).

⁶⁶ Care Act, ss 67 and 68 and Welsh Government, *Social Services and Well-Being (Wales) Act 2014: Part 10 Code of Practice (Advocacy)* (2015).

Recommendation 30.

If a responsible body proposes to authorise arrangements which would give rise to a deprivation of a person's liberty, it should be required to appoint an independent mental capacity advocate to represent and support the person (if there is no appropriate person appointed) unless:

- (1) the person does not consent to being represented; or**
- (2) if the person lacks capacity to consent, being represented by an advocate would not be in his or her best interests.**

If a responsible body proposes to authorise arrangements which would give rise to a deprivation of a person's liberty and an appropriate person is appointed, the responsible body should be required to appoint an independent mental capacity advocate to support the appropriate person unless the appropriate person does not consent.

This recommendation is given effect by clause 10 of the draft Bill (new section 38A of the Mental Capacity Act).

Recommendation 31.

The Secretary of State and Welsh Ministers should have regulation-making powers to make provision about how an independent mental capacity advocate is to discharge the functions of representing or supporting the person.

This recommendation is given effect by clause 11 of the draft Bill (new section 36 of the Mental Capacity Act).

Recommendation 32.

If a responsible body proposes to authorise arrangements, it should be required to determine if there is an appropriate person to represent and support the person. He or she must not be involved in providing care or treatment to the person in a professional capacity or for remuneration. If there is an appropriate person, the responsible body must appoint them to represent and support the person, unless:

- (1) the person has capacity and does not consent to that appointment; or**
- (2) if the person lacks capacity to consent, and being represented by an advocate would not be in his or her best interests.**

This recommendation is given effect by schedule 1 to the draft Bill (new paragraphs 47 to 50 of schedule AA1 to the Mental Capacity Act).

Recommendation 33.

The UK Government and the Welsh Government should review the adequacy of the current levels of advocacy provision under the Mental Capacity Act, Care Act, Social Services and Well-being (Wales) Act, Mental Health Act and Mental Health (Wales) Measure 2010.

RIGHTS OF LEGAL CHALLENGE

12.54 Article 5(4) of the ECHR requires that everyone deprived of their liberty be entitled to take proceedings by which the lawfulness of their detention shall be decided speedily by a court, and their release ordered if the detention is not lawful. Under the DoLS this right is given effect by section 21A of the Mental Capacity Act which enables the Court of Protection to review a standard or urgent authorisation, and vary or terminate it.

12.55 No permission is required for applications made under section 21A by any person.⁶⁷ Case law has confirmed that if an Independent Mental Capacity Advocate has failed to bring a challenge to court in circumstances where such a challenge is required to secure the person's Article 5(4) rights, the local authority is required to bring an application to the court.⁶⁸ Non-means-tested legal aid is available for those challenging a DoLS authorisation.⁶⁹

12.56 Whilst the Court of Protection's primary task is to consider whether the relevant criteria are satisfied, case law has made clear that it can also exercise all the powers that it has normally in relation to a person whose capacity is in doubt. This includes making declarations as to their capacity, decisions in their best interests, and declarations as to the lawfulness of actions done or to be done in relation to them.⁷⁰ As a result, it is widely accepted that Court of Protection hearings regarding the DoLS are often unfocused, take too long, and resemble a case conference.⁷¹

12.57 The consultation paper provisionally proposed that those subject to the restrictive care and treatment scheme should have a right to apply to the First-tier Tribunal, rather than the Court of Protection.⁷² We considered that the tribunal system (with particular reference being made to the mental health tribunal) possessed a number of advantages, which pointed in its favour. For instance:

- (1) it contains relevant expertise, as many members are mental health lawyers, psychiatrists or lay members with a mental health background;
- (2) it would be better able to encourage the participation of the person since it is relatively informal and generally sits wherever the patient is detained; and
- (3) it has flexible processes and could deliver cost efficiencies in ways which the Court of Protection cannot.

12.58 We did, however, note that the advantages of the tribunal system are not clear-cut. In particular, the consultation paper pointed out that Court of Protection judges have built up considerable expertise in the DoLS and wider mental capacity issues, and the

⁶⁷ Mental Capacity Act, s 50 and Court of Protection Rules 2007, SI 2007 No 1744, rule 51(c).

⁶⁸ *AJ v A Local Authority* [2015] EWCOP 5, [2015] 3 WLR 683.

⁶⁹ Civil Legal Aid (Financial Resources and Payment for Services) Regulations 2013, SI 2013 No 480, reg 5(1)(g)(i).

⁷⁰ Mental Capacity Act, ss 15-16, see also *CC v KK* [2012] EWHC 2136 (COP), [2012] COPLR 627 and *Briggs v Briggs (No 1)* [2016] EWCOP 48.

⁷¹ Consultation paper, para 11.24.

⁷² As above, paras, 11.14 to 11.25.

establishment of a tribunal jurisdiction would create a difficult interface with the rest of the Mental Capacity Act. We also urged caution in comparing the two judicial systems since the delays and costs involved in Court of Protection hearings may be due to the highly complex nature of its jurisdiction and a tribunal system would attract a higher volume of applications, which would add to its cost.⁷³ We provisionally proposed nevertheless, that legal challenges under the new scheme should be to the First-tier Tribunal.

12.59 We also made a number of ancillary proposals and posed a number of related questions. In particular, we proposed that local authorities should be required to refer people to the First-tier Tribunal if there had been no application made to the tribunal within a specified period of time.⁷⁴

Consultation responses

12.60 The majority of consultees supported our proposal to introduce a right to apply to the First-tier Tribunal.⁷⁵ Those who were in favour of this proposal focused their support around three central themes: the efficiency gains of a tribunal system, its accessibility for users, and its flexibility and simplicity. Responses also emphasised the advantages of the peripatetic, informal, and inquisitorial jurisdiction of the mental health tribunal system, and highlighted the benefits of the expertise provided by non-legal members.

12.61 However, we received strong disagreement with our proposal from Court of Protection stakeholders (particularly judges and lawyers) who argued that district judges, in particular, are in a position to hear cases without undue formality and regularly visit the person at their residence. They also emphasised that the Court of Protection is undergoing a significant reform programme, including both regionalisation and case management reforms, to ensure speedier outcomes.

12.62 A majority of consultees agreed with our proposal for automatic referrals to the tribunal.⁷⁶ Some did so on the basis that such was required as a “fail-safe” to ensure Article 5(4) protections, others did so on the basis that it was, in fact, a requirement of Article 5(4) itself.

Discussion

The Court of Protection or a tribunal?

12.63 There was strong overall support amongst consultees for the introduction of a tribunal jurisdiction. Nevertheless, we received detailed counter-arguments, albeit from a minority, which claimed that the consultation paper had underestimated the merits of the Court of Protection.

12.64 The arguments are finely balanced. Whichever model were adopted would probably not greatly affect the judicial personnel hearing the cases; Court of Protection judges would be likely to be “ticketed” for the tribunal. It is also unlikely that the model adopted would

⁷³ As above, paras 11.26 to 11.32.

⁷⁴ As above, PP 11-4.

⁷⁵ Consultation analysis, PP 11-1, para 10.1.

⁷⁶ As above, PP 11-4, para 10.49.

affect the venues used, since it would be impractical for tribunals to sit for example in care homes in the way the mental health tribunal sits in hospitals, so that it is likely that local HM Courts and Tribunals Service venues would have to be used. The advantages of a tribunal system include its accessibility, informality and speedy decision-making. It also offers potential cost savings in the long run. But there are disadvantages; for example, the introduction of a tribunal jurisdiction would create difficulties of demarcation or overlap with the remainder of the Mental Capacity Act jurisdiction. Court of Protection judges stressed to us that upholding a challenge to a DoLS authorisation could involve the court in making or approving other arrangements for the person, possibly including use of the court's jurisdiction over an incapacitated person's property and financial affairs. The setting up costs for a new tribunal – or even an expansion of the jurisdiction of the existing mental health tribunal – could be significant. Clearly a major attraction of the Court of Protection is that it already operates under the Mental Capacity Act and has built up a good deal of knowledge and expertise.

12.65 On the other hand the Court has been justifiably criticised for being slow, cumbersome and expensive. We think it important that the Court of Protection maintains its regionalisation and case management reform programmes introduced in 2015 and 2016 and takes further steps to secure the better involvement of the person who is the subject of its proceedings.

12.66 There would be a number of practical issues associated with creating a mental capacity jurisdiction in or alongside the mental health tribunal. One is that of demarcation of mental capacity jurisdiction between the tribunal and the Court of Protection. Unless jurisdiction were moved entirely away from the Court of Protection to the tribunal, the two bodies would exercise their respective jurisdictions in parallel, with the tribunal having jurisdiction in cases involving a challenge to a deprivation of liberty authorisation and the Court of Protection in other cases. If the tribunal's jurisdiction were confined to setting aside deprivation of liberty authorisations it would be necessary to transfer a case to the Court of Protection if it appeared appropriate for further powers of the Court of Protection to be exercised in relation to the person concerned. Alternatively, to give the tribunal the same powers as the Court of Protection in respect of the health and welfare and / or the property and affairs of people lacking capacity would create a situation in which two judicial bodies exercised the same jurisdiction in parallel; which body was dealing with a particular case would depend purely on whether the proceedings originated in a challenge to a deprivation of liberty authorisation. Neither of these situations seems entirely satisfactory.

12.67 Particular practical issues would arise in relation to Wales. The Mental Health Review Tribunal for Wales is not part of Her Majesty's Courts and Tribunals Service. It is one of a number of tribunals local to Wales that are funded by the Welsh Government.⁷⁷ The Court of Protection's jurisdiction, by contrast, extends over England and Wales and Cardiff is one of the regional hubs established as part of its regionalisation programme. The creation of a tribunal jurisdiction over mental capacity in Wales would involve either setting up a First-tier Tribunal jurisdiction separate from the Mental Health Review

⁷⁷ Others include Special Educational Needs, Agricultural Land and Residential Property Tribunals and the Welsh Language Tribunal.

Tribunal for Wales or expanding the jurisdiction of that tribunal. Either course would need to be discussed between the UK Government and the Welsh Government.

12.68 In 2016 the Lord Chancellor, the Lord Chief Justice and the Senior President of Tribunals jointly launched a programme of reform of courts and tribunals under the heading *Transforming Our Justice System*.⁷⁸ One of the aims is that:

By 2020, tribunals will be part of a single justice system with a single judiciary. They will offer a range of choices to resolve appeals and claims with the needs of people who use the tribunals being put at the centre; from virtual hearings, online decision making, early evaluation, mediation and conciliation to the traditional face-to-face hearing. Cases will be resolved at the right level for the issues at hand, giving all parties better quality, faster and less stressful resolution of claims.⁷⁹

12.69 The programme involves a number of Ministry of Justice consultations, including one which contemplates reducing the participation of non-judicial tribunal members.⁸⁰ We were struck by the number of responses to our consultation which identified the specific benefits of the multi-disciplinary composition of the mental health tribunal. The benefits of a tribunal, composed of a legal chair, a medical member and a lay member (for example a mental health service user or social work professional), include not just the diversity of training of the tribunal's members, but also the fact that it would enable more flexibility in evidence gathering. We see the participation of non-judicial members as an advantage of the mental health tribunal model over the Court of Protection, and it is our view that they would be a valuable addition to any judicial body hearing cases under our scheme. We were pleased to note the statement, in the Government's response to the consultation, that it is not intended that single member panels will apply to every case or every jurisdiction, and that the Government intends for non-judicial members to continue to be able to contribute expertise in cases where the Senior President of Tribunals considers this to be needed.⁸¹

12.70 We would also welcome the greater use of cross-ticketing to allow suitably qualified judges to exercise the powers of the Court of Protection and the mental health tribunal at the same time in cases requiring the exercise of both. One aspect of this is discussed from para 12.79.⁸²

12.71 In the light of, in particular, the *Transforming our Justice System* programme, we do not consider it appropriate for us to make at this stage any recommendation for or against moving the forum for legal challenge under the Liberty Protection Safeguards away from the Court of Protection. We do not know what procedures will operate in the Court of Protection and other parts of the court and tribunal system in 2020. Our draft Bill

⁷⁸ Ministry of Justice and others, *Transforming Our Justice System: By the Lord Chancellor, the Lord Chief Justice and the senior President of Tribunals* (2016).

⁷⁹ As above, p 15.

⁸⁰ Ministry of Justice and others, *Transforming Our Justice System: Summary of Reforms and Consultation* (2016), para 7.3.

⁸¹ Ministry of Justice, *Transforming our justice system: assisted digital strategy, automatic online conviction and statutory standard penalty, and panel composition in tribunals: Government Response* (February 2017), para 54(d).

⁸² The interface between the Mental Capacity Act and the Mental Health Act is discussed in chapter 13.

accordingly makes only those changes to the status quo that are necessary in consequence of the replacement of the DoLS by the Liberty Protection Safeguards.⁸³

12.72 We recommend that, in tandem with the *Transforming our Justice System* programme, the Lord Chancellor, the Lord Chief Justice and the Senior President of Tribunals review the question of the appropriate judicial body for determining challenges to authorisations of deprivation of liberty under the Liberty Protection Safeguards. This should be done with a view to promoting the accessibility of the judicial body, the participation in the proceedings of the person concerned, the speedy and efficient determination of cases and to the desirability of including medical expertise within the panel deciding the case.

12.73 We think that the introduction in our recommended scheme of the role of the Approved Mental Capacity Professional might allow the court or tribunal to focus its attention on whether the authorised arrangements that it is considering are necessary and proportionate. If it found that the authorised arrangements were not necessary and proportionate, it could confine itself to setting the authorisation aside on the basis of a reasoned judgment which would guide the responsible body in putting fresh arrangements in place. If the person concerned objected to the new arrangements, those arrangements would in turn need to be approved by an Approved Mental Capacity Professional and it should be possible to have confidence that the Approved Mental Capacity Professional would conscientiously follow any guidance given in the judicial decision. This would be a more efficient alternative to the court or tribunal taking over the management of the person's health and welfare, as the Court of Protection currently tends to do. It occurs to us that the President of the Court of Protection might consider giving guidance to the court's judiciary along these lines.

Article 5(4)

12.74 The draft Bill does not alter the current position in relation to permission, namely that the person does not need to seek permission to challenge an authorisation, so there is no need for them to show as a preliminary matter that the challenge has merit.⁸⁴ This reflects the importance of the right under Article 5(4). Indeed, following rule changes in 2015, no permission is now required where an application is brought by any person under section 21A of the Mental Capacity Act challenging a DoLS authorisation.⁸⁵ We would not expect the Court of Protection Rules to be changed in this regard in respect of the new application route under the draft Bill.

12.75 Legal aid for the person and their representative in proceedings under section 21A is not subject to a means test, but is subject to a merits test.⁸⁶ Many consultees raised the subject of legal aid, and sought our reassurance that rights to non-means tested legal aid would not be undermined in the new scheme. The need for effective legal representation is part of the special procedural guarantees required in cases of

⁸³ Draft Bill, cl 4 (new s 21ZA of the Mental Capacity Act).

⁸⁴ Draft Bill, cl 4(2)(a).

⁸⁵ Court of Protection Rules 2007, SI 2007 No 1744, r 51(c). The rules changes were introduced by Court of Protection (Amendment) Rules 2015, SI 2015 No 548, r 22).

⁸⁶ Civil Legal Aid (Financial Resources and Payment for Services) Regulations 2013, SI 2013 No 480, reg 5(1)(g), and Legal Aid, Sentencing and Punishment of Offenders Act 2012, sch 1, pt 1.

deprivation of liberty involving those of unsound mind.⁸⁷ The current legal aid provisions reflect the policy intention that such cases “are regarded as a particularly strong example of State intervention involving the human rights of a vulnerable individual”.⁸⁸ Our recommendation above is based on the understanding that non-means tested legal aid will continue, at a minimum, to be available for challenges to deprivation of liberty authorisations under the Liberty Protection Safeguards on the same basis that it is available under the DoLS. To provide otherwise would hamper the provision of effective legal representation of persons deprived of liberty that is required by Article 5(4).

Automatic referrals

12.76 The Liberty Protection Safeguards do not introduce a system of automatic referrals. Such a system is not a requirement of Article 5(4). The Strasbourg court held in *MH v United Kingdom* that while automatic periodic referral to a court might be one way of providing the requisite Article 5(4) safeguards, “it is not necessarily the only means”.⁸⁹ We consider that the requisite safeguards can instead be provided by the duty to appoint an advocate or appropriate person to support and represent the person, which would include supporting the person to bring an application to court challenging an authorisation (see from para 12.20). We would expect the new Code of Practice to reinforce the duty of the advocate or appropriate person to bring a case to court if there is reason to believe that this is what the person wishes, whether or not the person has any chance of success. We would also reiterate that Article 5(4) allows no room to deny access to the court based on an advocate or appropriate person’s assessment of the best interests of a person manifesting a wish for the proceedings to be brought.⁹⁰

Referral to an Approved Mental Capacity Professional

12.77 In cases where the approval of the Approved Mental Capacity Professional was not provided at the initial authorisation of the arrangements (because the person did not then object to the arrangements), an application to the court would, in most cases, indicate that the person does not wish to reside in or receive treatment at the place specified in the authorisation. This would give rise to a duty of the responsible body to refer the case to an Approved Mental Capacity Professional for a review.⁹¹

12.78 The involvement of an Approved Mental Capacity Professional may, in many cases, be speedier, more cost-effective and less intrusive than taking the matter to court. In our view, there is merit in the Approved Mental Capacity Professional’s review taking place before the merits of a case are considered by the court. This could reduce the workload of the court and provide a less formal and more accessible forum for the case to be reconsidered. However, we do not consider that we could make prior review by an Approved Mental Capacity Professional a pre-condition to any application to the Court of Protection. This would risk infringing Article 5(4) by placing a bar upon the required

⁸⁷ See, amongst others, *MS v Croatia (No 2)* [2015] ECHR 196 at [152] to [154].

⁸⁸ See, Mental Capacity Act 2005: Post-legislative scrutiny, Report of the Select Committee on the Mental Capacity Act 2005 (2013-14) HL 139, para 246 (recording the evidence of Lord McNally, the then Minister of State for Justice).

⁸⁹ *MH v UK* (2014) 58 EHRR 35 (App No 11577/06) at [82].

⁹⁰ *AJ v A Local Authority* [2015] EWCOP 5, [2015] 3 WLR 683 and *Re RD* [2016] EWCOP 49.

⁹¹ Draft Bill, sch 1 (new para 38(3) to (6) of sch AA1 to the Mental Capacity Act).

speedy access to a court. It is likely, if the Approved Mental Capacity Professional's review is conducted promptly and produces an outcome acceptable to the person (for example, the authorisation ceases or they no longer are unhappy with the authorisation), that the court proceedings could be discontinued before much judicial time had been spent on them.

Overlap cases

- 12.79 Deprivation of liberty issues give rise to a number of potential overlaps as regards jurisdiction. Under the Liberty Protection Safeguards, the most obvious is in circumstances where a person is also subject to requirements arising under legislation relating to mental health, such as a community treatment order or guardianship (see further at para 13.27). The mental health tribunal has no power to authorise deprivation of liberty of a mental health patient for the purposes of treatment outside hospital.
- 12.80 We consider that this rise might be assisted by authorising some mental health tribunal judges to exercise the powers of the Court of Protection in cases where a patient is under the Liberty Protection Safeguards and also subject to requirements arising under the Mental Health Act.
- 12.81 A second area of overlap, this time created by our recommendation, would be in respect of challenges brought in relation to 16 and 17 year olds subject to authorisations (see from para 7.20). Both the Family Court (and the Family Division of the High Court) and the Court of Protection have jurisdiction over those aged 16 and 17 who lack the material decision-making capacity. The view that has been taken to date is that the most appropriate court depends on which will better safeguard the individual child. This may often depend on whether the young person in question is likely to remain the subject of proceedings beyond their 18th birthday, due to the need for stable transitional arrangements).⁹² We have no intention of disturbing this general proposition.

Recommendation 34.

In tandem with the “Transforming our justice system” programme, the Lord Chancellor, the Lord Chief Justice and the Senior President of Tribunals should review the question of the appropriate judicial body for determining challenges to authorisations of deprivation of liberty under the Liberty Protection Safeguards. This review should be undertaken with a view to promoting the accessibility of the judicial body, the participation in the proceedings of the person concerned, the speedy and efficient determination of cases and to the desirability of including medical expertise within the panel deciding the case.

⁹² Mental Capacity (Transfer of Proceedings) Order 2007, SI 2007 No 1899 and *B v RM* [2010] EWHC 3802 (Fam) at [18] and [30].

Recommendation 35.

Pending the conclusion of our recommended review of the appropriate judicial body for determining challenges to authorisations of deprivation of liberty under the Liberty Protection Safeguards, the Court of Protection should have jurisdiction to determine any question relating to arrangements which are authorised under the Liberty Protection Safeguards. No permission should be required for any application made for such determination.

This recommendation is given effect by clause 4 of the draft Bill.

MONITORING AND REPORTING

12.82 Currently, the Secretary of State and Welsh Ministers have regulation-making powers to require prescribed bodies to monitor and report on the operation of the DoLS.⁹³ The prescribed bodies are, in England, the Care Quality Commission, and, in Wales, the Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales. These bodies have specific powers to visit hospitals and care homes, interview residents, and require the production of records related to the care or treatment of persons who are, or should be, subject to the DoLS.⁹⁴ Care providers are required to notify the relevant body of any request for a standard authorisation or direct application to the Court of Protection to authorise a deprivation of liberty.⁹⁵

12.83 Whilst there are no specific powers to enforce compliance with the DoLS, the bodies can rely on their general enforcement powers in relevant cases. For instance, action may be taken on the basis that the provider's non-compliance with the DoLS amounts to non-compliance with broader regulatory standards, including those relating to person-centred care or dignity.⁹⁶

12.84 The consultation paper provisionally proposed that the same bodies should continue to be responsible for monitoring and reporting on the new scheme. We acknowledged, however, that this would entail an expansion of their remit to include supported living and shared lives accommodation and other domestic settings. With a view to minimising the resource implications, we asked how the new legal framework might encourage greater joint working between the various health and social care bodies and regulatory schemes, and alternative forms of regulation.⁹⁷

⁹³ Mental Capacity Act, sch A1, paras 162 and 163.

⁹⁴ See, for example, the Mental Capacity (Deprivation of Liberty: Monitoring and Reporting; and Assessments - Amendment) Regulations 2009, SI 2009 No 827, reg 4.

⁹⁵ Care Quality Commission (Registration) Regulations 2009, SI 2009 No 3112, reg 18(4A). In Wales this is provided for by powers delegated by the Welsh Government to the Care and Social Services Inspectorate Wales under the Care Standards Act 2000, ss 5 and 31(1).

⁹⁶ See, for example, Care Quality Commission, *The Mental Capacity Act 2005 Deprivation of Liberty Safeguards: Guidance for Providers* (2011), p 10 and Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, SI 2014 No 2936.

⁹⁷ Consultation paper, paras 14.13 to 14.23.

12.85 The consultation paper also discussed the Optional Protocol to the United Nations Convention Against Torture which is designed to strengthen protections against the abuse of people deprived of liberty.⁹⁸ The United Kingdom ratified this in December 2003, and it came into force in June 2006. It requires adequate systems to be in place at a national level to conduct inspection visits to places of detention, and for State Parties to set up or designate one or more “national preventive mechanisms” to conduct visits to places of detention.⁹⁹ In the United Kingdom, the Government collectively designated 18 existing bodies (including the DoLS prescribed bodies). We asked for views on whether any aspects of the current regulatory arrangements do not comply with the Optional Protocol.¹⁰⁰

Consultation responses

12.86 A majority at consultation agreed that the bodies prescribed in relation to the DoLS should be responsible for the new scheme.¹⁰¹ In particular this was felt to be an effective use of existing resources and expertise. Some consultees suggested that Ofsted and Estyn might be given regulatory responsibilities for the new scheme in respect of 16 and 17 year olds, whilst the DoLS prescribed bodies might be responsible for adults.

12.87 Many consultees raised concerns about the extra resources that would be needed if the bodies’ remit was expanded beyond care homes and hospitals. Some suggested ways of achieving future cost efficiencies, such as reliance on data from care providers rather than visits, systems of visits by lay volunteers and social care professionals, and giving Safeguarding Adults Boards some level of responsibility for monitoring and reporting on the operation of the new scheme (particularly in relation to those deprived of liberty in private and domestic settings). There was some debate over whether new powers of entry were needed and whether the Care Quality Commission should review and assess local social services authorities.

12.88 Some consultees, including the Care Quality Commission, queried how deprivation of liberty would be monitored in “private settings”. Others argued that regulation in domestic settings would be an unacceptable intrusion into family life. Some housing stakeholders argued that the DoLS prescribed bodies should not have powers to inspect the physical environment in supported housing settings, and their role should be limited to the registered providers of personal care in these settings, which could be the supported living organisation or a separate domiciliary care agency.

12.89 We received some comments on the Optional Protocol to the United Nations Convention Against Torture.¹⁰² Bristol University’s Human Rights Implementation Centre (which has undertaken research into the Optional Protocol) suggested that the use of non-specialist inspectors for DoLS monitoring visits failed to ensure full compliance with the Optional Protocol. Whilst the Care Quality Commission does not take an official view, its consultation response indicated that the United Nations

⁹⁸ Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (18 December 2002) A/RES/57/199.

⁹⁹ As above, Arts 3 and 17.

¹⁰⁰ Consultation paper, paras 14.8 to 14.13.

¹⁰¹ Consultation analysis, PP 14-1, para 13.1.

¹⁰² As above, see PP 14-1 para 13.8 and para 13.17, and from para 13.42.

Subcommittee on the Prevention of Torture has adopted the view that any place in which a person is deprived of liberty (in the sense of not being free to leave) should fall within the scope of the Optional Protocol, including supported living, shared lives and domestic settings. However, the Care Quality Commission also stressed the need for proportionality when determining how this is implemented.

12.90 A number of consultees made suggestions on how the new legal framework might encourage greater joint working, including new duties to co-operate and to share information where needed.¹⁰³

Discussion

12.91 In our view it is essential that the Liberty Protection Safeguards provide for an effective and comprehensive monitoring scheme. This would not only ensure compliance with the Optional Protocol to the UN Convention Against Torture, but also recognise that in many situations the person subject to an authorisation will be in a highly vulnerable situation and some oversight of the operation of the system will be vital.

12.92 There was a broad consensus that the Care Quality Commission, the Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales should continue to be responsible for monitoring the operation of the new scheme. However, there was also concern that to expand their remit would have significant resource implications, and might be contentious politically, particularly if expanded to include domestic settings.

12.93 We think that it is therefore important to ensure that the level of oversight is proportionate to the risks posed and can deliver efficiencies. The draft Bill therefore provides flexibility as to which bodies are prescribed and how regulation is undertaken. The Secretary of State and Welsh Ministers are given regulation-making powers to require prescribed bodies to monitor and report on the operation of the new scheme.¹⁰⁴ This would allow both Governments to continue to make provision for the current prescribed bodies to undertake this role, and prescribe other bodies, for instance Ofsted and Estyn (in respect of some, or all, 16 and 17 year olds), and Safeguarding Adults Boards. The draft Bill would also enable the regulations to provide for the body to visit only certain types of institutions or to visit certain types of institutions more frequently than others. The UK Government and the Welsh Government would also be able to introduce “light-touch” forms of regulation, such as gathering information, interviewing people, surveys and reporting on certain types of deprivation of liberty.

12.94 The monitoring of advance decisions is discussed at para 15.24.

12.95 The draft Bill also requires responsible bodies to notify a relevant prescribed body if it authorises a deprivation of liberty.¹⁰⁵ This is intended to ensure that the regulator (whoever that may be) is aware of cases where a deprivation of liberty has been authorised. This is a change to the current legal position whereby care providers must notify the relevant body of any request or a standard authorisation, and reflects the change in emphasis under the new scheme which makes the relevant NHS body or

¹⁰³ As above, Q 14-2, from para 13.22.

¹⁰⁴ Draft Bill, sch 1 (new para 51(1) of sch AA1 to the Mental Capacity Act).

¹⁰⁵ Draft Bill, sch 1 (new para 52(1) of sch AA1 to the Mental Capacity Act).

local authority responsible for any deprivation of liberty it is authorising. However, it is important to understand that this is a duty to notify the prescribed body, and does not necessarily mean that the body should, for example, publish statistics on the numbers of authorisations (which would duplicate the existing role of NHS Digital).

12.96 We do not recommend any further reforms to the regulatory framework. In particular we do not recommend the introduction of any new powers to enter premises or reinstate the duty of the Care Quality Commission to undertake periodic reviews of local authority social services. Both of these matters were the subject of recent extensive Parliamentary debate during the passage of the Care Act 2014 and have been ruled out by the UK Government.

12.97 We are not persuaded that additional changes need to be made to the legal framework to encourage greater joint working between the various health and social care bodies and regulatory schemes, and alternative forms of regulation. The current legal framework contains a number of duties to co-operate (such as section 6 of the Care Act and section 82 of the National Health Service Act 2006) and powers to share information. At this stage, the greatest improvements can be made through practice rather than through further legislative change.

Recommendation 36.

The Secretary of State and Welsh Ministers should be given regulation-making powers to require one or more prescribed bodies to monitor and report on the operation of the new scheme, and make provision for how the prescribed bodies must undertake these functions.

This recommendation is given effect by schedule 1 to the draft Bill (new paragraphs 51 and 52 of schedule AA1 to the Mental Capacity Act).

Chapter 13: The Mental Health Act interface

- 13.1 In England and Wales, the non-consensual care and treatment of people with mental health problems is governed largely by two parallel legal schemes – the Mental Health Act and the Mental Capacity Act. In broad terms, the Mental Health Act provides for detention based on protection of the patient and the public, irrespective of mental capacity. The Mental Capacity Act applies only to those who lack capacity, and provides for deprivation of liberty based on the person’s best interests. But there is considerable overlap between the two regimes, and the relationship can be extremely complex.
- 13.2 This chapter sets out the existing interface between the DoLS and the Mental Health Act and considers the interface between the Liberty Protection Safeguards and the Mental Health Act.

The eligibility requirement

- 13.3 As set out in para 4.4(5), in order to be eligible for the DoLS an adult must meet the “eligibility requirement”. The provisions governing this requirement are contained in schedule 1A to the Mental Capacity Act. In simplified terms, schedule 1A sets out that a person is ineligible for the DoLS in any of the following five cases:
- (1) case A: detained patients – the person is detained in hospital under the Mental Health Act, or another similar enactment;¹
 - (2) case B: patients on leave of absence or conditional discharge – where they are subject to a requirement with which the DoLS authorisation would be inconsistent, or the DoLS authorisation would be for medical treatment for mental disorder in hospital;
 - (3) case C: patients subject to a community treatment order – where they are subject to a requirement with which the DoLS authorisation would be inconsistent, or the DoLS authorisation would be for medical treatment for mental disorder in hospital;
 - (4) case D: people subject to guardianship – where they are subject to a requirement with which the DoLS authorisation would be inconsistent, or the DoLS authorisation would be for medical treatment for mental disorder in hospital (and the person objects, or a donee / deputy does not consent); and
 - (5) case E: people “within the scope” of the Mental Health Act and objecting to the proposed psychiatric treatment.
- 13.4 It is the final category (case E) that has caused professionals and the courts most difficulties. First, the DoLS assessor must decide if the person is “within the scope” of the Mental Health Act. This depends on whether the person could be detained under

¹ For example, the Criminal Procedure (Insanity) Act 1964.

sections 2 or 3 of that Act. The assessor should not consider what a reasonable doctor would decide, or whether the person would inevitably be admitted.²

- 13.5 The DoLS assessor must then determine whether the proposed DoLS authorisation would authorise the person to be a “mental health patient”. This is defined as a person accommodated in a hospital for the purpose of being given medical treatment for a mental disorder. In *GJ v The Foundation Trust*, Mr Justice Charles held that assessors should apply the “but for” test. Put simply, this test provides that if “but for” their *physical* treatment needs the person would not be detained, they are eligible under DoLS. This test would also, in general, determine whether the person was within the scope of the Mental Health Act.³
- 13.6 Secondly, the assessor is required to establish whether the person objects to being a mental health patient, or to some, or all, of the proposed mental health treatment. If so, they are ineligible for the DoLS.⁴ Some objections are verbal and persistent. But other cases are not so clear-cut. In deciding whether a person objects, consideration must be given to all the circumstances including their behaviour, wishes, views, beliefs, feelings and values, including those expressed in the past to the extent that they remain relevant.⁵ The assessor’s role is not to consider whether any objection is reasonable.⁶
- 13.7 If the person is within the scope of the Mental Health Act and does not object (and so does not fall within case E), there may be a choice between detention under the Mental Health Act or the DoLS. In such cases, Mr Justice Charles in *AM v South London and Maudsley NHS Foundation Trust* held that decision-makers should consider which is the least restrictive way of achieving the proposed assessment or treatment, by adopting a “fact sensitive approach” and having regard to all relevant circumstances. It was accepted that it will generally, but not always, be more appropriate to rely on the DoLS in such circumstances.⁷
- 13.8 The consultation paper discussed this interface, and was critical of the complexities of the statutory provisions and the resulting case law.⁸ We suggested that most problems arise in case E, and that this was because DoLS assessors are expected to make a speculative determination about the availability of an alternative detention regime; a matter which will ultimately be decided by different assessors under the Mental Health Act. This is not only a difficult determination to make, but is also one that will not necessarily reflect the decision which is actually taken by those assessors. The provisions on detention under the Mental Health Act create a power, not a duty, if the relevant criteria are met. It is therefore possible for a person to be “within the scope” of the Mental Health Act but not be detained.

² *GJ v The Foundation Trust* [2009] EWHC 2972 (Fam), [2010] Fam 70 at [80].

³ As above, at [87] to [90].

⁴ Mental Capacity Act, sch 1A, para 5(4).

⁵ As above, sch 1A, paras 5(6) to (7).

⁶ *DoLS Code of Practice*, paras 4.46 to 4.47.

⁷ *AM v South London and Maudsley NHS Foundation Trust* [2013] UKUT 365 (AAC), [2014] MHLR 181.

⁸ Consultation paper, paras 10.10 to 10.26.

13.9 We took the provisional view that a more rational approach would be to construct a solution based in the Mental Health Act, especially since case E exclusively concerns mental health patients, and the Mental Health Act already provides a comprehensive scheme in this respect. We provisionally proposed to extend the Mental Health Act to cover all necessary deprivations of liberty for mental health patients for the purposes of mental health treatment. This would mean that our new scheme, and the Mental Capacity Act, could not be used to authorise the detention in hospital of incapacitated people who required treatment for a mental disorder. Instead, there would be a new mechanism under the Mental Health Act to enable the admission to hospital of compliant, incapacitated patients in circumstances that amount to deprivation of liberty, while those objecting could be detained, if necessary, under the existing provisions of the Mental Health Act. The safeguards provided to such patients would include rights to advocacy and to apply to the mental health tribunal.

Consultation responses

13.10 A majority of consultees agreed with our provisional proposal.⁹ Many argued that it would bring much needed clarity and certainty into decision-making. There was agreement that it would make sense conceptually for such cases to fall under the Mental Health Act, and that mental health professionals were already familiar with using this legal framework. Some felt that our proposal would force mental health services to take responsibility for “compliant incapacitated patients”. We were told that currently many psychiatrists consider that decisions to detain such patients are not their responsibility since they fall under the DoLS.

13.11 Many responses described the difficulties that currently arise in practice. We were told about “stand-offs” between mental health and DoLS assessors over which regime should be used to detain the patient. In cases where there was a choice between detention under the Mental Health Act or the DoLS, practitioners described difficulties in deciding which regime was the less restrictive. In particular, they noted matters such as the stigma that is associated with detention under the Mental Health Act and entitlement to free after-care services under section 117 of the Mental Health Act are relevant considerations.

13.12 Many consultees asked for further clarification about our proposal, especially as to whether the patient would be admitted to hospital following an assessment by two doctors and an Approved Mental Health Professional (which is the normal procedure under the Mental Health Act). They also asked for further clarification about whether patients would be entitled to after-care services free of charge under section 117 of the Mental Health Act.

13.13 A number of consultees (including those supporting the proposal) pointed to difficulties that might arise under our proposal. For instance, some felt that disputes could arise over whether or not the primary purpose of treatment was for mental disorder because in many cases it might not be obvious, such as a former mental health patient who has recovered and is awaiting a care home placement to become available. It was argued that our proposal would create a “hierarchy of power” based on objection.¹⁰ Others felt

⁹ Consultation analysis, PP 10-1, para 9.1.

¹⁰ Neil Allen.

that the broad definition of medical treatment under section 145 of the Mental Health Act would mean that very few psychiatric hospital patients would fall outside of the remit of this Act.¹¹

- 13.14 Some consultees felt that interface issues were inevitable when two pieces of legislation govern the same area. Most of them wanted mental health and mental capacity law to be “fused” together, so that compulsory treatment in all cases would be linked to a lack of material decision-making capacity. The Mental Capacity (Northern Ireland) Act 2016 provides for such a legal framework and was frequently cited by these consultees.¹²
- 13.15 Those who disagreed with the proposal frequently mentioned the perceived and actual stigmatisation conferred by the use of the Mental Health Act. Some felt that our proposal would lead to a watering down of the safeguards available under the Mental Health Act – in particular, they doubted that patients admitted to hospital under a new admissions process would be entitled to free after-care services under section 117 of the Mental Health Act. It was also suggested that there would need to be a mechanism for moving patients between the new section and other detention powers if they gained or lost capacity, or started or stopped being compliant.
- 13.16 A number of consultees argued that the current interface is relatively straightforward, but that problems can arise due to the paternalistic culture that still dominates in mental health care. It was also argued by Richard Rook (former Department of Health policy manager) that the complexity of the interface has been exaggerated by “viewing it through the lens of those relatively few hard cases which reached (and exercised the mind of) the Court of Protection”.¹³ Several responses referred to a paternalistic and risk-adverse culture dominating psychiatry. It was suggested that any new scheme located in the Mental Health Act would soon become “infected” by this culture or “swamped by the Mental Health Act rules”.¹⁴

Discussion

- 13.17 The concept of “fusion law” loomed large at consultation.¹⁵ Consultation events with mental health stakeholders were often dominated by this subject, and it also featured prominently in the written responses from mental health stakeholder groups such as Mind, the Royal College of Psychiatrists and the Mental Health Foundation. That this issue generated such interest did not come as a complete surprise. Our consultation process coincided with the passage of the Mental Capacity (Northern Ireland) Act 2016 through the Northern Ireland Assembly, which introduced the first ever example (as far as we are aware) of fusion law anywhere in the world. In fact the implications of the Northern Ireland reforms are more far-reaching than the term “fusion” suggests. In

¹¹ Under s 145 of the Mental Health Act, the purpose of medical treatment is defined as alleviating, or preventing a worsening of, the mental disorder or of one of its symptoms or manifestations, and which can include nursing, rehabilitation and care

¹² The Act was not in force at the time of publishing the report.

¹³ Consultation analysis, para 9.13.

¹⁴ As above.

¹⁵ This term is commonly used to describe a single legislative scheme governing the non-consensual care or treatment of people suffering from physical and / or mental disorders, whereby such care or treatment may only be given if the person lacks the capacity to consent.

effect, mental capacity law has now ousted mental health law, and all non-consensual care and treatment depends entirely upon the person lacking capacity to make the material decision.

- 13.18 It is beyond the remit of this project to recommend such a radical reformulation of mental health law. Nevertheless, fusion law does represent, potentially, the future direction for mental health law reform in England and Wales. At its heart, fusion law presents a watershed issue of whether it is right to treat a psychiatric patient with capacity who refuses mental health treatment differently from someone with capacity who refuses physical health treatment. It also seeks to apply modern values to mental health care and treatment, which put the person at the centre of decision-making and addresses the stigma and discrimination faced by those with mental health problems. In our view, the introduction of fusion law in Northern Ireland provides a unique opportunity to review mental health law in England and Wales with a view to the introduction of mental capacity-based care and treatment for mental disorders. We strongly urge the UK Government and the Welsh Government to take this opportunity.
- 13.19 In the absence of fusion, we must consider the interface between our scheme and the Mental Health Act, whilst recognising that our primary goal is to minimise the complexities that arise when seeking to allocate a person who may have mental health and mental capacity difficulties to one or other legislative scheme.
- 13.20 Consultation has confirmed our view that the new scheme should not attempt to maintain parallel legal regimes for detaining people in hospital for mental health treatment. There was much evidence to suggest that the existing interface creates significant confusion and uncertainty in practice.
- 13.21 Consultation also provided a strong challenge (albeit by a minority) to our proposal that a specific mechanism was needed in the Mental Health Act to allow for the admission of compliant incapacitated patients. We had assumed that a new mechanism would assist because clinicians might not feel comfortable in using the existing Mental Health Act detention powers for compliant incapacitated patients, since historically they have not been used for this group of patients. But some consultees suggested that any reluctance would just be part and parcel of the general reluctance to use the Mental Health Act at all (which would apply equally to a new mechanism). There were also powerful rights-based arguments, which suggested that compliant, incapacitated patients could have reduced entitlements under our new mechanism (compared to other Mental Health Act patients), and practical problems put to us.
- 13.22 For these reasons, we are persuaded that there should be no additional mechanism inserted into the Mental Health Act to cater for compliant incapacitated patients. Instead the underlying policy aim of the provisional proposal can be achieved by providing that, if arrangements (which the draft Bill refers to as “mental health arrangements”) are to be carried out in hospital for the purpose of assessing, or providing medical treatment for mental disorder, the Liberty Protection Safeguards cannot be used to authorise those arrangements.¹⁶ Instead, the relevant provisions of the Mental Health Act (or equivalent compulsory provisions such as the Criminal Procedure (Insanity) Act 1964) might be appropriate. But if the arrangements are for the assessment or treatment of

¹⁶ Draft Bill, sch 1 (new paras 1(1)(c) and 53 of sch AA1 to the Mental Capacity Act).

physical disorder, then the Mental Health Act would not be applicable, and the Liberty Protection Safeguards could be used. We recognise that in some cases this would mean that decision-makers will have to exercise their professional discretion to determine in any given case whether or not a person is in hospital for the primary purpose of the assessment or treatment of a mental disorder. However, not least because it will no longer be relevant whether the person is objecting, we consider that the test is a simpler one that – especially when amplified by the new Code of Practice – can be applied without the undue risk of arbitrariness in allocating a person to either the Mental Health Act or the Liberty Protection Safeguards.

13.23 It is also important in this regard to highlight that the provisions we recommend inserting into the Mental Capacity Act in relation to advance consent (see from para 15.2) would apply equally in the mental health setting. Where a patient has given suitably specific advance consent to arrangements that may be implemented in the mental health setting, it would be possible for them to be treated as an informal patient under section 131 of the Mental Health Act (and without invoking the Liberty Protection Safeguards). We see that this as an important tool in securing a proper place for informality in the mental health setting, and also an important incentive to implement advance care planning in relation to those with fluctuating or cyclical conditions such as bi-polar affective disorder.

13.24 However, the draft Bill does provide that authorisation under the Liberty Protection Safeguards would not cease if a person was admitted for a short period of 28 days or less under the Mental Health Act. This is because otherwise the responsible body would be in the situation of having to initiate a new authorisation process when the patient was ready to be discharged, when in practice the authorisation which was in place before admission would be likely to be perfectly adequate. In these circumstances the authorisation is suspended, and can be reinstated if the person is discharged within 28 days. If a person has not been discharged after 28 days then the authorisation ceases to have effect. The draft Bill also ensures that the ability to renew an authorisation is not affected by a period of suspension.¹⁷

13.25 There are some rare cases where a patient is detained under the Mental Health Act and he or she needs additional further treatment for a purely physical disorder which is unrelated to his or her mental disorder, and that treatment has to be delivered in circumstances which amount to a deprivation of liberty. The Liberty Protection Safeguards could be used to authorise such additional arrangements that amount to a deprivation of liberty. This would mean that the person would be detained under the Mental Health Act for the purposes of treating their mental disorder, and in addition subject to an authorisation under the Liberty Protection Safeguards to enable the delivery of treatment for their physical disorder. This means that, in cases such as *A NHS Trust v Dr A*, arrangements which would give rise to a deprivation of liberty could be authorised by the Liberty Protection Safeguards.¹⁸ In that case a court authorisation was needed to provide physical treatment to a detained Mental Health Act patient who was refusing food (but not as a result of a mental disorder) and needed to be deprived of liberty to enable the administration of artificial nutrition and hydration. This was identified as a gap akin to the Bournemouth gap by the House of Lords Select Committee

¹⁷ Draft Bill, sch 1 (new paras 35(1)(e) and 41 of sch AA1 to the Mental Capacity Act).

¹⁸ *A NHS Trust v Dr A* [2013] EWCOP 2442, [2014] 1 Fam 161.

on the Mental Capacity Act, which it is important to close.¹⁹ We emphasise that in our opinion such cases will be rare, and where there is debate amongst clinicians over whether the additional treatment and the associated restraint are justified, the sanction of the Court of Protection should be sought. In our view, the new Code of Practice should emphasise these points.

13.26 The consultation paper asked for further views on cases B to D (see para 13.3(2) to (5)) and whether the Mental Health Act should be amended to include a power of detention in such cases.²⁰ Whilst we received few responses specifically on this question, consultees provided useful information on the use of the Mental Health Act alongside a DoLS authorisation (in cases B to D), and the practical problems that arise.²¹ In the consultation paper we expressed concern that the expansion of Mental Health Act detention into community settings may not be something that would be attractive politically.²² The Department of Health has confirmed its intention to undertake further work in this area, following engagement with stakeholders.²³

13.27 In the meantime, we have designed the legislation so as to maintain, as far as possible, the current legal position. Therefore the Liberty Protection Safeguards could be used to authorise arrangements amounting to a deprivation of liberty where a patient is subject to section 17 leave, guardianship, a community treatment order, a restriction order or conditional discharge. But the Liberty Protection Safeguards could not be used to authorise arrangements which are inconsistent with any requirement, condition or direction arising under one of these powers (such as a requirement to live somewhere else).²⁴ They could also not be used to authorise arrangements inconsistent with a requirement, condition or direction arising under a Scottish or Northern Irish provision having effect in England and Wales and prescribed for these purposes.²⁵

13.28 Currently, the Mental Health Act provides that for certain purposes of the Act a person may not be considered to be suffering from a mental disorder simply as a result of having a learning disability; the disability must be “associated with abnormally aggressive or seriously irresponsible conduct”.²⁶ The effect is that such individuals cannot be made subject to certain provisions of the Act (such as section 3 detention and guardianship) solely for treatment for their learning disabilities. The consultation paper asked for further views on whether or not such people should fall under our scheme.²⁷

¹⁹ House of Lords Select Committee on the Mental Capacity Act: Report of Session 2013-14: Mental Capacity Act 2005: Post-legislative Scrutiny (2014) HL 139, paras 298 to 300.

²⁰ Consultation paper, para 10.25.

²¹ Consultation analysis, chapter 10, from para 9.1.

²² Consultation paper, para 10.25.

²³ Government Response to No Voice Unheard, No Right Ignored – A Consultation for People with Learning Disabilities, Autism and Mental Health Conditions (2015) Cm 9142, para 87.

²⁴ Draft Bill, sch 1 (new paras 1(1)(d) and 54 of sch AA1 to the Mental Capacity Act).

²⁵ Draft Bill, sch 1 (new para 54(g) of sch AA1 to the Mental Capacity Act).

²⁶ Mental Health Act, s 1(2A) and (2B).

²⁷ Consultation paper, para 10.24.

13.29 We received very few comments on this specific point.²⁸ Whilst there are no specific data on the numbers of people who fall into this exemption category, at the end of February 2016 there were 285 inpatients in England diagnosed with a learning disability and / or autism who were not detained under the Mental Health Act. Between March 2015 and February 2016, 505 patients with learning disabilities and / or autism were admitted to hospital who were not subject to the Mental Health Act and 620 were discharged.²⁹ It is likely that if a patient fell within the learning disability exception and needed to be deprived of their liberty, the DoLS would currently be the main legal provision available to deliver Article 5 safeguards. The Department of Health has previously stated an intention to consider “whether and how the Mental Health Act should apply to people with learning disabilities and / or autism”.³⁰ In the meantime we have designed the legislation so as to maintain, as far as possible, the existing legal position. The Liberty Protection Safeguards could therefore be used to authorise arrangements in hospital for the purposes of treatment of a learning disability where that disability is not associated with abnormally aggressive or seriously irresponsible conduct.³¹

13.30 As discussed in para 9.30, under the Liberty Protection Safeguards, there would be circumstances in which arrangements have been authorised on the basis that they are necessary and proportionate, wholly or mainly by reference to the likelihood of harm to other individuals. This creates an overlap with the Mental Health Act which enables detention of those with a mental disorder on the basis of public protection. The draft Bill therefore provides that in such cases the assessor must consider whether it would be more appropriate for an application to be made under sections 2 or 3 of the Mental Health Act.³² Moreover, the draft Bill provides that all such cases must be referred to an Approved Mental Capacity Professional (see para 10.42).³³

13.31 As we noted in para 1.6, the drafting of schedule 1A of the DoLS (which contains the existing interface between the DoLS and the Mental Health Act) has been the subject of considerable criticism. In developing the relevant provisions of the Liberty Protection Safeguards we have been mindful of the need to avoid the “veritable smorgasbord of double negatives and subordinate clauses” and “extreme opacity”.³⁴ Instead, we have developed provisions which are concise (they are contained in two clauses, rather than an entire schedule of 17 paragraphs) and that we believe are much simpler, clearer and easier to understand than the DoLS.

²⁸ Consultation analysis, para 9.30 to 9.32.

²⁹ NHS Digital, *Learning Disability Statistics – Annual Overview, England 2015-2016* (2016).

³⁰ Government Response to No Voice Unheard, No Right Ignored – A Consultation for People with Learning Disabilities, Autism and Mental Health Conditions (2015) Cm 9142, paras 17 to 22.

³¹ Draft Bill, sch 1 (new para 53(2) of sch AA1 to the Mental Capacity Act).

³² Draft Bill, sch 1 (new para 21(4) of sch AA1 to the Mental Capacity Act).

³³ Draft Bill, sch 1 (new para 24(3) of sch AA1 to the Mental Capacity Act).

³⁴ As per the observations of Mr Justice Mostyn – see para 1.6 of this report.

Recommendation 37.

The Liberty Protection Safeguards should not apply to arrangements carried out in hospital for the purpose of assessing, or providing medical treatment for, mental disorder within the meaning it is given by the Mental Health Act. But the Liberty Protection Safeguards should be available to authorise arrangements in hospital for the purpose of providing medical treatment where those arrangements arise by reason of learning disability where that disability is not associated with abnormally aggressive or seriously irresponsible conduct.

This recommendation is given effect by schedule 1 to the draft Bill (new paragraphs 1(1)(c) and 53 of schedule AA1 to the Mental Health Act).

Recommendation 38.

The Liberty Protection Safeguards should not apply to arrangements which are inconsistent with:

- (1) a requirement imposed by a guardian under section 8 of the Mental Health Act;**
- (2) a condition or direction under section 17 of the Mental Health Act;**
- (3) a condition in a community treatment order made under section 17A of the Mental Health Act;**
- (4) a condition or direction in respect of a hospital order under section 37 of the Mental Health Act;**
- (5) a requirement imposed by a guardian under section 37 of the Mental Health Act;**
- (6) a condition in respect of a restriction order under section 42 of the Mental Health Act;**
- (7) a condition imposed when a person is conditionally discharged under section 73 of the Mental Health Act; or**
- (8) a condition or requirement imposed under any other enactment prescribed by regulations.**

This recommendation is given effect by schedule 1 to the draft Bill (new paragraphs 1(1)(d) and 54 of schedule AA1 to the Mental Health Act).

Recommendation 39.

The UK Government and the Welsh Government should review mental health law in England and in Wales with a view to the introduction of a single legislative scheme governing non-consensual care or treatment of both physical and mental disorders, whereby such care or treatment may only be given if the person lacks the capacity to consent.

Chapter 14: Placing the person at the heart of decision-making

14.1 This chapter discusses a number of wider reforms of the Mental Capacity Act. We recommend that these be introduced alongside the Liberty Protection Safeguards as additional mechanisms to protect Article 8 rights and improve decision-making under the Mental Capacity Act whether or not a person is being deprived of their liberty. Specifically the chapter addresses three topics: best interests determinations under section 4 of the Mental Capacity Act, immunity from legal proceedings under section 5 of the Mental Capacity Act, and supported decision-making. Our over-arching intention is to ensure that the person for whom or about whom decisions are taken is placed at the heart of decision-making.

THE PLACE OF WISHES AND FEELINGS IN BEST INTERESTS DECISIONS

14.2 Section 1(5) of the Mental Capacity Act establishes the principle that an act done or decision made for or on behalf of a person lacking capacity must be in their best interests. This principle applies to all decision-makers under the Act, including the court, health and social care professionals, and family and other informal carers.

14.3 Although the concept of a person's best interests is not defined, section 4 of the Act sets out a number of factors which must be, or must not be, considered when a decision-maker is making such a determination. The listed factors require that a decision-maker must:

- (1) not make their determination merely on the basis of the age or the appearance of the person, or on the basis of unjustified assumptions from the person's condition or behaviour;
- (2) consider whether the patient is likely to regain capacity and, if so, when that is likely to occur;
- (3) encourage the person to participate as fully as possible in the decision before making it for the person;
- (4) not be motivated by a desire to bring about the person's death;
- (5) consider the person's past and present wishes and feelings (including written statements), the person's beliefs and values, and any other factors that the person would be likely to consider if they were able; and
- (6) consult a number of people including carers, holders of lasting powers of attorney, deputies and anyone else named by the person.

- 14.4 There is no hierarchy between these factors and the weight attached to each varies according to the circumstances of the individual case.¹ Neither the Mental Capacity Act, nor the *Mental Capacity Act Code of Practice*, provides an indication of the relative weight to be given to the various factors.² In approaching the best interests test, the courts have endorsed a “balance sheet” approach whereby the relevant benefits and burdens of a particular course of action are to be listed and, only where the “account” can be said to be in “significant credit”, can a decision be said to be in a person’s best interests.³ Case law has confirmed that, despite the lack of hierarchy, certain factors can become “magnetic” depending on the circumstances of the case, and so tilt the balance towards a certain resolution.⁴
- 14.5 In the consultation paper we highlighted a line of cases which emphasised the importance of the person’s wishes and feelings when determining their best interests.⁵ These cases included *Aintree University Hospitals NHS Foundation Trust v James* in which the Supreme Court held that the purpose of the best interests test is to consider matters from the patient's point of view, and that the Court of Appeal had been wrong to suggest it was an objective test.⁶ Rather, insofar as it is possible to ascertain the patient’s wishes and feelings, these should be taken into account because “they are a component in making the choice which is right for him as an individual human being”.⁷
- 14.6 The consultation paper argued that the law fails to give sufficient certainty for best interests decision-makers on how much emphasis should be given to the person’s wishes and feelings.⁸ We highlighted case law which demonstrated failures by public authorities to give sufficient recognition to the person’s wishes and feelings, and argued that prioritising wishes and feelings would be consistent with the aims and aspirations of the UN Convention on the Rights of Persons with Disabilities. The consultation paper therefore provisionally proposed that section 4 of the Mental Capacity Act should be amended to establish that decision-makers should begin with the assumption that the person’s past and present wishes and feelings should be determinative of the best interests decision.

Consultation responses

- 14.7 A majority of consultees agreed with this proposal.⁹ Family carers reported that best interests decisions by health and social care professionals were often made without reference to their loved one’s wishes and feelings, and that professionals often “pick

¹ See, for example, *Re M* [2009] EWHC 2525 (Fam), [2009] 12 CCLR 635 and *W v M* [2011] EWHC 2443 (Fam), (2011) 14 CCLR 689. See also the consultation paper, paras 12.30 to 12.36.

² *Mental Capacity Act Code of Practice*, paras 5.5 to 5.7.

³ *Re A* [2000] 1 FCR 193, 206 by Thorpe LJ. This was endorsed in *Ealing LBC v KS* [2008] EWHC 636 (Fam), [2008] MHLR 256 at [71].

⁴ For example, see *Re M* [2009] EWHC 2525 (Fam), [2009] 12 CCLR 635 at [29] and *W v M* [2011] EWHC 2443 (Fam), (2011) 14 CCLR 689 at [249].

⁵ Consultation paper, paras 12.31 to 12.35.

⁶ *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67, [2014] AC 591.

⁷ As above, at [45].

⁸ Consultation paper, paras 12.36 to 12.47.

⁹ Consultation analysis, PP 12-2, para 11.20.

and choose” which factors on the check-list to prioritise to suit their own preferred outcomes. Consultees suggested that the concept of best interests was often interpreted in a medical and paternalistic sense. Several responses pointed to the alleged failings of the Court of Protection in this respect. For example, one consultee listed a number of examples of judgments that first identify a person’s wishes and feelings, and then go on to arrive at a decision that conflicts with them without providing any reason for this departure.¹⁰

- 14.8 It was argued that the requirement merely to “consider” wishes and feelings under section 4(6) of the Mental Capacity Act was a violation” of the UN Convention on the Rights of Persons with Disabilities. The Essex Autonomy Project suggested an approach based on a “rebuttable presumption” that wishes and feelings should be followed (with departure only occurring if there were “compelling reasons” or “serious adverse consequences”). Others wanted a softer wording that nudged decision-makers in the direction of following the person’s wishes and feelings.
- 14.9 Those who disagreed with the proposal often argued that in many cases following the person’s wishes and feelings would be unrealistic and impractical. It was further suggested that uncertainty would arise in cases where, for example, past and present wishes and feelings conflicted, were unclear, or fluctuated. There was opposition to the proposal from some members of the judiciary who argued that the proposal would simply lead to debate about whether or not there was “good reason” to depart from the assumption, and that all that was needed was to properly apply the Mental Capacity Act as it stands.

Discussion

- 14.10 Consultation has reinforced our view that section 4 of the Mental Capacity Act should be amended in order to give additional weight to a person’s wishes and feelings. Some responses – albeit from a minority – felt that no reform was needed or that it was sufficient for the new Code of Practice to emphasise the importance of wishes and feelings. We consider that such a limited response would represent a wasted opportunity for a number of reasons.
- 14.11 First, it is clear from the evidence provided to us, and contained in the report by the House of Lords Select Committee on the Mental Capacity Act, that best interests decisions regularly fail to give essentially any weight to – let alone prioritise – the person’s wishes and feelings. Cases such as *London Borough of Hillingdon v Neary* and *Essex County Council v RF* (summarised in para 1.26) illustrate the consequences of such failures.¹¹ We therefore disagree that it is simply a matter of properly applying the Mental Capacity Act. Section 4 sets out a procedure, rather than a substantive outcome, and, as one consultee put it, it is difficult to see how almost any best interests decision could be unlawful provided that the decision-maker has consulted the right people and turned their minds to the relevant considerations.

¹⁰ Consultation analysis, para 11.37.

¹¹ *Hillingdon LB v Neary* [2011] EWHC 1377 (COP), [2011] 4 All ER 584 and *Essex CC v RF* [2015] EWCOP 1 (see summary of these cases at para 1.26 of this report).

- 14.12 Secondly, circumstances have changed greatly since the introduction of the Mental Capacity Act; much of the Act was based on the work of the Law Commission in the 1990s and predates more recent developments such as the Human Rights Act 1998 and the ratification of the UN Convention on the Rights of Persons with Disabilities. The trend in national and international developments in the context of decision-making on behalf of others is firmly towards requiring greater account to be taken of the wishes and feelings (or will and preferences) of the individual concerned.¹² In our view these developments need to be reflected at the core of the Mental Capacity Act.
- 14.13 There was some concern amongst the judiciary that the proposal would lead to debate about whether or not there was good reason to depart from the person's wishes and feelings. This would not be a wholly undesirable outcome. Best interests determinations will inevitably provoke debate and this focus would be a step forward from the current focus of debate on whether any weight should be given to wishes and feelings at all (which the current wording of section 4 necessitates).
- 14.14 Consultees provided useful suggestions on how section 4 might be reformed. Whilst we were attracted by the idea of a rebuttable presumption, we do not consider this would fit into the structure of section 4. The requirements of section 4 are largely procedural. Logically, the introduction of a duty to make wishes and feelings generally determinative would require the amendment of section 1 (not section 4), in order to give them a higher status than best interests. However, we did not consult on this and such a reform would be far beyond our remit.
- 14.15 We have also considered a suggestion that section 4 should be amended to provide that best interests determinations should not be based on any unjustified assumption that less weight should be given to wishes and feelings because the person lacks capacity. However, in our view this would be insufficiently robust since it would fail to guarantee that any priority at all was given to a person's wishes and feelings. It is also unclear what precisely would count as an "unjustified" assumption and how the giving of "less weight" should be assessed.
- 14.16 Instead, we have concluded that the better approach is to make clearer that steps need to be taken to identify a person's wishes and feelings and to bolster the weight to be given to ascertainable wishes and feelings in the best interests determination. Further "teeth" would be given to this approach by placing additional requirements on professionals to explain their decisions not to follow a person's ascertainable wishes and feelings. Currently, section 4(6) requires the decision-maker to "consider, so far as is reasonably ascertainable" the person's wishes and feelings. We think that this passive formulation is too weak, and the draft Bill amends this to establish that the decision-maker must "ascertain, so far as is reasonably practicable" the person's wishes and feelings.¹³ Our intention is to ensure that in most cases there would be a clear duty to ascertain wishes and feelings; it would be rare, in our view, for this not to be reasonably practicable. We would expect the new Code of Practice to elaborate further on the steps which could be taken by the decision-maker in order to ascertain

¹² At the national level, see the Mental Capacity (Northern Ireland) Act 2016 (discussed in para 13.17 of this report) and in Ireland, the Assisted Decision-Making (Capacity) Act 2015. At the international level, see the UN Convention on the Rights of Persons with Disabilities.

¹³ Draft Bill, cl 8(2) and (3).

wishes and feelings, such as meeting and communicating directly with the person, consulting with friends and family members, and considering documentation which indicates the person's wishes and feelings.

14.17 The draft Bill then requires that, in making the best interests determination, the decision-maker "must give particular weight to any wishes or feelings ascertained".¹⁴ Whilst the meaning of "particular weight" is too case specific to be capable of being defined precisely, it would evidently give ascertained wishes and feelings a higher status than all the other factors which a decision-maker is required to consider under section 4(6). It is also our intention that, as a general rule, the stronger and clearer the ascertainable wishes and feelings, the greater the weight that should be given to them – due to the greater infringement on the person's autonomy under Article 8(1) of the ECHR if they are not followed.

14.18 In some cases departure from ascertained wishes and feelings will be justified. In our view, departing from such wishes and feelings should be permitted only where it is necessary and proportionate. This is mandated, we consider, by the obligations imposed by Article 8(1) of the ECHR, which emphasises the importance of having respect for the autonomy of the person and the need to justify any interference with that autonomy.¹⁵ Similarly, the obligation to respect the person's rights, will and preferences under the UN Convention on the Rights of Persons with Disabilities may give rise to a need (for instance) to balance the person's right to make their own choices (a governing principle of the Convention under Article 3(a)) with their right to be free from exploitation, violence and abuse (enshrined under Article 16). Potentially, there might be a whole range of factors that could be relevant in deciding whether a departure is necessary or proportionate, such as the views of the family, the risk of harm to the person and the likelihood of severe financial consequences. This would be something that the new Code of Practice could usefully flesh out.

14.19 The draft Bill also places additional requirements on professionals to explain their decisions not to follow wishes and feelings. As set out at para 14.38, under our reforms a professional could not rely on the section 5 defence under the Mental Capacity Act in respect of certain important decisions unless there is a written record which must include (amongst other matters) a description of the person's ascertained wishes and feelings and, if the best interests decision conflicts with anything ascertained, an explanation of the reason for making that decision.¹⁶

14.20 Some very useful points were raised at consultation in respect of cases where the person's wishes and feelings are inconsistent or unclear. This might be the case where:

- (1) present wishes and feelings are inconsistent (for example, the person expresses different views on their care and treatment to different members of the family); or

¹⁴ Draft Bill, cl 8(4).

¹⁵ See, for instance, *Pretty v UK* (2002) 35 EHRR 1 (App No 2346/02).

¹⁶ Draft Bill, cl 9.

- (2) past wishes and feelings are inconsistent with current wishes and feelings (for example, the person's long-held view about their diet changes when they become incapacitated); or
- (3) the person cannot communicate any wishes or feelings, and there are no records of past wishes and feelings (for example, when incapacity results from an unexpected event such as a road accident).

14.21 In many such cases, we consider it would be right to say that it is not reasonably practicable to ascertain wishes and feelings, and therefore the requirement to “give particular weight” to ascertainable wishes and feelings would not arise. Under our reforms, the best interests checklist would continue to apply as it currently does, and all the factors would be given their due consideration without any specific statutory weighting. There would also be a need to consider the principles of the Mental Capacity Act set out in section 1, and, importantly, to have regard to whether the purpose for which an act is to be done or decision made can be effectively achieved in a way that is less restrictive of the person's rights and freedoms of actions.¹⁷ We consider this should be sufficient to steer decision-makers in such circumstances.

Recommendation 40.

Section 4(6) of the Mental Capacity Act should be amended to require that the individual making the best interests determination must ascertain, so far as is reasonably practicable:

- (1) the person's past and present wishes and feelings (and, in particular, whether there is any relevant written statement made by him or her when they had capacity);**
- (2) the beliefs and values that would be likely to influence the person's decision if he or she had capacity; and**
- (3) any other factors that the person would be likely to consider if he or she were able to do so;**

and in making the determination must give particular weight to any wishes or feelings ascertained.

This recommendation is given effect by clause 8 of the draft Bill.

SECTION 5 ACTS: ADDITIONAL LIMITATIONS

14.22 As we reported in the consultation paper, the House of Lords Select Committee on the Mental Capacity Act heard evidence regarding poor implementation of the Act. In particular, it found that the presumption of capacity is widely misunderstood, the least restrictive option is not routinely or adequately considered and decision-making continues to be dominated by professionals without input from families and carers. We also highlighted a number of high-profile cases, including *London Borough of Hillingdon*

¹⁷ Mental Capacity Act, s.1(6).

v Neary, which have brought to the fore instances of flawed decision-making by public authorities.¹⁸

14.23 The consultation paper provisionally proposed the system of supportive care with a view to ensuring that a proper assessment takes place, care planning arrangements are adhered to, and the need for more restrictive forms of care and treatment is prevented or at least delayed.¹⁹ The reforms were intended to protect Article 8 rights, especially at a time when a person was being placed in (for example) a care home and lacked capacity to consent to the move.²⁰

Consultation responses

14.24 The supportive care scheme received the backing of a majority of consultees.²¹ Many felt that it would ensure greater compliance with sections 1 to 4 of the Mental Capacity Act and strengthen the existing rights of incapacitated people generally. Whilst the intentions underlying these reforms were widely supported, concerns were raised about the resource implications.

14.25 Consultees also took the opportunity to make general comments about the operation of the Mental Capacity Act. We frequently heard of “blanket” assessments of capacity being undertaken, which were based on a person’s diagnosis alone and excluded family members, and the assumption of capacity being used by professionals in order to justify not providing assessments or assistance to people. Family members reported that hospital and care home workers were often too ready to use restrictive forms of intervention (such as restraint and sedation). One consultee described the Mental Capacity Act as a “tool” used by professionals to “bully” and “side line” vulnerable people and their families.²²

14.26 We also received general comments from health and social care professionals. Many were concerned that poor knowledge of the Mental Capacity Act was widespread; many pointed to NHS staff and doctors as falling short in this respect. Stuart Turner (social worker) stated that “one of the greatest failings in how the Mental Capacity Act has been implemented is that the majority of health and social care staff just did not understand it”.²³ Some suggested that, rather than reforming the DoLS, money would be better spent on improving education and understanding of the Mental Capacity Act. Others were of the view that the problem did not lie in poor understanding, but rather in the resource constraints faced by public authorities; examples were given illustrating the difficulties of making a best interests decision when there are limited services available and personal budgets are being capped.

¹⁸ Consultation paper, paras 3.5 and 6.087 to 6.104. See summary of this case at para 1.26 of this report.

¹⁹ As above, chapter 6.

²⁰ The supportive care scheme is described in more detail from para 5.2 of this report.

²¹ Consultation analysis, chapter 6. See also summary from para 5.18 of this report.

²² Views were expressed at a consultation event in Bristol with family carers, organised by Hft Carers Charity.

²³ Consultation analysis, para 15.4.

Discussion

14.27 The objectives underlying our supportive care scheme were widely supported at consultation. In particular, many felt that supportive care would help to ensure greater compliance with the Mental Capacity Act; the evidence from consultation of poor implementation echoed that reported by the House of Lords Select Committee on the Mental Capacity Act. However, legitimate concerns were raised about the resource implications of the supportive care scheme. We have therefore considered how some of these objectives might be furthered alongside the Liberty Protection Safeguards, whilst also recognising the need to achieve the maximum benefits for the minimum cost. Specifically we have looked towards limiting the availability of the defence under section 5 of the Mental Capacity Act.

14.28 In essence, section 5 codified aspects of the common law defence of necessity which enabled care and treatment to be delivered to those who could not give valid consent.²⁴ It provides statutory protection against civil and criminal liability for certain acts done in connection with the care or treatment of a person. If an act qualifies as a “section 5 act” then (assuming that they are not acting negligently) those giving care or treatment can be confident that they will not face civil liability or criminal prosecution purely on the grounds that the person lacked capacity to give the necessary consent.

14.29 In broad terms, a person providing care or treatment does not incur any liability that they would have incurred in the case of a consenting person of full capacity if:

- (1) reasonable steps are taken to establish whether the person lacks capacity in relation to the matter in question;
- (2) consideration has been given to the principles of the Mental Capacity Act set out in section 1; and
- (3) the action taken is in the person’s best interests.

14.30 Section 6 of the Mental Capacity Act imposes limitations on the section 5 defence, in that where an act is intended to restrain a person who lacks capacity, the person carrying out the act must reasonably believe it is necessary to do so in order to prevent harm to the person and the act must be a proportionate response to the likelihood of the suffering of harm and the seriousness of that harm. Sections 5 and 6 provide no defence as regards the carrying out of acts of restraint that amount to a deprivation of liberty.²⁵

14.31 In *ZH v Commissioner of Police for the Metropolis*, Lord Dyson MR recognised that “a striking feature” of the section 5 defence is “the extent to which it is pervaded by the concepts of reasonableness, practicability and appropriateness” and that “strict liability therefore has no place here”. But he also saw “force” in the argument that if a best interests decision does not comply with the requirements of the Mental Capacity Act (in this case a failure to consult carers), the section 5 defence is not available.²⁶ In *Winspear v City Hospitals Sunderland NHS Foundation Trust* the court considered a failure to consult with the parent of a patient without capacity before a “do not

²⁴ *Re F* [1991] UKHL 1, [1989] 2 WLR 1025.

²⁵ Mental Capacity Act, s 4A.

²⁶ *ZH v Commissioner of Police for the Metropolis* [2013] EWCA Civ 69, [2013] 1 WLR 3021 at [40] to [41].

resuscitate” order was placed in the patient’s records.²⁷ That failure – in circumstances where such consultation was both practicable and appropriate – meant that the NHS Trust was unable to rely upon section 5 in a claim for a breach of the patient’s Article 8 rights brought on his behalf (after his death) by his mother.

- 14.32 Case law has not expressly addressed the extent to which the standards required of professionals before they can rely upon the section 5 defence differ from those expected of, for instance, family members. However, the *Mental Capacity Act Code of Practice* suggests that professionals will be held to a higher standard than family members and informal carers when it comes to determining whether they can benefit from the section 5 defence.²⁸
- 14.33 The Mental Capacity (Northern Ireland) Act 2016 provides in section 9 for a general defence against liability for certain acts, but, significantly, requires additional safeguards to be put in place, where the intervention is serious, before this legal protection is available. The definition of “serious intervention” in section 63 of the Act extends to any intervention which has serious consequences (physical or non-physical) for the person. The safeguards required differ depending on the intervention in question, but may include a formal assessment of capacity, the appointment of a nominated person, a second opinion for certain treatments, the appointment of an advocate, authorisation by a Health and Social Care Trust panel and the right of legal challenge to a tribunal.²⁹
- 14.34 The consultation paper did not consider the reform of section 5 of the Mental Capacity Act. However, in the light of case-law and the legislative developments in Northern Ireland, we consider that strengthening the safeguards for the person affected has the potential to provide an effective way in which to seek to secure better quality decision-making. It may therefore serve as an alternative route to achieving the same policy aims as those addressed by supportive care in our consultation paper.
- 14.35 Our intention is to provide safeguards for people not by way of affording them express rights, but rather by focusing upon the liabilities that would attach to decision-makers if they do not take the additional steps required in any given case. The *Winspear* case, in particular, suggests that the restriction of the section 5 defence in this way would help to ensure better quality decision-making in relation to people who lack or may lack the requisite capacity.³⁰
- 14.36 Therefore, the draft Bill provides for a restriction of the defence contained in section 5 of the Mental Capacity Act; if a professional does an act in connection with the care or treatment his or her immunity from civil or criminal liability is qualified in respect of acts implementing certain key decisions unless he or she has prepared a written record (or has reviewed a written record produced by someone else, and believes it is accurate).³¹

²⁷ *Winspear v City Hospitals Sunderland NHS Foundation Trust* [2015] EWHC 3250 (QB), [2016] 2 WLR 1089.

²⁸ *Mental Capacity Act Code of Practice*, para 6.32.

²⁹ Mental Capacity (Northern Ireland) Act 2016, part 2.

³⁰ *Winspear v City Hospitals Sunderland NHS Foundation Trust* [2015] EWHC 3250 (QB), [2016] 2 WLR 1089.

³¹ Draft Bill, cl 9.

14.37 We have focused on five decisions in this respect. These are all decisions that, analysed under Article 8 of the ECHR, constitute a serious interference with the person's autonomy and therefore require further steps to be taken to ensure against arbitrariness.³² The relevant decisions are:

- (1) to move the person into long-term accommodation (which is defined as accommodation of a kind prescribed in regulations – which could include care home, supported living and shared lives accommodation – where the move is for more than 28 days);
- (2) to restrict the person's contact with others (this could include named individuals or a class of individuals);
- (3) to provide serious medical treatment (which is defined as treatment which involves providing, withholding or withdrawing treatment of a kind prescribed by regulations);
- (4) to administer "covert" medication or treatment (whether by misrepresenting to the person what is being administered or otherwise); and
- (5) to administer medication or treatment which the decision-maker knows, or reasonably suspects, to be against the person's wishes.³³

14.38 The written record must contain the following:

- (1) a description of the steps which have been taken to establish whether the person lacks capacity in relation to the matter in question;
- (2) a description of the steps which have been taken to help the person to make the decision or an explanation as to why it was not practicable to take such steps;
- (3) an explanation of why it is believed that the person lacks capacity in relation to the matter in question, including:
 - (a) identification of the impairment or disturbance in the functioning of the person's brain; and
 - (b) an explanation, by reference to section 3 of the Mental Capacity Act, of why the person is unable to make the decision;
- (4) a description of the steps which have been taken to establish whether or not it is in the person's best interests for the act to be done;
- (5) a description of any ascertained wishes, feelings, beliefs or values for the purposes of a best interests determination and, if the best interests decision

³² See *Shtukaturov v Russia* [2012] 54 EHRR 27 (App No 33985/96), *X v Finland* App No 34806/04 and *Lashin v Russia* App No 33117/02.

³³ Draft Bill, cl 9(2) (new s 6B of the Mental Capacity Act).

conflicts with the person's ascertained wishes, feelings, beliefs or values, an explanation of the reason for that decision;

- (6) confirmation that any duty to provide an advocate has been complied with; and
- (7) confirmation that the act would not be contrary to an advance decision.³⁴

14.39 The written record must be provided before the professional does the act. However, this requirement does not apply if the professional reasonably believes that delaying doing the act in order to comply with the requirement to provide a written record would result in serious harm to the person.³⁵

14.40 The draft Bill also includes a regulation-making power to alter the descriptions of decisions, or add to the descriptions of decisions, to which the duty to prepare a written record applies. This would enable the Secretary of State (following consultation with the Welsh Ministers) to introduce, amongst other matters, procedural protections that might be identified in the future by the Strasbourg court as necessary to protect Article 8 rights in certain cases.

14.41 It is important to emphasise that the restriction of the section 5 defence would only apply to those acting in a professional capacity or for remuneration.³⁶ In our view, it would be undesirable to introduce excessive formality as regards decision-making by family members, as this would be to go against the scheme of the Mental Capacity Act, a scheme which we wish broadly to preserve.³⁷ Moreover, it is unrealistic to expect family members and informal carers to have the level of knowledge of the Act that is properly to be expected of professionals (and as noted at para 14.32, this accords with the general approach of the *Mental Capacity Act Code of Practice*). Therefore, section 5 would continue to apply in the normal way to family members and informal carers.

14.42 One of our key intentions underlying our restriction of the section 5 defence is to make clearer that, where the professional has prepared a written record containing the required information or this has been prepared by someone else, he or she may act without recourse to the Court of Protection. This would apply unless it is clear that the authority of the Court is required either to resolve a dispute or to put the lawfulness of their actions beyond doubt. We expect that the new Code of Practice would set out the circumstances in which court authority might be required.

³⁴ Draft Bill, cl 9(2) (new section 6C of the Mental Capacity Act).

³⁵ Draft Bill, cl 9(2) (new section 6A(3) of the Mental Capacity Act).

³⁶ Draft Bill, cl 9(2) (new section 6A(2) of the Mental Capacity Act).

³⁷ As described by Baker J in *G v E* [2010] EWCOP 2512, [2011] 1 FLR 1652 at [57]

Recommendation 41.

If someone acting in a professional capacity or for remuneration does an act pursuant to a relevant decision, the statutory defence under section 5 of the Mental Capacity Act should not be available unless before doing the act he or she has prepared a written record (or one been prepared by someone else) containing required information. The relevant decisions should be those relating to:

- (1) moving the person to long-term accommodation;**
- (2) restricting the person’s contact with others;**
- (3) the provision of serious medical treatment;**
- (4) the administration of “covert” treatment; and**
- (5) the administration of treatment against the person’s wishes.**

The required information should be:

- (1) the steps taken to establish that the person lacks capacity;**
- (2) the steps taken to help the person to make the decision;**
- (3) why it is believed that the person lacks capacity;**
- (4) the steps taken to establish that the act is in the person’s best interests;**
- (5) a description of ascertained wishes and feelings for the purposes of a best interests determination and if the decision conflicts with the person’s ascertained wishes, feelings, beliefs or values, an explanation of the reason for that decision;**
- (6) that any duty to provide an advocate has been complied with; and**
- (7) that the act would not be contrary to an advance decision.**

This recommendation is given effect by clause 9 of the draft Bill.

SUPPORTED DECISION-MAKING

14.43 Supported decision-making refers to the process of providing support to a person whose decision-making ability is impaired, to enable them to make their own decisions wherever possible. Supported decision-making therefore starts from the assumption that most people are capable of making decisions in all aspects of their life, if – where necessary – they are provided with appropriate support to do so. Where this is achieved, most of the Mental Capacity Act would not apply because, through the provision of support, the person would have decision-making capacity.

14.44 The Mental Capacity Act does not create a formal process for supported decision-making, although the second principle of the Act requires that all practicable steps must

be taken to help a person to make decision before they are treated as lacking capacity to make that decision.³⁸ A number of common law jurisdictions have introduced, or are in the process of moving towards, a formal supported decision-making scheme in legislation.³⁹

- 14.45 The main impetus for supported decision-making schemes has been the UN Convention on the Rights of Persons with Disabilities. In particular, Article 12 (the right of disabled people to enjoy legal capacity on an equal basis with others) has been interpreted by the UN Committee on the Rights of Persons with Disabilities as indicating that national laws should provide support to people with disabilities to ensure that their will and preferences are respected, rather than overruled by action which is considered to be in the person's objective best interests.⁴⁰ We share the aim of ensuring that the person is supported so as to be able to exercise their legal capacity, including through making their own decisions, although, as noted above, we consider that there are some situations in which it may nonetheless be necessary and proper to overrule the ascertainable wishes and feelings of a person lacking the mental capacity to make a particular decision or decisions.
- 14.46 The consultation paper noted the evidence received by the House of Lords Select Committee on the Mental Capacity Act which showed that supported decision-making under the Act was "rare in practice".⁴¹ We argued that there are a number of clear benefits in introducing a supported decision-making scheme. In particular, it would give greater certainty and transparency for individuals, families, carers, professionals and service providers, and could help to ensure that the Mental Capacity Act works as intended. We provisionally proposed that a scheme should be introduced to allow a person to formally appoint another person (known as a "supporter") to assist with decision-making. In order to make an appointment, the person would need to confirm that they had formed a trusting relationship with the supporter and specify which decisions they need assistance with, and the supporter must agree to provide the support.
- 14.47 We sought further views on whether professionals or volunteers should be prohibited from becoming supporters, whether the proposed supporter should be required to demonstrate particular values, qualities or formal qualifications, and whether supported decision-making arrangements should give rise to fiduciary duties. We also provisionally proposed that the legislation should set out the objective of the supported decision-making process which, in line with the UN Convention on the Rights of Persons with Disabilities, would be to provide people with access to the support they require in order to exercise their legal capacity.

³⁸ Mental Capacity Act, s 1(3).

³⁹ For example: Assisted Decision-Making (Capacity) Act 2015 (Ireland); Ontario Law Commission, *Legal Capacity, Decision-making and Guardianship* (May 2014); Adult Guardianship and Co-decision-making Act 2000 (Saskatchewan); and Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Final Report (2014).

⁴⁰ UN Committee on the Rights of Person with Disabilities, *General Comment No 1* (2014) paras 20 to 21.

⁴¹ Consultation paper, paras 12.2 to 12.27. See, House of Lords Select Committee on the Mental Capacity Act: Report of Session 2013-14: Mental Capacity Act 2005: Post-legislative Scrutiny (2014) HL 139, paras 79, 104 and 108.

Consultation responses

- 14.48 A majority of consultees supported this proposal.⁴² Many argued that in practice there was too little focus by health and social care professionals on assisting people to make decisions, and too much focus on protection and safeguarding. Responses from professionals acknowledged that resource and time pressures meant that supported decision-making was often not a priority. A number of academics agreed that a supported decision-making scheme would help to ensure greater compliance with the UN Convention on the Rights of People with Disabilities. Detailed responses were received from Dr Lucy Series and the Centre for Disability Law and Policy at the National University of Ireland, Galway who argued that the proposal needed to go further to secure compliance with the Convention.
- 14.49 Those who disagreed with the proposal frequently argued that there was potential for confusion and dispute between the supporter and the various other Mental Capacity Act roles (such as the advocate, relevant person's representative, attorney, and deputy). In addition, it was argued that the need for a supporter is otiose as a person may be provided with an advocate or has the power to make a Lasting Power of Attorney if they have capacity to do so.
- 14.50 Some consultees commented on the detail of our proposed scheme. A number of responses argued that the supporter must not be someone directly involved in providing care or treatment to the person, or have views that were contrary to the person's best interests, as this would create a conflict of interest. Others felt that the law should not restrict who can become a supporter, and that for instance a family member, friend or professional could be appointed. Some felt that a supporter should only ever be removed from their role by the person themselves or a court; others suggested that health and social care professionals should be given this power (subject to a right to appeal to the court).

Discussion

- 14.51 We remain of the view that the establishment of a supported decision-making scheme would offer clear benefits. In particular, it would bolster the second principle of the Mental Capacity Act which requires that all practicable steps must be taken to help a person to make a decision before they are treated as lacking capacity to make that decision; the evidence from consultation suggested that compliance with the principle is patchy and inconsistent, which was consistent with the findings of the House of Lords Select Committee on the Mental Capacity Act. Service users and patients also welcomed the opportunity of being able to appoint someone they knew and trusted to help them make important decisions and felt this would lead to improved outcomes.
- 14.52 There was some concern that a supported decision-making scheme is unnecessary because this is already the role of a Care Act advocate. This argument is true to some extent. The role of the Care Act advocate does include (amongst other matters) assisting a person to make decisions in respect of care and support arrangements.⁴³ But fundamentally an advocate is not intended to be the same thing as a "supporter". The Care Act advocate has not been chosen personally by the person, and is not

⁴² Consultation analysis, PP 12-1, para 11.1.

⁴³ Care and Support (Independent Advocacy Support) (No 2) Regulations 2014 SI 2014 No 2889, reg 5.

involved on an on-going basis with the person (the advocate is only involved on a one-off basis relating to certain local authority decisions). Care Act advocates provide professional support to the person to make and challenge key decisions made by local authorities; this is very different role to providing support to enable an individual to make their own decisions on an ongoing basis.

- 14.53 Some consultees felt that confusion would arise by adding to the list of advocates, representatives and others provided for under the Mental Capacity Act. Whilst this does not detract from the desirability of a supported decision-making scheme, it does suggest that there needs to be a clear delineation of the responsibilities of each role, supported by the new Code of Practice. For example, it will be important for the new Code of Practice to make it clear that the role of supporter is to assist in decision-making, whilst that of an independent advocate is to assist the person in making their views known.
- 14.54 However, as matters stand, we do not have a sufficient evidence base upon which to draft a detailed legal process. Disappointingly, we received few responses on the precise detail of our proposed supported decision-making scheme. The draft Bill therefore provides a regulation-making power to allow the Secretary of State and the Welsh Ministers to establish a supported decision-making scheme.⁴⁴ Crucially, this would allow the Governments to undertake a public consultation on the details of the process, and provide the opportunity to learn lessons from the mechanisms introduced into Irish law by the Assisted Decision-Making (Capacity) Act 2015 of “assisted decision-making” and “co-decision-making”.⁴⁵
- 14.55 Whilst the power to make regulations must give the Government flexibility to design a scheme from a range of policy options, the power also needs to be sufficiently detailed in order for Parliament to properly scrutinise and debate the provision. The draft Bill therefore specifies the kind of decisions the scheme is concerned with, namely personal welfare and property and affairs. It also describes the people who can be supported under the scheme; the person must be aged 16 or over and have capacity to appoint a person to assist them with the particular decision. It also provides that a supporter must be aged 16 or over.⁴⁶
- 14.56 The remainder of the scheme can be specified in regulations including how supporters are appointed, the role of the supporter, the standards which must be met by a supporter, and the costs and monitoring of the scheme. Our draft Bill also leaves open the possibility that the Governments could introduce pilot schemes to test the wider impact of introducing a supported decision-making scheme.

Recommendation 42.

The Secretary of State and Welsh Ministers should be given the power, by regulations, to establish a supported decision-making scheme to support persons making decisions about their personal welfare or property and affairs (or both).

This recommendation is given effect by clause 12 of the draft Bill.

⁴⁴ Draft Bill, cl 12.

⁴⁵ The Act was signed into law on 30 December 2015 but was not in force at the time of the publication of our report.

⁴⁶ Draft Bill, cl 9 (new s 63A(4) of the Mental Capacity Act).

Chapter 15: Other matters

15.1 This chapter considers some of the remaining areas discussed in our consultation paper, as well as other issues that emerged during consultation. Specifically, it considers the questions of advance consent, interim and emergency authorisation of deprivation of liberty, unlawful deprivation of liberty, and amendment of the Coroners and Justice Act 2009.

ADVANCE CONSENT

15.2 There are several legal mechanisms that enable a person to make decisions which will endure in the event of future incapacity. These mechanisms include advance decisions to refuse treatment and Lasting Powers of Attorney. Our consultation paper discussed whether the concept of “advance consent” should similarly be given statutory recognition.¹

15.3 Advance consent, in this context, refers to the ability of a person to consent in advance to specific care or treatment arrangements that would otherwise amount to a deprivation of liberty. This would mean that the subjective element of deprivation of liberty (that a person has not validly consented to the confinement in question) would not be present and Article 5 would therefore not be engaged (see discussion from para 2.27).

15.4 The consultation paper argued that advance consent would potentially offer people greater choice and control over their future care and treatment arrangements and would be particularly useful in certain settings, such as intensive care and end of life care, where those arrangements are relatively predictable and of a time-limited nature. We therefore provisionally proposed that advance consent should be given statutory recognition in the new scheme, but restricted to a defined event of relatively limited duration.²

Consultation responses

15.5 Our provisional proposal was supported by a majority of consultees.³ Many agreed that advance consent would enable people to have a greater say over their future care or treatment arrangements, and prevent unnecessary intrusion by the State into private lives. In the context of end-of-life care, family carers told us that DoLS assessments had been pointless and distressing for a person in the final days when the person had already agreed to their care and treatment plan before admission to the hospice. A number of palliative care providers, and clinicians working on intensive care units, reported that they were already operating advance consent schemes informally. Some consultees suggested that further safeguards were needed, including a review and monitoring process and requirements that the advance consent should be in writing and witnessed.

15.6 Those who disagreed with our proposal frequently expressed concern that people would be left without Article 5 protections, even though they were being objectively

¹ Consultation paper, paras 13.14 to 13.15, 13.23 to 13.27 and 13.35.

² Consultation paper, paras 13.14 to 13.15, 13.23 to 13.27 and 13.35.

³ Consultation analysis, PP 13-1, para 12.1.

deprived of their liberty. Others doubted whether (as a matter of law) advance consent could be provided whereby the adult gave up their Article 5 rights.

Discussion

- 15.7 Following consultation, we remain of the view that advance consent should be codified in statute law. The principle that people should be able to make decisions which will endure in the event of future incapacity is already recognised in law. For instance, a person can make an advance decision to refuse medical treatment under the Mental Capacity Act, even when the decision will have significant consequences for them. The ability to consent in advance to certain arrangements would enable people to plan ahead and have a say in the provision made for their future care or treatment, and avoid the imposition of unnecessary and potentially distressing assessments. Furthermore, advance consent – to some extent – is already being operated in practice, but without a proper legal framework.
- 15.8 Some consultees argued that advance consent to a deprivation of liberty cannot be effective in law because a person cannot give up their Article 5 rights. We do not agree with that analysis of the position. The Strasbourg court has confirmed that a person can only be considered to be deprived of their liberty if he or she has not validly consented to the confinement in question.⁴ We see no reason why this principle should not apply to consent provided by a person of full capacity in advance of losing capacity, provided that care has been taken to ensure that the consent is valid and relates to specific arrangements. In our view it would be erroneous to say that a person who had given informed consent to an operation under general anaesthesia was then deprived of their liberty in the period after the operation when they were confined in their best interests during a period of post-operative delirium. This is subject to the proviso that the consent process had informed the patient of the likely effects of the anaesthesia and the operation proceeded in accordance with what the patient had been told. We see it as being possible and right to extend this approach more generally, so long always as consent is applicable and valid. To provide otherwise would mean imposing on the person processes such as capacity and medical assessments which they had already indicated would be unwarranted and not what they wished for.
- 15.9 The draft Bill therefore includes provisions which would enable a person to give advance consent to specified arrangements that would (but for that consent) amount to a deprivation of their liberty.⁵

How advance consent is to be given

- 15.10 The draft Bill provides that an “eligible person” may consent to specified arrangements being put in place at a later time; these are defined as arrangements enabling the care or treatment of the person which, if the person did not consent to them, would give rise to a deprivation of liberty.⁶ An eligible person is someone aged 16 or over who has capacity to consent to the arrangements. In order to give advance consent, the person must clearly articulate the particular arrangements to which they are consenting. The draft Bill would not enable a person to make a general declaration that they consent to any future care or treatment arrangements which would give rise to a deprivation of their liberty; otherwise there would be a danger that a person could forego his or her Article

⁴ *HL v UK* (2005) 40 EHRR 32 (App No 45508/99).

⁵ Draft Bill, cl 6 (new ss 26A and 26B of the Mental Capacity Act).

⁶ Draft Bill, cl 6 (new s 26A(1) and (2) of the Mental Capacity Act).

5 protections for a potentially unlimited period of time and in circumstances that were not foreseen when the consent was given.

15.11 There are no formalities in the draft Bill about the format of advance consent. It can be written or verbal. Similarly, a withdrawal or partial withdrawal need not be in writing, and could occur up to the point at which the person loses capacity to withdraw their advance consent.⁷ This lack of formality is in keeping, generally, with advance decisions to refuse treatment under the Mental Capacity Act. It is also right in principle that advance consent given orally should not be discounted, particularly where a person is unable to give the consent in writing due to disability or their circumstances. However, we envisage that the Code of Practice would suggest formalities that can help to establish greater certainty, similar to the approach to advance decisions in the current *Mental Capacity Act Code of Practice*.⁸ In addition, we have provided the Secretary of State with regulation-making powers to prescribe the form in which advance consent must be given in particular circumstances and the level of detail about the arrangements which must be provided in the consent (including certain formalities in specific cases).⁹

Deciding whether the advance consent remains valid

15.12 If a person has given advance consent to specified arrangements then – in line with advance decisions – it would not remain valid if:

- (1) the person withdraws their consent when they have capacity to do so;
- (2) there are reasonable grounds to believe that circumstances exist which the person did not anticipate at the time of giving the advance consent and which would have affected their decision had he or she anticipated them; or
- (3) the person does anything else clearly inconsistent with the advance consent remaining their fixed decision.¹⁰

15.13 We intend by the third criterion, which mirrors that relating to advance decisions to refuse treatment, to cover two potential situations:

- (1) the person does something while they still have the capacity to appreciate that their actions will have the consequence of invalidating their advance consent. They could, for instance, make a further statement which is plainly incompatible with the advance consent. Alternatively, a person who had previously given advance consent to treatment arrangements in a hospital, might lose the power of verbal communication but (whilst they retain capacity) seek to leave the hospital and make clear that they no longer wish to be there; and
- (2) a person is subject to a confinement to which they do not have the capacity to consent, and to which their advance consent would on its face apply, but where their actions provide a clear indication that that advance consent should not be relied upon. This might include the level of distress exhibited by the individual at the circumstances in which they now find themselves.

⁷ Draft Bill, cl 6 (new s 26A(5)(c) and (6) of the Mental Capacity Act).

⁸ *Mental Capacity Act Code of Practice*, para 9.19.

⁹ Draft Bill, cl 6 (new s 26A(4)) of the Mental Capacity Act).

¹⁰ Draft Bill, cl 6 (new ss 26A(5)(c) and (d) and 26B(3)(b)) of the Mental Capacity Act). In relation to advance decisions, see Mental Capacity Act, ss 25(4) and 25(2).

15.14 In addition, the draft Bill confirms that advance consent is not valid if the advance consent contains a time period within which it is valid, and that period has ended.¹¹ For example, the person may consent in advance to specified care or treatment arrangements in a hospice for up to a week, in order to reflect their prognosis. The advance consent would come to an end at the end of the period specified. The draft Bill gives power to prescribe, in regulations, limits on the duration of advance consent which would apply if no period was specified by the person giving consent.¹²

Deciding whether the advance consent is applicable

15.15 Again by analogy with advance decisions to refuse treatment, advance consent would only apply to arrangements that were being put into effect while the person who had given it did not have the capacity to give or withhold consent to them. The arrangements must fall within the parameters specified by the advance consent.¹³

15.16 The Court of Protection would have the power to declare whether an advance consent exists, is valid, or is applicable to particular arrangements, either proposed or put in place.¹⁴

Settings

15.17 The draft Bill does not limit the use of advance consent to things done in particular settings, although we appreciate that there are some settings in which it may be more appropriate, such as end-of-life care. It would be possible to use advance consent for a set of arrangements in a psychiatric hospital, which would mean that compulsory provisions of the Mental Health Act would not apply (for further discussion, see para 13.23).

The legal effect of advance consent

15.18 Where the advance consent is valid and applicable to a specified set of arrangements, its effect is that any confinement that a person may be subject to, as a result of those arrangements, does not amount to a deprivation of liberty within the meaning of Article 5 of the ECHR. This is because the person will be taken to have consented to the arrangements.¹⁵ Accordingly, the NHS body or local authority that is responsible for the specified arrangements will not have to authorise those arrangements through the Liberty Protection Safeguards, nor would care providers incur any liability under the Human Rights Act for unlawful deprivation of liberty and / or the new statutory tort set out from para 15.41.¹⁶

15.19 It is important to emphasise that advance consent could only be used to address the potential that the person may be deprived of their liberty in consequence of arrangements made for them to enable care and treatment. In particular, it cannot serve as consent to particular medical treatment or treatments. These provisions do not alter the principles already set down in the Mental Capacity Act concerning medical

¹¹ Draft Bill, cl 6 (new s 26A(5)(a)) of the Mental Capacity Act).

¹² Draft Bill, cl 6 (new s 26A(5)(b)) of the Mental Capacity Act).

¹³ Draft Bill, cl 6 (new s 26A(1) to (3)) of the Mental Capacity Act).

¹⁴ Draft Bill, cl 6 (new s 26B(4)) of the Mental Capacity Act)..

¹⁵ Draft Bill, cl 6 (new ss 26A(1) and 26B(1)) of the Mental Capacity Act). The corresponding effect in relation to advance decisions to refuse medical treatment arises by operation of Mental Capacity Act, s 26(1).

¹⁶ Draft Bill, cl 6 (new s 26B(2)) of the Mental Capacity Act).

treatment, including those providing that a patient cannot demand treatment that is not available, or which it would not be lawful for a medical professional to administer.¹⁷

16 and 17 year olds

15.20 The draft Bill provides that 16 and 17 year olds can give advance consent (as well as adults). Currently, 16 and 17 year olds cannot make advance decisions under the Mental Capacity Act.¹⁸ They were excluded because it was thought there would be little point in an anticipatory refusal of treatment by persons under the age of 18 since the court, in the exercise of its statutory and/or inherent jurisdiction, could overrule the refusal of a minor, whether competent or not, to accept medical treatment.¹⁹

15.21 However, when it comes to advance consent it is important to consider the Family Law Reform Act 1969, which provides that 16 and 17 year olds are presumed to be capable of consenting to their own medical treatment and any ancillary procedures involved.²⁰ Given that advance consent concerns the mechanism for consenting to a deprivation of liberty for purposes of receiving care or treatment, we think it right that our scheme be more closely aligned with the legal position under the Family Law Reform Act 1969, as opposed to that under the Mental Capacity Act for refusing medical treatment.

15.22 We also note developments in the law since the Mental Capacity Act was passed. For example, it has been held that the principles relating to deprivation of liberty (including the need for the individual themselves to consent) apply with equal force to those aged 16 and 17 as they do to those aged 18 and above (discussed in para 7.22).²¹ We also note the increasing caution that is expressed as regards some of the older case law on medical treatment in relation to 16 and 17 year olds which pre-dates the Human Rights Act.²² We therefore think that the better course is to allow the provisions relating to advance consent to apply to those aged 16 and above.

Lasting powers of attorney and court appointed deputies

15.23 The draft Bill confirms that a donee under a lasting power of attorney, or a deputy appointed by the Court of Protection, cannot consent on behalf of a person to arrangements which give rise to a deprivation of that person's liberty.²³ However, a lasting power of attorney or deputyship could co-exist with advance consent. Thus, a donee or deputy could consent on the behalf of the person to their admission to the relevant care setting. If the person had also given valid advance consent which was applicable to the arrangements made for their care or treatment, the result would be that any confinement to which they were subject would not amount to a deprivation of their liberty within the meaning of article 5 of the ECHR.

¹⁷ See in this regard *Aintree University Hospitals NHS Trust v James* [2013] UKSC 67, [2014] AC 591 at [18].

¹⁸ Mental Capacity Act, s 24.

¹⁹ *Re W* [1993] Fam 64. See Law Commission: Report on Mental Incapacity (1995) Law Commission Report No 231, para 5.18.

²⁰ Family Law Reform Act 1969, s 8.

²¹ *Birmingham City Council v D* [2016] EWCOP 8. An appeal against this decision was heard by the Court of Appeal in February 2017 but the outcome was not known at the time of publishing this report.

²² See for instance Department of Health *Mental Health Act Code of Practice* (2015), para 19.39.

²³ Draft Bill, cl 3 (new s 29A of the Mental Capacity Act).

Monitoring

15.24 We have considered whether the draft Bill should include a monitoring provision to require certain individuals or bodies to oversee and report on the use of advance consent. This could take the form of a regulatory requirement placed on bodies to seek information about and report on the use of advance consent generally, or a duty placed on professionals to review individual cases where there are concerns about the use of advance consent. On balance we have decided not to include a monitoring provision in the draft Bill. Oversight could be achieved outside our reforms, for example, through existing regulatory standards or Departmental review. In addition, safeguarding duties would already require local authorities to make enquires if they had concerns about the misuse of advance consent in individual cases. We urge the UK Government and the Welsh Government to consider the monitoring of advance consent if the Bill is taken forward.

Recommendation 43.

A person aged 16 or over who has capacity to do so, should be able to consent to specified care or treatment arrangements being put in place at a later time, which would otherwise give rise to a deprivation of that person's liberty.

This recommendation is given effect by clause 6 of the draft Bill.

INTERIM AND EMERGENCY DEPRIVATION OF LIBERTY

15.25 At present, a DoLS authorisation can be sought up to 28 days in advance of the person in question becoming a “detained resident” in a hospital or a care home.²⁴ However, because not all deprivations of liberty will be planned (for instance, following a rapid and unexpected deterioration in a person's condition), a hospital or care home can grant itself an “urgent authorisation” for seven days. This is pending the supervisory body's assessment of the application for a standard authorisation, which must be made at the same time.²⁵ It is possible for the hospital or care home to apply to the supervisory body for one extension of the urgent authorisation (a maximum of 14 days in total). However, such a request should only be granted where there are exceptional reasons why it has not yet been possible for the request for a standard authorisation to be disposed of.²⁶

15.26 The courts have emphasised on a number of occasions the guidance contained in the *DoLS Code of Practice* that urgent authorisations should normally only be used in response to sudden unforeseen events.²⁷ There have been no reported cases in which this point has been determined. However, this suggests that in cases where the deprivation of liberty could reasonably have been anticipated, it cannot be made lawful by the purported grant of an urgent authorisation.

²⁴ Mental Capacity Act, sch A1, para 24.

²⁵ Mental Capacity Act, sch A1, Part 5.

²⁶ Mental Capacity Act, sch A1, para 84(4).

²⁷ See, for instance, *NHS Trusts v FG* [2014] EWCOP 30, [2015] 1 WLR 1984 at [101] and *AJ v A Local Authority* [2015] EWCOP 5, (2015) CCLR 158 at [48]. Both referring to the *DoLS Code of Practice*, p 28.

15.27 The consultation paper expressed concerns that “enabling self-authorisation by care providers is one of the least satisfactory elements of the DoLS”. We provisionally proposed that, in urgent cases, the first recourse of the care provider should be to an Approved Mental Capacity Professional who would be able to give temporary authority for care and treatment for up to 7 days (extendable once for up to a further 7 days) pending a full assessment. This would be similar to the position of a Court of Protection judge receiving an emergency application.²⁸

Consultation responses

15.28 This proposal was supported by a majority of consultees.²⁹ Many agreed that self-authorisation should no longer be permitted. Some consultees provided examples of managing authorities granting themselves urgent authorisations for convenience, rather than in exceptional cases. Stakeholders from the hospital and care home sectors told us that, following *Cheshire West*, it was now common for a supervisory body to have failed to arrange the assessments for a standard authorisation within the maximum 14 day period for urgent authorisations. This in turn potentially left the person unlawfully deprived of their liberty and the providers at risk of violating their regulatory standards. Some consultees (including those supporting the proposal) raised resource concerns. They argued that there would not be a sufficient number of Approved Mental Capacity Professionals to respond to urgent referrals. There was some debate over whether the timescales for an urgent authorisation should be increased to 28 days.

15.29 Consultees also raised concern that there is some degree of doubt as to precisely what powers health and social care professionals have to restrain people who lack the capacity to consent to the restraint. Hospital clinicians told us about the difficulties they experience as a result of being unsure whether or not they can prevent agitated patients who appear to lack capacity from leaving the hospital; these difficulties were frequently encountered in accident and emergency departments.

Discussion

15.30 It is of some concern that hospital and care home workers are currently being exposed to significant legal uncertainty as to the lawfulness of their actions in the period following the expiry of an urgent authorisation where the application for a standard authorisation has not been determined. In our view, it is unlikely that authority for ongoing deprivation of liberty would be derived, for instance, from the common law doctrine of necessity. In *HL v United Kingdom* it was held that the necessity principle did not provide the safeguards required for the purposes of Article 5(1)(e).³⁰ Depending on the circumstances of the case, it is possible that the hospital / care home or the relevant supervisory body (or both) could be liable to a claim for unlawful deprivation of liberty brought under the Human Rights Act.

15.31 Consultation has confirmed that the solution does not lie in retaining the current system of urgent authorisations. Under the DoLS the issuing of urgent authorisations often amounts to self-authorisation by the hospital or care provider and offers no real protection to the person concerned but simply adds to the burden of paperwork on those who need to seek it. Our provisional proposal offered more safeguards, but would have

²⁸ Consultation paper, para 7.200.

²⁹ Consultation analysis, PP 7-35, para 6.370.

³⁰ *HL v UK* (2005) 40 EHRR 32 (App No 45508/99).

had workload implications for approved Mental Capacity Professionals. It would also have potentially have left a gap between the expiry of the urgent authorisation and completion of the assessment, leaving care providers in the meantime potentially exposed to a claim for unlawful deprivation of liberty.

- 15.32 Instead, we have looked to section 4B of the Mental Capacity Act to provide the solution. Section 4B currently provides that while a decision is being sought from the Court of Protection (broadly) as to whether a person may be deprived of their liberty, the person may be so deprived to enable the provision of life sustaining treatment or the taking of action believed necessary to prevent a serious deterioration in the person's condition. The draft Bill amends section 4B to provide in addition that a person may be deprived of their liberty to enable life sustaining treatment or action believed necessary to prevent a serious deterioration in the person's condition while a responsible body is determining whether to authorise arrangements giving rise to a deprivation of liberty.³¹ The interim authority provided by this amendment would expire at the point where the responsible body had made its determination either to authorise or not to authorise the arrangements. The amended section 4B would also permit deprivation of liberty, for the same purposes, in emergencies (this is discussed separately from para 15.35).
- 15.33 The draft Bill does not place a time-limit on the length of time for which authority under this interim provision lasts. In our view a time-limit could be seen as reducing the incentive on those involved in the formal assessment process to complete their tasks in a timely fashion. The use of time-limits may encourage responsible bodies to aim for the maximum time allowed rather than improve their performance to the best possible standard. Furthermore, we do not want to create disputes or uncertainty as to the legal position where the period has expired as to whether the periods set down are directory or mandatory.³² No time limit currently applies to the authorisation given by section 4B pending an application to the Court of Protection.
- 15.34 We recognise the danger that the interim authority might last for longer than would be ideal, for instance if the responsible body failed to determine whether to authorise arrangements in a timely fashion. However, it is important to emphasise that this interim authority applies only for limited purposes, either to give life sustaining treatment or take action believed necessary to prevent a serious deterioration in the person's condition, pending a determination of whether to authorise arrangements. If the responsible body were to be taking an undue period of time, we would expect those relying upon the interim authority and the advocate or appropriate person to be pressing the issue. Failures to complete a determination on a timely basis, especially where systemic in nature, would also be matters for complaint under the relevant procedures (and also to the relevant Ombudsmen).
- 15.35 Separately, we are also concerned about the current lack of clarity over the use of restraint in sudden emergency situations. As described from para 14.28, section 5 gives immunity from liability for an act that "restrains" a person, provided that the further conditions in section 6(2) and (3) are satisfied.³³ Sections 5 and 6 provide no defence

³¹ Draft Bill, cl 2.

³² See, by analogy (in relation to urgent authorisations), *Re B* [2010] EWHC 2508 (COP).

³³ The conditions are that the act is necessary to do so in order to prevent harm to the person and a proportionate response to the likelihood of the suffering of harm and the seriousness of that harm.

as regards the carrying out of acts of restraint that amount to a deprivation of liberty.³⁴ Health and social care professionals are reluctant to rely on sections 5 and 6 of the Mental Capacity Act as a basis for intervening to protect a person lacking capacity to consent to the intervention, from immediate harm. This is because of the lack of clarity as to when restraint shifts from being a (lawful) restriction upon liberty to an (unlawful) deprivation of liberty.

- 15.36 The draft Bill therefore further amends section 4B to authorise deprivation of liberty in an emergency situation. An emergency situation is defined as one where immediate steps need to be taken to prevent serious harm to the person and it is not reasonably practicable to apply to a court for an order to authorise the deprivation of liberty, for a responsible body to determine whether to authorise the arrangements under the Liberty Protection Safeguards, or to make an application for detention under the Mental Health Act.
- 15.37 We have deliberately limited the scope of this authority to situations of immediate risk to the person themselves. This is because it is clear from case law that there is a general common law power (which applies whether or not the person has the requisite decision-making capacity) to take such steps as are reasonably necessary and proportionate to protect others from the immediate risk of significant harm.³⁵ This power – which might in fact be better characterised as a defence to liability – should be familiar to health and social professionals, and there is not the same need to confirm the position in statutory form.
- 15.38 Our recommended amendments to section 4B ensure that in non-emergency situations (where the need for a deprivation of liberty could have been anticipated) a person cannot be lawfully deprived of liberty until the process of obtaining authorisation (whether under the Liberty Protection Safeguards or by way of application to the Court of Protection) has started. This is intentional, as we wish to ensure that, wherever possible, deprivations of liberty must be planned in advance. We would expect the Code of Practice to highlight this point.

³⁴ Mental Capacity Act 2005, s 4A.

³⁵ *R (Munjaz) v Mersey Care NHS Trust* [2003] EWCA Civ 1036, [2005] 3 W.L.R 793 at [46].

Recommendation 44.

Section 4B of the Mental Capacity Act should be amended to provide that a person may be deprived of liberty to enable life sustaining treatment or action believed necessary to prevent a serious deterioration in the person's condition if there is a reasonable belief that the person lacks capacity to consent to the steps being taken, and:

- (1) there is a question about whether the decision-maker is authorised to deprive the person of liberty and a decision is being sought from the court;**
- (2) a responsible body is determining whether to authorise arrangements which would give rise to a deprivation of P's liberty (and it does not matter if the steps taken by D which deprive P of P's liberty as mentioned in subsection (1) do not correspond to the arrangements which the responsible body is determining whether to authorise); or**
- (3) it is an emergency.**

This is given effect by clause 2 of the draft Bill.

UNLAWFUL DEPRIVATION OF LIBERTY

15.39 The consultation paper set out the various criminal sanctions and civil remedies that may apply when a person lacking capacity is deprived of liberty unlawfully.³⁶ These include false imprisonment, kidnapping, regulatory offences, remedies under the Human Rights Act 1998, assault and battery and ill-treatment and wilful neglect. We concluded that there was a small category of cases where criminal offences do not apply; such as people deprived of liberty and living in ordinary family homes and supported living placements who do not express a wish to leave their accommodation and are receiving acceptable standards of care. We expressed the provisional opinion that it was legitimate in this small category of cases for criminal sanctions not to apply. We noted in particular that this group of people would still have a civil remedy under the Human Rights Act against public authorities which have failed to protect their human rights. But we also asked whether a new offence of unlawful deprivation of liberty should be created.

Consultation responses

15.40 A majority of consultees considered that a new criminal offence should not be created.³⁷ Many considered this question in the context of the current DoLS arrangements. They argued that a new offence would criminalise care home managing authorities who are depriving people of liberty unlawfully as a result of the inability of local authorities to process DoLS applications within the statutory time-limit. Others felt that there was sufficient protection within other civil and criminal regimes not to warrant the introduction of a further criminal offence. Some noted the difficulty in obtaining civil remedies against public authorities for deprivation of liberty, and suggested, in particular, fixed "tariffs" by

³⁶ Consultation paper, paras 15.25 to 15.42.

³⁷ Consultation analysis, Q 15-5, para 14.48.

way of awards of damages for unlawful deprivation of liberty.³⁸ A number of consultees also thought that protection was afforded by virtue of the law of false imprisonment.

Discussion

- 15.41 Consultation provided limited evidence that a new criminal offence is required of unlawful deprivation of liberty as regards those without capacity. We agree with consultees that the crime of false imprisonment is a sufficient criminal sanction for the more serious cases of deprivation of liberty; we do not therefore recommend the creation of any new criminal offence.
- 15.42 However, we have considered further the position under the civil law of those subject to a deprivation of liberty at the hands of a private care provider (particularly those in a private care home or hospital). The Mental Capacity Act at present does not provide an express remedy for a deprivation of liberty which has not been authorised through the DoLS or by the Court of Protection. If the State is directly responsible for the arrangements, the person could bring a claim under the Human Rights Act 1998 on the basis of breaches of Articles 5 and (usually) 8 of the ECHR; the claim would lie against the public body involved and also, in cases falling within section 73 of the Care Act, against the care provider.³⁹
- 15.43 The position is different where there is no direct State involvement, the confinement is at the hands of a private individual or body and the situation only falls within the scope of Article 5 (if at all) through the operation of the State's positive obligations (as discussed from para 2.31). In such a case it will often be difficult to make a claim for breach of an obligation to secure the person's right to liberty. A claimant would need to take a complicated legal route, identifying the relevant public authority (most obviously, a local authority with safeguarding obligations) and establishing first that it was aware or ought to have been aware of the situation and secondly that it had failed to respond appropriately. No claim under the Human Rights Act would lie against the care provider.
- 15.44 The person concerned may be able to bring a claim in tort for false imprisonment. However, as noted in the consultation paper, this would not apply to a person who did not express or manifest (by their actions) a desire to leave their accommodation, or was not aware that they would be prevented from leaving if they attempted to do so.⁴⁰ This is so even if they were being deprived of liberty for the purposes of article 5 of the ECHR; deprivation of liberty is wider than the domestic law concept of false imprisonment.⁴¹
- 15.45 In our view, there are clear advantages in establishing a directly effective remedy in tort against a care provider who is not a public authority for the purposes of the Human Rights Act 1998. Primarily this would close a gap in the law in order to give protection to a vulnerable group of people, give "teeth" to the need to comply with the Liberty Protection Safeguards, and avoid potentially complex legal arguments and procedures. We consider it clear that such confinements at the hand of regulated care providers can in general be considered to be imputable to the State, and hence to constitute deprivations of liberty for the purposes of Article 5 of the ECHR. This is because the

³⁸ For example, Paul Bowen QC.

³⁹ A private care home providing personal care that has been arranged or funded (in part or in whole) by a public authority is treated as a public authority for Human Rights Act purposes by section 73 of the Care Act.

⁴⁰ Consultation paper, para 15.27. Referring to *R v Bournewood Community Mental Health NHS Trust* [1998] UKHL 24, [1999] 1 AC 458.

⁴¹ *HL v UK* (2005) 40 EHRR 32 (App No 45508/99) at [90].

State either knows (or should know) of such matters, for example, through its statutory role in regulating the way in which such providers deliver care. If such situations amount to deprivations of liberty for the purposes of Article 5, then it is incumbent upon the State to provide an effective remedy where a breach of this Article has occurred.⁴²

- 15.46 The draft Bill therefore provides that where care or treatment arrangements are put in place by, or on behalf of, a “private care provider” which give rise to a deprivation of liberty and have not been authorised, a person may bring civil proceedings against the private care provider. Those proceedings could be brought either as standalone proceedings in the county court or High Court or as part of Court of Protection proceedings concerning the person. The proceedings would in substance be very similar to those which can currently be brought against public bodies under section 7 of the Human Rights Act 1998. The care provider would not be liable if it reasonably believed that the arrangements did not give rise to a deprivation of liberty or the deprivation of liberty was authorised.⁴³
- 15.47 The draft Bill has limited the definition of a private care provider to, broadly speaking, those responsible for the management of private care homes and independent hospitals. The definition would cover non-NHS hospitals and care homes providing personal care that has not been arranged or funded by a public authority. The Secretary of State is given the power to add to this definition (after consulting the Welsh Ministers).⁴⁴ Such a power might in due course be used to extend the definition to registered private domiciliary care providers who are implementing arrangements which give rise to a confinement to which the person concerned cannot consent, for example in supported living or private and family settings.
- 15.48 In determining the amount of any award of damages, the court is required to take into account the principles applied by the Strasbourg court in relation to the award of compensation under Article 41 of the ECHR (which affords “just satisfaction” to the injured party).⁴⁵ The wording follows (in part) that contained in section 8(4) of the Human Rights Act. We would envisage that the redress available will be materially identical to that available in a claim brought under the Human Rights Act against a public body.
- 15.49 We note the suggestion that there should be a “tariff” for claims for unlawful deprivation of liberty. Given the historic paucity of decisions in this area, and the consequent difficulty for advisors and the judiciary in determining appropriate figures, there is an attraction to outlining such a tariff. However, we consider that this is a matter that is best left to development by the courts, which have already started to develop a small but growing corpus of decisions.⁴⁶ On occasion, the failure will be “merely” procedural. Whilst in such a case the individual will be entitled to a declaration as to the breach of their rights, we would not anticipate that courts would find an award of damages necessary for purposes of providing them with the necessary just satisfaction.⁴⁷ However, on occasion, the failure to follow the procedures and the consequent arbitrary

⁴² *Storck v Germany* (2006) 43 EHRR 96 (App No 61603/00) at [89], and also Article 5(5) ECHR.

⁴³ Draft Bill, cl 7 (new section 4C of the Mental Capacity Act).

⁴⁴ Draft Bill, cl 7 (new section 4C(4) of the Mental Capacity Act).

⁴⁵ Draft Bill, cl 7 (new section 4D(4) of the Mental Capacity Act).

⁴⁶ For a summary of the current position, see *Essex CC v RF* [2015] EWCOP 1.

⁴⁷ See *Essex CC v RF* [2015] EWCOP 1 and, by analogy (concerning the Mental Health Act), *Bostridge v Oxleas NHS Foundation Trust* [2015] EWCA Civ 79, (2015) 18 CCLR 144.

deprivation of the person's liberty will have occasioned them real harm. We would anticipate that in such cases damages (and on occasion substantial damages) will be warranted.

15.50 In order to ensure that there is no overlap with a claim under the Human Rights Act, the draft Bill makes clear that a public authority for the purposes of section 6 of the Human Rights Act 1998 is not a private care provider for the purposes of the new tort.⁴⁸

Recommendation 45.

A person should be able to bring civil proceedings against the managers of a private care home or an independent hospital when arrangements giving rise to a deprivation of their liberty have been put in place and have not been authorised under the Mental Capacity Act, the Mental Health Act or by an order of a court.

This recommendation is given effect by clause 7 of the draft Bill.

AMENDMENT OF THE CORONERS AND JUSTICE ACT 2009

15.51 The duties of coroners in England and Wales are set out in the Coroners and Justice Act 2009. Coroners are independent judicial office holders who carry out investigations into the cause of a person's death. They are appointed by a local authority, although some will cover more than one local authority area. The cost of coronial investigations is generally met by the local authority for the relevant area.⁴⁹ Coroners are usually lawyers but sometimes doctors. The Chief Coroner heads the coroner service and gives guidance on standards and practice.

15.52 A coroner must, as soon as practicable, conduct an investigation into a person's death if (amongst other cases) "the deceased died while in custody or otherwise in State detention".⁵⁰ In such cases the coroner must, as part of the investigation, conduct an inquest.⁵¹ The purpose of the inquest is to ascertain who the deceased was, how they came by their death, when they came by their death, where they were at the time of death, and where Article 2 of the ECHR applies (considered further below), in what circumstances the deceased came by their death.⁵²

15.53 "State detention" is currently defined to include persons "compulsorily detained by a public authority within the meaning of section 6 of the Human Rights Act 1998".⁵³ It has been held that "at least to some extent, State detention overlaps with deprivation of liberty under Article 5".⁵⁴ Guidance issued by the Chief Coroner, which is not binding on coroners, explains that those who die when subject to a DoLS authorisation or a judicial authorisation of the deprivation of their liberty under the Mental Capacity Act are within

⁴⁸ Draft Bill, cl 7 (new section 4C(5) of the Mental Capacity Act).

⁴⁹ Ministry of Justice, *Guide to Coroner Services* (2014), para 2.5.

⁵⁰ Coroners and Justice Act 2009, ss 1(1) and (2)(c).

⁵¹ Coroners and Justice Act 2009, s 6.

⁵² Coroners and Justice Act 2009, s 1(1).

⁵³ Coroners and Justice Act 2009, s 48(2). This provision has been amended by the Policing and Crime Act 2017, s 178. At the time of publishing this report, the amendment had not been commenced.

⁵⁴ *R (Ferreira) v HM Senior Coroner for Inner South London* [2017] EWCA Civ 31 at [78].

the meaning of State detention.⁵⁵ In the consultation paper, we agreed that this statement represented the correct legal position.⁵⁶

15.54 The consequence is that where a person dies while under a DoLS authorisation (or if their deprivation of liberty has been authorised by the Court of Protection under sections 15 and 16 of the Mental Capacity Act) there must be an inquest, even if the cause of their death is known to be a natural one. The inquest must be conducted with a jury and witness evidence if there is reason to suspect that the death was “violent or unnatural or the cause of death remains unknown”.⁵⁷

15.55 In the case of a natural death the inquest, which must be held in public, can be conducted “on the papers” (with the coroner pronouncing his or her determination as to the deceased’s identity and cause of death on the basis of written materials in the case file). Coroners have developed procedures for doing this expeditiously. However, it still involves an amount of work that would not have been required at all were it not for the applicability of the “State detention” provisions of the Act.

15.56 Article 2 of the ECHR imposes additional requirements on the State as regards investigating deaths. According to the Strasbourg court, where a person came by their death in circumstances where “the evidence suggests a possible breach of the State’s substantive duty to protect the life of those in its direct care”, there is a need to conduct a proactive investigation.⁵⁸ Where Article 2 is engaged, the coroner may be obliged to exercise the power under section 32 of the Coroners and Justice Act 2009 to report matters to some person believed to have power to take action to prevent future deaths.⁵⁹ The consultation paper suggested that, whilst the Strasbourg court has not considered this matter, it is likely that the Article 2 procedural duty may apply where an individual subject to a DoLS authorisation dies, for example where they commit suicide.⁶⁰

15.57 The majority of deaths in England and Wales do not come to the attention of a coroner at all. There is a duty to report a death to the registrar of births and deaths for the sub-district in which the death occurred; the duty falls on one of the relatives of the deceased or certain other specified persons.⁶¹ The details to be reported include the place of death.⁶² There is also a duty of a registered medical practitioner who has attended the deceased to complete a medical certificate on the cause of death and send it to the registrar.⁶³ The registrar is under a duty to report the death to the coroner in certain prescribed circumstances, including where there is no medical certificate or the cause of death appears to be unnatural or unknown.⁶⁴ The prescribed circumstances do not

⁵⁵ Chief Coroner, *Chief Coroner’s Guidance No 16: Deprivation of Liberty Safeguards* (2016), para 45.

⁵⁶ Consultation paper, para 15.48.

⁵⁷ Coroners and Justice Act 2009, s 7(2)(a).

⁵⁸ *R (Humberstone) v Legal Services Commission* [2010] EWCA Civ 1479, [2011] 1 WLR 1460 at [52].

⁵⁹ *R (Lewis) v Mid and North Shropshire Coroner* [2009] EWCA Civ 1403, [2010] 1 WLR 1836 at [11] and [35].

⁶⁰ Consultation paper, para. 15.53.

⁶¹ Births and Deaths Registration Act 1953, ss 16 and 17.

⁶² Registration of Births and Deaths Regulations 1987, reg 39 and sch 2, prescribed form 13.

⁶³ Births and Deaths Registration Act 1953, s 22.

⁶⁴ Registration of Births and Deaths Regulations 1987, reg 41.

include the deceased having died in “State detention”, but this may be apparent from the details of the place of death.

- 15.58 In the consultation paper we reported that the requirement to conduct an inquest was both problematic for coroners (who are compelled to proceed to an inquest even in the most routine cases). It can also be upsetting for the relatives of the deceased who typically have no concerns about the circumstances in which their loved one died and are appalled to be told that the law regards their deceased parent or relative as having died in “State detention”. We also had reports of excessively intrusive handling of such deaths by the authorities and of delay to funeral arrangements, which were particularly troubling amongst communities where early funeral arrangements are a cultural norm.⁶⁵
- 15.59 We provisionally proposed that the Coroners and Justice Act 2009 should be amended to require inquests into the deaths of people subject to our new scheme only if the coroner was satisfied that there was a duty under article 2 of the ECHR to investigate the circumstances of the death. We also asked whether coroners needed a power to release the deceased’s body for burial or cremation before the investigation or inquest was concluded and whether consultees found the current law on reporting of deaths to be satisfactory.⁶⁶

Consultation responses

- 15.60 Our provisional proposal was supported by a majority of consultees.⁶⁷ Many consultees felt this proposal would help to reduce caseloads. One coroner told us that if our proposal had applied to the DoLS inquests the coroner had conducted in the past year, only one of the 90 cases would have resulted in an inquest. Some concern was expressed, by coroners and others, over the complexity of deciding what the requirements of Article 2 in a particular case were. A number of consultees argued that our proposal did not go far enough. They supported removing our proposed scheme entirely from the concept of “State detention”. One coroner identified the problem as being the need for coroners to be involved at all in deaths that did not raise any issues.
- 15.61 Many consultees provided evidence of the difficulties generated by the current legal position. We received reports, for example, of police arriving at the deceased’s deathbed. One consultee reported their impression of a “crime scene”, another referred to issues over whether the deceased’s body should be taken to the official mortuary rather than by the family’s preferred funeral director.
- 15.62 A majority of consultees felt coroners should have the power to release the deceased’s body for burial or cremation before the conclusion of an investigation or inquest.⁶⁸ However, some coroners told us that they already had adequate powers to release bodies for funerals to take place. A majority of consultees felt the current law on the reporting of deaths is unsatisfactory.⁶⁹ Most argued that the current law led to over-reporting.

⁶⁵ Consultation paper, paras 15.54 to 15.62.

⁶⁶ Consultation paper, paras 15.63 and 15.65.

⁶⁷ Consultation analysis, PP 15-6, para 14.63.

⁶⁸ Consultation analysis Q 15-7, para 14.78

⁶⁹ Consultation analysis Q 15-8, para 14.95.

Discussion

- 15.63 The Policing and Crime Act, which received Royal Assent on 31 January 2017, amends the Coroners and Justice Act 2009 to provide that a person is not in State detention at any time when he or she is deprived of liberty under the DoLS or pursuant to a relevant order of the Court of Protection.⁷⁰ At the time of publishing this report the amendment had not been commenced. We support the underlying aim of this amendment. In our view, there is a pressing need to remove people subject to deprivations of liberty authorised under the Mental Capacity Act from the definition of “State detention”. This is for two reasons: first, it is simply an offensive way in which to describe such people, and secondly, the consequent compulsory inquest is plainly disproportionate.
- 15.64 The amendment contained in our draft Bill would similarly provide that a person is not in State detention if they are subject to the Liberty Protection Safeguards (or deprived of their liberty pursuant to a relevant order of the Court of Protection). We have drafted our amendment by reference to the Coroners and Justice Act 2009 before the amendments made by the Policing and Crime Act 2017 take effect. Were those amendments to come into force before the draft Bill were to be enacted, our amendment would still be necessary but would need to be very slightly adjusted.⁷¹
- 15.65 However, we are concerned that simply removing the Liberty Protection Safeguards from the definition of State detention could potentially allow deaths, that were attributable to a lack of care to pass unnoticed, which may breach the State’s duty to investigate under Article 2 of the ECHR. Despite the existence of a very respectable body of opinion among coroners (to the effect that no special provision for cases under the Mental Capacity Act was required in coronial law), we detected a strong feeling amongst many coroners and consultees that the system should ensure that these cases came to a coroner’s attention. This is especially important given that the Liberty Protection Safeguards will apply in a wider range of settings, not just hospitals and care homes. We are also satisfied, as a result of discussions with coroners, that the necessary enquiries to reveal or dispel any concerns about the circumstances of the deceased’s death can be made without disproportionate effort or upset.
- 15.66 In 2016, the Department of Health published a consultation paper and draft regulations on the introduction of medical examiners and reforms of death certification in England and Wales.⁷² These reforms would introduce a unified form of scrutiny by medical examiners of all deaths in England and Wales that are not investigated by a coroner. In particular, they would require that medical certificates be submitted in draft to medical examiners. In turn, they will be under a duty to verify the cause of death and to refer the death to a coroner if the medical examiner forms the opinion that the death was attributable, among other things, to a failure of care or “in custody or otherwise in State detention”; it is clear from the draft accompanying guidance that that is taken to include a DoLS authorisation.
- 15.67 At the time of the publication of our report, the Department had yet to publish its response to the public consultation on its proposals. If they were to be introduced, the effect of our recommendation that authorisations under the Liberty Protection

⁷⁰ Policing and Crime Act 2017, s 178.

⁷¹ In cl 5 of the draft Bill it would be necessary to replace the words “after subsection (2) insert” with “for subsection (2A) substitute”.

⁷² See, <https://www.gov.uk/government/consultations/death-certification-reforms> (last visited 24 Jan 2017).

Safeguards do not fall within the definition of “State detention” would be that the deaths would come to the knowledge of medical examiners. They would be under a duty to make enquiries and to refer the death to a coroner if the medical examiner formed the opinion that the death was attributable, among other things, to a failure of care. This should, in our view, provide an adequate safeguard. In the event that the system were not introduced, our recommendation would be that, in addition to removing our proposed scheme from the definition of “State detention”, machinery should be created for ensuring that deaths of people subject to the Liberty Protection Safeguards (or deprived of their liberty pursuant to an order of the Court of Protection) are notified to the coroner. This might be done by requiring medical certificates of the cause of death to be annotated with a mention that the deceased died whilst subject to the Liberty Protection Safeguards or a relevant Court of Protection order; this is information which the certifying medical practitioner ought to possess or be able to ascertain from the person’s care plan or authorisation record. Alternatively, NHS bodies and local authorities might be required to notify the registrar that the death occurred in these circumstances. These circumstances could in turn be added to the prescribed circumstances in which registrars must report the death to the coroner. We anticipate that, upon receiving such a notification, coroners would make use of their power under section 1(7) of the 2009 Act to make preliminary enquiries as to whether the cause of death was unnatural or unknown.

Recommendation 46.

Section 48 of the Coroners and Justice Act 2009 should be amended to provide that a person is not in State detention if the compulsory detention, to which he or she is subject, arises as a result of arrangements which are authorised under Liberty Protection Safeguards, section 4B of the Mental Capacity Act or a provision of an order made under section 16 of the Mental Capacity Act.

This recommendation is given effect by clause 5 of the draft Bill.

Recommendation 47.

If the Department of Health decides not to introduce its proposed reform to require a medical examiner or medical practitioner to refer a case to a coroner if the death was attributable to a failure of care, measures should be put in place to ensure that deaths of people subject to the Liberty Protection Safeguards or deprived of their liberty pursuant to an order of the Court of Protection are notified to the coroner.

Appendix A: Draft Mental Capacity (Amendment) Bill and Explanatory Notes

Mental Capacity (Amendment) Bill

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A

B I L L

TO

Amend the Mental Capacity Act 2005; and for connected purposes

BE IT ENACTED by the Queen’s most Excellent Majesty, by and with the advice and consent of the Lords Spiritual and Temporal, and Commons, in this present Parliament assembled, and by the authority of the same, as follows:—

Arrangements etc giving rise to a deprivation of liberty

1 Deprivation of liberty: arrangements which are authorised

- (1) The Mental Capacity Act 2005 is amended as follows.
- (2) In section 4A (restriction on deprivation of liberty) for subsection (5) substitute—
 - “(5) See also section 4AA and Schedule AA1 which make provision for the authorisation of arrangements enabling the care and treatment of a person which would otherwise give rise to a deprivation of that person’s liberty.”
- (3) After that section insert—

“4AA Authorised arrangements: restriction of liability

- (1) This section applies where—
 - (a) arrangements enabling the care or treatment of a person (“the cared-for person”) are authorised in accordance with Schedule AA1, and
 - (b) another person carries out those arrangements.
- (2) No liability arises in relation to the carrying out of the arrangements if no liability would have arisen if the cared-for person—
 - (a) had had capacity to consent to the arrangements, and
 - (b) had consented.
- (3) Nothing in subsection (2) excludes a person’s civil liability for loss or damage, or a person’s criminal liability, resulting from the negligence of the person in carrying out the arrangements.

(4) See also paragraph 40(2) of Schedule AA1 (which makes provision about when arrangements are treated as authorised).”

(4) Before Schedule 1 insert the Schedule AA1 set out in Schedule 1 to this Act.

2 Deprivation of liberty necessary for life-sustaining treatment etc

(1) Section 4B of the Mental Capacity Act 2005 (deprivation of liberty necessary for life-sustaining treatment etc) is amended as follows.

(2) For subsections (1) and (2) substitute –

“(1) If the following conditions are met, D is authorised to take steps which deprive P of P’s liberty.

(2) The first condition is that D reasonably believes that P lacks capacity to consent to those steps being taken.

(2A) The second condition is that –

(a) a decision about whether D is authorised to deprive P of P’s liberty is being sought from a court,

(b) a responsible body is determining under Schedule AA1 whether to authorise arrangements which would give rise to a deprivation of P’s liberty (and it does not matter if the steps taken by D which deprive P of P’s liberty as mentioned in subsection (1) do not correspond to the arrangements which the responsible body is determining whether to authorise), or

(c) it is an emergency.

(2B) For the purposes of subsection (2A)(c) it is an “emergency” if D reasonably believes that –

(a) immediate steps need to be taken to prevent serious harm to P, and

(b) it is not reasonably practicable before taking those steps –

(i) to apply to a court for an order to authorise the deprivation of liberty,

(ii) to make an application for P to be detained under Part 2 of the Mental Health Act, or

(iii) to begin any other process to authorise the deprivation of liberty which would arise as a result of taking those steps.”

(3) In subsection (3) for “second” substitute “third”.

(4) In subsection (4) for “third” substitute “fourth”.

3 Restriction on power of attorneys and deputies

After section 29 of the Mental Capacity Act 2005 insert –

“29A Deprivation of liberty

Nothing in this Act authorises a donee of a lasting power of attorney or a deputy to consent on behalf of a person to arrangements which give rise to a deprivation of that person’s liberty.”

4 Rights of challenge

- (1) After section 21 of the Mental Capacity Act 2005 insert –

“Powers of the court in relation to Schedule AA1

21ZA Powers of court in relation to Schedule AA1

- (1) The court may determine any question relating to arrangements which are authorised, or which are proposed to be authorised, under Schedule AA1.
 - (2) If the court determines any question under subsection (1), the court may make an order –
 - (a) varying the arrangements or terminating the authorisation;
 - (b) directing the responsible body to vary the arrangements.
 - (3) Where the court makes an order under subsection (2) the court may make an order about a person’s liability for anything done in connection with the arrangements before the variation or the termination of the authorisation.
 - (4) An order under subsection (3) may, in particular, exclude a person from liability.”
- (2) In section 50(1A) of the Mental Capacity Act 2005, for “section 21A by the relevant person’s representative” substitute “section 21ZA by –
- (a) the appropriate person appointed for the cared-for person under paragraph 47 or 48 of Schedule AA1, or
 - (b) an independent mental capacity advocate appointed under section 38A to represent and support the cared-for person.”

5 Amendment of Coroners and Justice Act 2009

In section 48 of the Coroners and Justice Act 2009 (interpretation), after subsection (2) insert –

- “(2A) But a person is not in state detention if the compulsory detention mentioned in subsection (2) arises as a result of –
- (a) arrangements which are authorised under Schedule AA1 to the Mental Capacity Act 2005,
 - (b) steps being taken which are authorised by virtue of section 4B of that Act, or
 - (c) a provision of an order made under section 16 of that Act.”

Advance consent

6 Advance consent to certain arrangements

- (1) The Mental Capacity Act 2005 is amended as follows.

- (2) After section 26 insert –

“Advance consent to arrangements giving rise to a deprivation of liberty

26A Advance consent to certain arrangements

- (1) “Arrangements” means arrangements enabling the care or treatment of a person which, if the person did not consent to those arrangements, would give rise to a deprivation of that person’s liberty.
- (2) “Advance consent” means consent given by an eligible person to specified arrangements being put in place at a later time in respect of that person.
- (3) An “eligible person” is a person aged 16 or over who has capacity to give consent to the arrangements mentioned in subsection (2).
- (4) The Secretary of State may by regulations prescribe other requirements which must be met for consent to be advance consent for the purposes of this section, including –
 - (a) the form in which advance consent must be given, and
 - (b) the level of detail about the arrangements which must be provided in the consent.
- (5) Advance consent comes to an end –
 - (a) at the end of the period specified by the eligible person when giving the advance consent,
 - (b) if no period is specified, at the end of such period as is prescribed in relation to arrangements of that kind in regulations made by the Secretary of State,
 - (c) if it is withdrawn at a time when the eligible person has capacity to do so, or
 - (d) if the eligible person does anything else clearly inconsistent with the advance consent remaining the person’s fixed decision.
- (6) A withdrawal of an advance consent (including a partial withdrawal) need not be in writing.

26B Effect of advance consent

- (1) If arrangements are proposed or put in place in respect of a person at a time when that person lacks the capacity to consent to them, the person will be taken to have consented to the arrangements if –
 - (a) the person has given advance consent to those arrangements, and
 - (b) that advance consent is valid.
- (2) Accordingly, if subsection (1) applies in respect of arrangements, Schedule AA1 (arrangements for the care and treatment of persons who lack capacity) does not apply to those arrangements.
- (3) An advance consent is not valid if –
 - (a) it has come to an end, or
 - (b) there are reasonable grounds for believing that circumstances exist which the person did not anticipate at the time of giving

the advance consent and, if the person had anticipated them, would have affected the decision to give consent.

- (4) The court may make a declaration as to whether an advance consent—
 - (a) exists;
 - (b) is valid;
 - (c) has been given in respect of the particular arrangements which are proposed or have been put in place.
- (5) “Advance consent” and “arrangements” have the meaning given by section 26A.
- (3) In section 42 (codes of practice), in subsection (1), after paragraph (g) (but before the “and” following it) insert—
 - “(ga) with respect to the provisions of sections 26A and 26B (advance consent),”.

Unlawful deprivations of liberty

7 Unlawful deprivations of liberty

After section 4B of the Mental Capacity Act 2005 insert—

“4C Unlawful deprivation of liberty

- (1) This section applies where—
 - (a) arrangements are put in place by or on behalf of a private care provider enabling the care or treatment of a person,
 - (b) those arrangements give rise to a deprivation of that person’s liberty, and
 - (c) that deprivation of liberty is not authorised by—
 - (i) a provision of this Act,
 - (ii) a provision of Part 2 or 3 of the Mental Health Act, or
 - (iii) an order of a court.
- (2) The person may bring civil proceedings against the private care provider in relation to that deprivation of liberty.
- (3) It is a defence to a claim brought under subsection (2) that the private care provider reasonably believed that—
 - (a) the arrangements did not give rise to a deprivation of liberty, or
 - (b) the deprivation of liberty arising from the arrangements was authorised as mentioned in subsection (1)(c).
- (4) A “private care provider” means—
 - (a) a person registered, or required to be registered, under Chapter 2 of Part 1 of the Health and Social Care Act 2008 in respect of residential accommodation, together with nursing or personal care in relation to a care home;
 - (b) a person registered, or required to be registered, under Part 2 of the Care Standards Act 2000 in respect of a care home;
 - (c) a hospital manager of an independent hospital;

- (d) any other person prescribed for the purposes of this section by regulations made by the Secretary of State after consulting the Welsh Ministers.
- (5) A public authority for the purposes of section 6 of the Human Rights Act 1998 is not a private care provider for the purposes of this section.
- (6) In determining for the purposes of subsection (1)(c) whether a deprivation of liberty is authorised by a provision of this Act, the effect of paragraph 40(2) of Schedule AA1 is to be ignored.
- (7) In this section –
 - “care home” has the meaning given by section 3 of the Care Standards Act 2000;
 - “independent hospital” has the meaning given by paragraph 6(3) of Schedule AA1;
 - “hospital manager” has the meaning given by paragraph 8 of Schedule AA1.”

4D Section 4C: proceedings and remedies

- (1) Proceedings under section 4C may be brought in the county court or the High Court.
- (2) Alternatively, proceedings may be brought in the court if a decision as respects any other issue concerning the person bringing the proceedings is being sought from the court.
- (3) The proceedings must be brought before the end of –
 - (a) the period of one year beginning with the date on which the arrangements were first put in place, or
 - (b) such longer period as the court hearing the proceedings considers equitable having regard to all the circumstances.
- (4) In determining the amount of any award of damages on a claim under section 4C a court must take into account the principles applied by the European Court of Human Rights in relation to the award of compensation under Article 41 of the Human Rights Convention.”

Best interests

8 Best interests

- (1) Section 4(6) of the Mental Capacity Act 2005 (ascertaining a person’s wishes and feelings etc in order to determine best interests) is amended as follows.
- (2) For “consider, so far as is reasonably ascertainable”, substitute “ascertain, so far as is reasonably practicable”.
- (3) In paragraph (a) for “and, in particular,” substitute “in particular, by considering”.
- (4) In paragraph (c) –
 - (a) for “the” substitute “any”, and
 - (b) for “so.” substitute “so;
 and in making the determination must give particular weight to any wishes or feelings ascertained.”

*Acts connected with care or treatment***9 Restriction of defence under section 5 of the Mental Capacity Act 2005**

- (1) The Mental Capacity Act 2005 is amended as follows.
- (2) After section 6 insert –

“6A Section 5 acts: additional limitations

- (1) If D does an act pursuant to a relevant decision, it is not an act to which section 5 applies unless –
 - (a) before doing the act D prepares a written record containing the required information, or
 - (b) a written record has been prepared by someone else and D reasonably believes that that record contains the required information.
- (2) Subsection (1) applies only if D is acting in a professional capacity or for remuneration.
- (3) Subsection (1) does not apply to an act done pursuant to a relevant decision described in any of subsections (4) to (7) of section 6B if D reasonably believes that delaying doing the act in order to comply with the requirement in subsection (1) would result in serious harm to P.
- (4) See section 6B for the meaning of “relevant decision”.
- (5) See section 6C for the meaning of “required information”.

6B Section 6A: relevant decisions

- (1) Each of the following is a relevant decision for the purposes of section 6A.
- (2) A decision by a public authority to meet P’s care, support or health needs by arranging for P to move to accommodation of a kind prescribed by regulations made by the Secretary of State.
- (3) But a decision described in subsection (2) is not a relevant decision if the decision is for P to remain in the accommodation for 28 days or less.
- (4) A decision to prevent or restrict P’s contact with named individuals or a particular class of individuals.
- (5) A decision to provide or secure the provision of serious medical treatment to P.
- (6) A decision to administer treatment to P in a covert manner (whether by misrepresenting to P what is being administered or otherwise).
- (7) A decision to administer treatment to P which D knows, or reasonably suspects, to be against P’s wishes.
- (8) “Serious medical treatment” means treatment which involves providing, withholding or withdrawing treatment of a kind prescribed by regulations made by the Secretary of State.
- (9) The Secretary of State may amend this section by regulations to –

- (a) alter any of the descriptions of decisions which are relevant decisions;
 - (b) add to the descriptions of decisions which are relevant decisions.
- (10) Regulations made under subsection (9) may include such consequential amendments of sections 6A or 6C or this section as the Secretary of State considers necessary or expedient.
- (11) Before making regulations under subsection (2), (8) or (9) the Secretary of State must consult the Welsh Ministers.

6C Section 6A: required information

For the purposes of section 6A the “required information” is –

- (a) a description of the steps which have been taken to establish whether P lacks capacity in relation to the matter in question;
- (b) a description of the steps which have been taken to help P to make a decision in relation to the matter in question or an explanation as to why it was not practicable to take such steps;
- (c) an explanation of why it is believed that P lacks capacity in relation to the matter in question including –
 - (i) identification of the impairment or disturbance in the functioning of P’s mind or brain by reason of which it is believed P lacks capacity in relation to the matter, and
 - (ii) an explanation, by reference to the matters in paragraphs (a) to (d) of section 3, of why P is unable to make a decision in relation to the matter;
- (d) a description of the steps which have been taken to establish that it is in P’s best interests for the act to be done;
- (e) a description of anything ascertained pursuant to section 4(6) in relation to the matter in question and, if the relevant decision conflicts with anything ascertained, an explanation of the reason for making that decision;
- (f) where the act is pursuant to a relevant decision falling within section 6B(2), confirmation that any requirements which arise under any of sections 38, 38A and 39 in relation to that decision have been complied with;
- (g) where the act is pursuant to a relevant decision falling within section 6B(5), confirmation that any requirements which arise under section 37 in relation to that decision have been complied with;
- (h) where the act is pursuant to a relevant decision falling within section 6B(5), (6) or (7), confirmation that the act would not be contrary to an advance decision of P which has effect;
- (i) confirmation that any requirements which arise under section 67 of the Care Act 2014 in relation to a relevant decision have been complied with.”

Advocacy and representation

10 Appointment of independent mental capacity advocates

- (1) The Mental Capacity Act 2005 is amended as follows.

- (2) Omit sections 39A to 39E.
- (3) After section 38 insert—

“38A Arrangements under Schedule AA1

- (1) This section applies—
 - (a) if a responsible body proposes to authorise arrangements under Schedule AA1 in respect of a cared-for person (“the cared-for person”), and
 - (b) at any time when arrangements have been authorised under that Schedule in respect of the cared-for person.
- (2) If there is no appropriate person appointed for a cared-for person under paragraph 47 or 48 of Schedule AA1, the responsible body must appoint an independent mental capacity advocate to represent and support the cared-for person unless—
 - (a) the cared-for person has capacity to consent to being represented by an independent mental capacity advocate but does not so consent, or
 - (b) the cared-for person lacks capacity to consent to being so represented and the responsible body is satisfied that being represented by an independent mental capacity advocate would not be in the cared-for person’s best interests.
- (3) If an appropriate person is appointed for a cared-for person under paragraph 47 or 48 of Schedule AA1, the responsible body must appoint an independent mental capacity advocate to support the appropriate person unless the appropriate person does not consent.
- (4) In this section “responsible body” has the meaning given by paragraph 7 of Schedule AA1.”

11 Independent mental capacity advocates: functions

For section 36 of the Mental Capacity Act 2005 (functions of independent mental capacity advocates) substitute—

“36 Functions of independent mental capacity advocates

- (1) The appropriate authority may by regulations make provision about how an independent mental capacity advocate is to discharge the functions of representing or supporting.
- (2) Regulations under subsection (1) may include provision about—
 - (a) challenging, or providing assistance for the purpose of challenging, relevant decisions;
 - (b) facilitating a person’s involvement in relevant decisions.
- (3) “Relevant decisions” are—
 - (a) decisions under this Act that affect the person being represented or supported, or
 - (b) in a case where the independent mental capacity advocate is appointed to support an appropriate person (see section 38A), decisions under this Act which affect the person who the appropriate person is appointed to support.

- (4) In the case of an independent mental capacity advocate appointed under section 38A, regulations under subsection (1) may also include provision about how that independent mental capacity advocate is to –
 - (a) represent and support a person to enable the person to exercise relevant rights, or
 - (b) support an appropriate person to enable another person to exercise relevant rights.
- (5) “Relevant rights” are –
 - (a) the right to make an application to court, and
 - (b) the right to request a review under paragraph 38(2) of Schedule AA1 (arrangements enabling the care and treatment of persons who lack capacity).”

Supported decision-making

12 Supported decision-making

After section 63 of the Mental Capacity Act 2005 insert –

“Supported decision-making

63A Supported decision-making

- (1) The appropriate authority may, by regulations, establish a scheme (a “supported decision-making scheme”) to support persons in making decisions about their personal welfare or property and affairs (or both).
- (2) In order to be supported to make a decision under a supported decision-making scheme a person (a “decision-maker”) must –
 - (a) be aged 16 or over,
 - (b) have capacity to appoint a person to assist the decision-maker in making that decision, and
 - (c) meet such other requirements as to eligibility to participate in the supported decision-making scheme as are prescribed by regulations made under subsection (1).
- (3) In order to support another person to make a decision under a supported decision-making scheme a person (a “supporter”) must –
 - (a) be aged 16 or over, and
 - (b) meet such requirements as may be prescribed by regulations made under subsection (1).
- (4) Regulations under subsection (1) may –
 - (a) specify decisions relating to personal welfare or property and affairs which are not decisions to which a supported decision-making scheme may apply;
 - (b) make provision about how a decision-maker appoints a supporter and how an appointment may be varied or terminated;
 - (c) make provision for a decision-maker to appoint more than one supporter to assist the decision-maker in making decisions;
 - (d) make provision about the role of the supporter and how a supporter is to assist a decision-maker in making decisions;

- (e) prescribe standards which must be met by a supporter in acting as a supporter under a supported decision-making scheme;
 - (f) make provision for the monitoring of decisions taken with the assistance of a supporter under a supported decision-making scheme including provision for monitoring whether any standards prescribed pursuant to paragraph (e) have been met;
 - (g) make provision about how the costs associated with the establishment and use of a supported decision-making scheme are to be met.
- (5) The “appropriate authority” means –
- (a) in relation to a scheme in England, the Secretary of State, and
 - (b) in relation to a scheme in Wales, the Welsh Ministers.”

Supplemental

13 Regulations: procedure

- (1) Section 65 of the Mental Capacity Act 2005 (rules, regulations etc) is amended as follows.
- (2) In subsection (2), before paragraph (a) insert –
 - “(za) regulations under section 6B(9) (additional restrictions on when section 5 defence is available),
 - (zb) regulations under paragraph 8(3) of Schedule AA1 (changes to definition of “hospital manager”),”.
- (3) After subsection (2) insert –

“(2A) Any statutory instrument containing regulations made by the Welsh Ministers under this Act, other than a statutory instrument containing regulations under paragraph 8(3) of Schedule AA1, is subject to annulment in pursuance of a resolution of the National Assembly for Wales.”
- (4) In subsection (4), for “section 34 or 41” substitute “section 6B(9), 34 or 41 or paragraph 8(3) of Schedule AA1”.
- (5) After subsection (4) insert –

“(4AA) A statutory instrument containing regulations made by the Welsh Ministers under paragraph 8(3) of Schedule AA1 may not be made unless a draft has been laid before and approved by a resolution of the National Assembly for Wales.”
- (6) Omit subsections (4A) to (4C).

14 Consequential amendments etc

Schedule 2 makes minor and consequential amendments.

*Final***15 Extent, commencement and short title**

- (1) This Act extends to England and Wales only.
- (2) Sections 1 to 14 come into force on such day as the Secretary of State may by regulations made by statutory instrument appoint.
- (3) Regulations under subsection (2) may –
 - (a) appoint different days for different purposes or different areas;
 - (b) make consequential, transitional or saving provision.
- (4) This section comes into force on the day on which this Act is passed.
- (5) This Act may be cited as the Mental Capacity (Amendment) Act 2017.

SCHEDULES

SCHEDULE 1

Section 1(4)

SCHEDULE TO BE INSERTED AS SCHEDULE AA1 TO THE MENTAL CAPACITY ACT 2005

“SCHEDULE AA1

Section 4A(5)

ARRANGEMENTS ENABLING THE CARE AND TREATMENT OF PERSONS WHO LACK
CAPACITY

PART 1

INTRODUCTORY AND INTERPRETATION

Arrangements to which this Schedule applies

- 1 (1) This Schedule applies to arrangements –
 - (a) which are proposed or in place to enable the care or treatment of a person falling within sub-paragraph (2),
 - (b) which would give rise to a deprivation of that person’s liberty,
 - (c) which are not mental health arrangements (see paragraph 53), and
 - (d) which do not conflict with requirements arising under legislation relating to mental health (see paragraph 54).
- (2) A person falls within this sub-paragraph if the person –
 - (a) is aged 16 or over,
 - (b) lacks capacity to consent to the arrangements which are proposed or in place, and
 - (c) is of unsound mind.
- 2 (1) The arrangements to which this Schedule applies include –
 - (a) arrangements that a person is to reside in one or more particular places,
 - (b) arrangements that a person is to receive care or treatment at one or more particular places, and
 - (c) arrangements about the means by which and the manner in which a person can be transported to a particular place or between particular places.
- (2) In this Schedule “cared-for person” means the person who is, or will be, subject to arrangements to which this Schedule applies.

Definitions

- 3 Paragraphs 4 and 5 contain definitions for the purposes of this Schedule.
- 4 (1) In this Schedule –
- “appropriate person”, in relation to a cared-for person, means a person appointed to represent the cared-for person under paragraph 47 or 48;
 - “Approved Mental Capacity Professional” means a person approved as an Approved Mental Capacity Professional in accordance with paragraph 42;
 - “cared-for person” has the meaning given by paragraph 2(2);
 - “English responsible body” has the meaning given by paragraph 12;
 - “hospital” has the meaning given by paragraph 6;
 - “hospital manager” has the meaning given by paragraph 8;
 - “local authority” has the meaning given by paragraph 5;
 - “mental health arrangements” has the meaning given by paragraph 53;
 - “responsible body” has the meaning given by paragraph 7;
 - “specified”, apart from in paragraph 54, means specified in an authorisation record relating to a cared-for person;
 - “unsound mind” has the same meaning as in Article 5(1)(e) of the Human Rights Convention;
 - “Welsh responsible body” has the meaning given by paragraph 13.
- (2) References to “an authorisation” are to an authorisation of arrangements under this Schedule.
- (3) References to arrangements which conflict with requirements arising under legislation relating to mental health are to be interpreted in accordance with paragraph 54.
- 5 (1) “Local authority” means –
- (a) in England –
 - (i) the council of a county;
 - (ii) the council of a district for which there is no county council;
 - (iii) the council of a London borough;
 - (iv) the Common Council of the City of London;
 - (v) the Council of the Isles of Scilly;
 - (b) in Wales, the council of a county or county borough.
- (2) For the purposes of this Schedule the area of the Common Council of the City of London is to be treated as including the Inner Temple and the Middle Temple.

Meaning of hospital

- 6 (1) “Hospital” means an NHS hospital or an independent hospital.
- (2) “NHS hospital” means –

- (a) a health service hospital as defined by section 275 of the National Health Service Act 2006 or section 206 of the National Health Service (Wales) Act 2006, or
 - (b) a hospital as defined by section 206 of the National Health Service (Wales) Act 2006 vested in a Local Health Board.
- (3) “Independent hospital” –
- (a) in relation to England, means a hospital as defined by section 275 of the National Health Service Act 2006 that is not an NHS hospital, and
 - (b) in relation to Wales, means a hospital as defined by section 2 of the Care Standards Act 2000 that is not an NHS hospital.

Responsible body

- 7 The responsible body, in relation to a cared-for person, means –
- (a) if the arrangements or proposed arrangements are being, or will be, carried out primarily in a hospital, the hospital manager;
 - (b) if paragraph (a) does not apply and the arrangements or proposed arrangements are being, or will be, carried out primarily through the provision of NHS continuing health care under arrangements made by a clinical commissioning group or Local Health Board, that clinical commissioning group or Local Health Board;
 - (c) if neither paragraph (a) nor paragraph (b) applies, the responsible local authority (see paragraph 11).
- 8 (1) “Hospital manager” means –
- (a) if the hospital –
 - (i) is vested in the relevant national authority for the purposes of its functions under the National Health Service Act 2006 or the National Health Service (Wales) Act 2006, or
 - (ii) consists of any accommodation provided by a local authority and used as a hospital by or on behalf of the relevant national authority under either of those Acts,the Local Health Board or Special Health Authority responsible for the administration of the hospital;
 - (b) in relation to England, if the hospital falls within paragraph (a)(i) or (ii) and no Special Health Authority has responsibility for its administration, the Secretary of State;
 - (c) if the hospital is vested in an NHS trust or an NHS foundation trust, that trust;
 - (d) if the hospital is an independent hospital –
 - (i) in relation to England, the person registered, or required to be registered, under Chapter 2 of Part 1 of the Health and Social Care Act 2008 in respect of regulated activities (within the meaning of that Part) carried on in the hospital, or

- (ii) in relation to Wales, the person registered, or required to be registered, under Part 2 of the Care Standards Act 2000 in respect of the hospital;
- (e) if the hospital is an independent hospital and there is no person registered, or required to be registered, as described in sub-paragraphs (i) and (ii) of paragraph (d) –
 - (i) in relation to a hospital in England, the Secretary of State, or
 - (ii) in relation to a hospital in Wales, the Welsh Ministers.
- (2) For the purposes of sub-paragraph (1) the “relevant national authority” means –
 - (a) in relation to England, the Secretary of State;
 - (b) in relation to Wales, the Welsh Ministers;
 - (c) in relation to England and Wales, the Secretary of State and the Welsh Ministers acting jointly.
- (3) The definition of “hospital manager” in sub-paragraph (1) may, by regulations, be amended –
 - (a) in relation to England, by the Secretary of State, and
 - (b) in relation to Wales, by the Welsh Ministers.
- 9 In paragraph 7(b), “clinical commissioning group” means a body established under section 14D of the National Health Service Act 2006.
- 10 In paragraphs 7 and 8 “Local Health Board” means a Local Health Board established under section 11 of the National Health Service (Wales) Act 2006.
- 11 (1) In paragraph 7(c), “responsible local authority” means –
 - (a) if the cared-for person has needs for care and support which are being met under Part 1 of the Care Act 2014 or under Parts 4 or 6 of the Social Services and Well-being (Wales) Act 2014, the local authority meeting those needs,
 - (b) if the cared-for person is being provided with accommodation under section 20 of the Children Act 1989, the local authority –
 - (i) providing that accommodation, or
 - (ii) if the expense incurred in providing that accommodation can be recovered from another local authority, that other local authority,
 - (c) if the cared-for person is being provided with accommodation under Part 6 of the Social Services and Well-being (Wales) Act 2014, the local authority –
 - (i) providing that accommodation, or
 - (ii) if the expense incurred in providing that accommodation can be recovered from another local authority, that other local authority, or
 - (d) in any other case, the local authority determined in accordance with sub-paragraph (5).

- (2) If more than one local authority is meeting the needs of a cared-for person for care and support under Part 1 of the Care Act 2014 the responsible local authority is the local authority in which the cared-for person is ordinarily resident for the purposes of that Part of that Act.
- (3) If more than one local authority is meeting the needs for care and support of, or providing accommodation to, a cared-for person under the Social Services and Well-being (Wales) Act 2014, the responsible local authority is the local authority in which the cared-for person is ordinarily resident for the purposes of that Act.
- (4) If the cared-for person is having needs for care and support met or being provided with accommodation (or both) under more than one of the Acts mentioned in sub-paragraph (1), the responsible local authority is the local authority determined in accordance with sub-paragraph (5).
- (5) In the cases mentioned in sub-paragraph (1)(d) and (4), the “responsible local authority” is –
- (a) if the arrangements or proposed arrangements provide for the cared-for person to reside in one place, the local authority for the area in which that place is situated;
 - (b) if the arrangements or proposed arrangements provide for the cared-for person to reside in more than one place, the local authority for the area in which the place of primary residence is situated;
 - (c) in any other case, the local authority for the area in which the arrangements or proposed arrangements are primarily being, or will primarily be, carried out.
- (6) If a building is situated in the areas of two or more local authorities, it is to be regarded for the purposes of sub-paragraph (5) as situated in whichever of the areas the greater (or greatest) part of the building is situated.
- 12 For the purposes of this Schedule, each of the following is an English responsible body –
- (a) a hospital manager of a health service hospital as defined by section 275 of the National Health Service Act 2006;
 - (b) a hospital manager of an independent hospital in England;
 - (c) a clinical commissioning group established under section 14D of that Act;
 - (d) a local authority in England.
- 13 For the purposes of this Schedule, each of the following is a Welsh responsible body –
- (a) a hospital manager of –
 - (i) a health service hospital as defined by section 206 of the National Health Service (Wales) Act 2006;
 - (ii) an independent hospital in Wales;
 - (iii) a hospital as defined by section 206 of that Act vested in a Local Health Board;
 - (iv) a hospital as defined by section 2 of the Care Standards Act 2000 that is not an NHS hospital;

- (b) a Local Health Board established under section 11 of the National Health Service (Wales) Act 2006;
- (c) a local authority in Wales.

PART 2

AUTHORISATION OF ARRANGEMENTS

Authorisation of arrangements: conditions

- 14 The responsible body may authorise arrangements if –
- (a) an assessment (a “capacity assessment”) has been carried out in respect of the cared-for person which confirms that the person lacks the capacity to consent to the arrangements which are proposed or in place (see paragraph 17),
 - (b) an assessment (a “medical assessment”) has been carried out in respect of the cared-for person which confirms that the person is of unsound mind (see paragraph 17),
 - (c) the necessary and proportionate condition is met (see paragraph 21),
 - (d) any consultation required by paragraph 22 has been carried out,
 - (e) an independent review has been carried out (see paragraph 23) and the person carrying it out has either –
 - (i) confirmed that it is reasonable for the responsible body to conclude that the conditions in paragraphs (a) to (d) are met, or
 - (ii) referred the case to an Approved Mental Capacity Professional, and
 - (f) in cases which are referred to an Approved Mental Capacity Professional, the approval of the Approved Mental Capacity Professional has been obtained (see paragraph 26).
- 15 The responsible body may not authorise arrangements which provide for the cared-for person to reside in, or to receive care or treatment at, a particular place if there is a valid decision of –
- (a) a donee of a lasting power of attorney granted by the cared-for person, or
 - (b) a deputy appointed for the cared-for person by the court, that the cared-for person should not reside in, or (as the case may be) receive care or treatment at, that place.
- 16 Paragraphs 17 to 29 contain further provision about the matters in paragraphs (a) to (f) of paragraph 14.

Capacity and medical assessments

- 17 (1) A responsible body may rely on –
- (a) a capacity assessment for the purpose of paragraph 14(a),
or
 - (b) a medical assessment for the purpose of paragraph 14(b),

- only if the assessment was carried out by a person who met such requirements as are prescribed in relation to an assessment of that kind in regulations made by the appropriate authority.
- (2) The “appropriate authority” means –
- (a) where the assessment is relied on by an English responsible body, the Secretary of State, and
 - (b) where the assessment is relied on by a Welsh responsible body, the Welsh Ministers.
- 18 (1) The responsible body may rely on an assessment carried out –
- (a) for the purpose of determining whether to authorise any arrangements under this Schedule on a previous occasion, or
 - (b) for any other purpose,
- provided it is reasonable to do so.
- (2) In deciding whether it is reasonable to rely on an assessment the responsible body must have regard to –
- (a) the length of time that has elapsed since that assessment was carried out;
 - (b) the purpose for which that assessment was carried out;
 - (c) whether there has been any significant change in the cared-for person’s condition since that assessment was carried out which is likely to affect either of the matters in paragraph 1(2)(b) or (c).
- 19 The same person may provide the capacity assessment and the medical assessment (but see paragraph 29).
- 20 A capacity assessment which is carried out for the purpose of authorising arrangements under this Schedule must state –
- (a) whether the capacity of the cared-for person to consent to arrangements which are proposed or in place is likely to fluctuate, and
 - (b) if so, the likely duration of any periods during which the cared-for person is likely to have capacity to consent to those arrangements.

Necessary and proportionate

- 21 (1) The necessary and proportionate condition is met if an assessment by a person described in sub-paragraph (2) determines that the arrangements are necessary and proportionate having regard to either or both of the matters in sub-paragraph (3).
- (2) The person mentioned in sub-paragraph (1) is a person who appears to the responsible body to have appropriate experience and knowledge to determine the matter in question.
- (3) The matters are –
- (a) the likelihood of harm to the cared-for person if the arrangements were not in place and the seriousness of that harm, and

- (b) the likelihood of harm to other individuals if the arrangements were not in place and the seriousness of that harm.
- (4) A person proposing to conclude that the arrangements are necessary and proportionate wholly or mainly in reliance on the matter set out in sub-paragraph (3)(b) must consider whether it would be more appropriate for an application to be made for the cared-for person to be admitted to hospital for assessment or treatment under section 2 or 3 of the Mental Health Act 1983.
- (5) If the same person provides the capacity assessment and the medical assessment that person may not provide the assessment for the purposes of this paragraph (see also paragraph 29).

Consultation

- 22 (1) The responsible body must consult –
- (a) anyone named by the cared-for person as someone to be consulted about arrangements of the kind which are proposed or in place,
 - (b) anyone engaged in caring for the cared-for person or interested in the cared-for person’s welfare,
 - (c) any donee of a lasting power of attorney or an enduring power of attorney (within the meaning of Schedule 4) granted by the cared-for person,
 - (d) any deputy appointed for the cared-for person by the court, and
 - (e) any appropriate person or independent mental capacity advocate appointed in respect of the cared-for person (see paragraphs 47 and 48 and section 38A).
- (2) The responsible body must also consult –
- (a) in the case of a cared-for person aged 16 or 17, anyone with parental responsibility (within the meaning of the Children Act 1989) for that person, and
 - (b) in the case of a cared-for person aged 16 or 17 who is being looked after by a local authority (within the meaning of section 22 of the Children Act 1989 or section 74 of the Social Services and Well-being (Wales) Act 2014), the local authority concerned.
- (3) The main purpose of the consultation required by sub-paragraphs (1) and (2) is to try to ascertain the cared-for person’s wishes or feelings in relation to the arrangements which are proposed or in place.
- (4) If it is not practicable or appropriate to consult a particular person falling within sub-paragraph (1) or (2) the duty to consult that person does not apply.

Independent review

- 23 (1) An independent review for the purposes of paragraph 14(e) may not be carried out by a person who is involved in the day-to-day care of, or providing any treatment to, the cared-for person.

- (2) If the person carrying out the independent review determines that a case falls within paragraph 24, the person must refer that case to an Approved Mental Capacity Professional.
 - (3) The person carrying out the independent review may refer a case not falling within paragraph 24 to an Approved Mental Capacity Professional if –
 - (a) the person considers that the case is one which is appropriate to be considered by the Approved Mental Capacity Professional, and
 - (b) the Approved Mental Capacity Professional agrees to accept the referral.
 - (4) If a case is not referred to an Approved Mental Capacity Professional, the person carrying out the independent review must review the information on which the responsible body has relied in order to determine whether it is reasonable for the responsible body to conclude that the conditions in paragraph 14(a) to (d) are met.
 - (5) The person carrying out the independent review must –
 - (a) give the responsible body written notice of the result of the review, or
 - (b) notify the responsible body in writing if the case has been referred to an Approved Mental Capacity Professional.
- 24 (1) The following cases must be referred to an Approved Mental Capacity Professional.
- (2) The first case is where –
 - (a) the arrangements which are proposed or in place provide for the cared-for person to reside in, or to receive care or treatment at, a particular place, and
 - (b) it is reasonable to believe that –
 - (i) where the arrangements provide for the cared-for person to reside in a particular place, the cared-for person does not wish to reside in that place, or
 - (ii) where the arrangements provide for the cared-for person to receive care or treatment at a particular place, the cared-for person does not wish to receive care or treatment at that place.
 - (3) The second case is where the person who carries out the assessment under paragraph 21 determines that the arrangements are necessary and proportionate wholly or mainly for the reason set out in paragraph 21(3)(b).
- 25 (1) In determining whether the cared-for person wishes to reside in, or receive care or treatment at, a particular place the person carrying out the independent review must consider all the circumstances so far as they are reasonably ascertainable, including the cared-for person's behaviour, wishes, feelings, views, beliefs and values.
- (2) But circumstances from the past are to be considered only so far as it is still appropriate to consider them.

- (3) In determining whether the cared-for person's wishes are ascertainable the person carrying out the independent review may take into account any views about the cared for person's wishes which are expressed by a person consulted pursuant to paragraph 22.

Approval by an Approved Mental Capacity Professional

- 26 (1) Where a case is referred to an Approved Mental Capacity Professional, if the Approved Mental Capacity Professional determines that the conditions in paragraphs (a) to (d) of paragraph 14 are met, the Approved Mental Capacity Professional must approve the arrangements.
- (2) The approval must be notified in writing to the responsible body.
- (3) An approval for the purposes of paragraph 14(f) may not be given by a person who is involved in the day-to-day care of, or providing any treatment to, the cared-for person.
- 27 If the Approved Mental Capacity Professional determines that the conditions in paragraphs (a) to (d) of paragraph 14 are not met, the Approved Mental Capacity Professional must give the responsible body written notice –
- (a) stating that the arrangements have not been approved,
 - (b) giving the reasons why they have not been approved, and
 - (c) describing any steps the responsible body can take in order to obtain approval.
- 28 (1) In order to make the determination described in paragraph 26 or 27 the Approved Mental Capacity Professional must –
- (a) review the information on which the responsible body has relied in concluding that the conditions mentioned in the paragraph concerned are met, and
 - (b) meet with the cared-for person, unless it is not practicable or appropriate to do so.
- (2) In making the determination the Approved Mental Capacity Professional may –
- (a) consult any person mentioned in paragraphs (a) to (e) of paragraph 22(1) or paragraphs (a) and (b) of paragraph 22(2), and
 - (b) take such further steps (including obtaining information or making further enquiries) as the Approved Mental Capacity Professional considers appropriate in order to determine whether or not the conditions in paragraphs (a) to (d) of paragraph 14 are met.

Assessments: requirement of independent person

- 29 (1) If all of the relevant assessments are provided by two persons those persons must be independent from each other.
- (2) If the relevant assessments are provided by more than two persons at least two of those persons must be independent from each other.

- (3) Each of the following is a relevant assessment –
- (a) the capacity assessment;
 - (b) the medical assessment;
 - (c) the assessment for the purposes of paragraph 21 (the necessary and proportionate condition).

PART 3

AUTHORISATION RECORD

- 30 If a responsible body authorises arrangements it must –
- (a) produce an authorisation record relating to the cared-for person, or
 - (b) if an authorisation record already exists in relation to the cared-for person, revise that record.
- 31 An authorisation record must –
- (a) specify the arrangements which are authorised and the date or dates from which they are authorised;
 - (b) explain why the conditions in paragraphs (a) to (f) of paragraph 14 have been met;
 - (c) if the capacity assessment obtained in respect of the cared-for person states that the person’s capacity to consent to arrangements is likely to fluctuate (see paragraph 20), specify that fact;
 - (d) confirm that paragraph 15 does not apply in respect of any of the arrangements;
 - (e) specify the date or dates on which the authorisation of the arrangements will come to an end pursuant to whichever is relevant of paragraphs (a) to (d) of paragraph 35(1);
 - (f) set out the responsible body’s proposals for reviewing the authorisation of the arrangements;
 - (g) state that the arrangements are not mental health arrangements;
 - (h) explain why the responsible body is of the view that the arrangements do not conflict with requirements arising under legislation relating to mental health;
 - (i) identify any appropriate person or independent mental capacity advocate appointed in respect of the person (see paragraphs 47 and 48 and section 38A).
- 32 The responsible body must revise an authorisation record if there is any change to any of the matters mentioned in paragraphs (a) to (i) of paragraph 31.
- 33 The responsible body must, as soon as reasonably practicable, give a copy of the authorisation record, and any revision of it, to –
- (a) the cared-for person to whom it relates,
 - (b) any person the responsible body consulted pursuant to paragraph 14(d) in determining whether to authorise the arrangements, and
 - (c) any other person mentioned in paragraphs (a) to (e) of paragraph 22(1) or paragraphs (a) and (b) of paragraph

22(2) who the responsible body considers ought to receive a copy.

PART 4

AUTHORISATION: DURATION, REVIEW AND SUSPENSION

Duration and cessation

- 34 An authorisation has effect –
- (a) immediately on the responsible body determining that the conditions for authorisation are met (see paragraph 14), or
 - (b) from such later date as is specified by the responsible body, being no later than 28 days from the day the responsible body made the determination mentioned in paragraph (a).
- 35 (1) An authorisation ceases to have effect –
- (a) at the end of the period of 12 months beginning with the day it first had effect,
 - (b) at the end of such shorter period determined by the responsible body at the time it determines that the conditions for authorisation are met,
 - (c) on such earlier date than the date given by paragraph (a) as the responsible body may from time to time determine,
 - (d) if the authorisation is renewed in accordance with paragraph 37, at the end of the renewal period, or
 - (e) when a suspension comes to an end as described in paragraph 41(2)(b).
- (2) An authorisation also ceases to have effect if, at any time, the responsible body believes or ought reasonably to suspect –
- (a) that the cared-for person has, or has regained, capacity to consent to the arrangements which are authorised,
 - (b) that the cared-for person is no longer of unsound mind, or
 - (c) that the arrangements are no longer necessary and proportionate.
- (3) But an authorisation does not cease to have effect for the reason described in sub-paragraph (2)(a) if –
- (a) the capacity assessment which was relied on in determining that the condition in paragraph 14(a) is met states –
 - (i) that the cared-for person’s capacity to consent to arrangements is likely to fluctuate, and
 - (ii) that any periods during which the person is likely to have capacity to consent is likely to last only for a short period of time, and
 - (b) the responsible body reasonably believes that the gaining or regaining of capacity will last only for a short period of time.
- (4) In a case where –

- (a) an authorisation relates to arrangements which provide for the cared-for person to reside in, or to receive care or treatment at, a specified place, and
 - (b) at any time, the responsible body believes or ought reasonably to suspect that there is a conflicting decision about the cared-for person residing in, or receiving care or treatment at, that place,
- the authorisation ceases to have effect in so far as it relates to those arrangements.
- (5) There is a conflicting decision for the purposes of sub-paragraph (4)(b) if there is a valid decision of –
 - (a) a donee of a lasting power of attorney granted by the cared-for person, or
 - (b) a deputy appointed for the cared-for person by the court, that the cared-for person should not reside in, or (as the case may be) receive care or treatment at, the specified place.
 - (6) If at any time an authorisation relates to arrangements which conflict with requirements arising under legislation relating to mental health, the authorisation ceases to have effect in so far as it relates to those arrangements.

Notification that arrangements have ceased to have effect

- 36 If an authorisation of arrangements –
- (a) ceases to have effect (in whole or in part) for any of the reasons in paragraph 35(2), (4) or (6), or
 - (b) is suspended in accordance with paragraph 41(1),
- the responsible body must take such steps as are reasonable to notify any person who is likely to be carrying out those arrangements that the arrangements are no longer authorised.

Renewal

- 37 (1) If the conditions in sub-paragraphs (3) and (4) are met, the responsible body may renew an authorisation on one or more occasions for a period (“the renewal period”) of –
- (a) 12 months or less, on the first renewal, and
 - (b) 3 years or less, on any subsequent renewal.
- (2) The renewal period begins with the day the responsible body determines it should be renewed.
- (3) The condition in this sub-paragraph is that the responsible body reasonably believes –
- (a) that the cared-for person continues to lack capacity to consent to the arrangements which are authorised,
 - (b) that the cared-for person continues to be of unsound mind,
 - (c) that the arrangements continue to be necessary and proportionate, and
 - (d) that it is unlikely that there will be any significant change in the cared-for person’s condition during the renewal

period which would affect any of the matters in paragraphs (a) to (c).

- (4) The condition in this sub-paragraph is that, in a case which is referred to an Approved Mental Capacity Professional under sub-paragraph (5), the Approved Mental Capacity Professional determines that, at that time, the conditions in paragraphs (a) to (c) of paragraph 14 are met in relation to the cared-for person.
- (5) A case must be referred to an Approved Mental Capacity Professional if –
 - (a) the reason the responsible body believes that the arrangements continue to be necessary and proportionate is wholly or mainly due to the matter in paragraph 21(3)(b), and
 - (b) the authorisation of those arrangements was not approved by an Approved Mental Capacity Professional.
- (6) In making the determination described in sub-paragraph (4), the Approved Mental Capacity Professional –
 - (a) must meet with the cared-for person, unless it is not practicable or appropriate to do so,
 - (b) may consult any person mentioned in paragraphs (a) to (e) of paragraph 22(1) or paragraphs (a) and (b) of paragraph 22(2), and
 - (c) may take such further steps (including requiring information or making further enquiries) as the Approved Mental Capacity Professional considers appropriate in order to determine whether or not the conditions in paragraphs (a) to (c) of paragraph 14 are met.
- (7) Sub-paragraph (8) applies in a case where the capacity assessment which was relied on in determining that the condition in paragraph 14(a) is met states –
 - (a) that the cared-for person’s capacity to consent to arrangements is likely to fluctuate, and
 - (b) that any periods during which the person is likely to have capacity to consent to those arrangements is likely to last only for a short period of time.
- (8) If the only reason the condition in sub-paragraph (3) is not met is because the responsible body believes that the person has, or has regained, capacity, the condition is to be treated as met if the responsible body reasonably believes that the gaining or regaining of capacity will last only for a short period of time.
- (9) An authorisation which has ceased to have effect cannot be renewed in accordance with this paragraph.

Reviews

- 38 (1) A responsible body must keep an authorisation under review.
- (2) A responsible body must also review an authorisation –
 - (a) on a reasonable request by a person with an interest in the arrangements which are authorised;

- (b) if the cared-for person to whom it relates becomes subject to mental health arrangements;
 - (c) if the cared-for person to whom it relates becomes subject to any conditions or requirements arising under the Mental Health Act or under any enactment prescribed for the purposes of this Schedule under paragraph 54(1)(g);
 - (d) if it becomes aware of a significant change in the cared-for person's condition or circumstances.
- (3) Sub-paragraph (4) applies in a case where –
- (a) arrangements have been authorised which provide for a cared-for person to reside in, or to receive care or treatment at, a specified place,
 - (b) the responsible body becomes aware that –
 - (i) where the arrangements provide for the cared-for person to reside in a specified place, the cared-for person does not wish to reside in that place, or
 - (ii) where the arrangements provide for the cared-for person to receive care or treatment at a specified place, the cared-for person does not wish to receive care or treatment at that place, and
 - (c) the authorisation of those arrangements was not approved by an Approved Mental Capacity Professional.
- (4) The responsible body must refer the case to an Approved Mental Capacity Professional.
- (5) In determining whether the cared-for person wishes to reside in, or receive care or treatment at, a specified place the responsible body must consider all the circumstances so far as they are reasonably ascertainable, including the cared-for person's behaviour, wishes, feelings, views, beliefs and values.
- (6) But circumstances from the past are to be considered only so far as it is still appropriate to consider them.
- 39 (1) Where a case is referred to an Approved Mental Capacity Professional under paragraph 38(4) the Approved Mental Capacity Professional must –
- (a) review the authorisation, and
 - (b) determine whether, at that time, the conditions in paragraphs (a) to (c) of paragraph 14 are met in relation to the cared-for person.
- (2) In making the determination described in sub-paragraph (1)(b), the Approved Mental Capacity Professional –
- (a) must meet with the cared-for person, unless it is not practicable to do so,
 - (b) may consult any person mentioned in paragraphs (a) to (e) of paragraph 22(1) or paragraphs (a) and (b) of paragraph 22(2), and
 - (c) may take such further steps (including requiring information or making further enquiries) as the Approved Mental Capacity Professional considers appropriate in

order to determine whether or not the conditions in paragraphs (a) to (c) of paragraph 14 are met.

Authorisation coming to an end early: arrangements to be treated as authorised

- 40 (1) This paragraph applies if an authorisation of arrangements –
- (a) ceases to have effect (in whole or in part) for any of the reasons in paragraph 35(2), (4) or (6), or
 - (b) is suspended in accordance with paragraph 41(1).
- (2) For the purposes of section 4AA (authorised arrangements: restriction of liability) the arrangements are to be treated as authorised in accordance with this Schedule unless the person carrying out the arrangements knew or ought to have known that –
- (a) the arrangements were no longer authorised or the authorisation was suspended,
 - (b) any of the circumstances in paragraphs (a) to (c) of paragraph 35(2) had arisen,
 - (c) the arrangements conflicted with requirements arising under legislation relating to mental health, or
 - (d) if the arrangements provided for the cared-for person to reside in, or to receive care or treatment at, a specified place, there was a conflicting decision about the cared-for person residing in, or (as the case may be) receiving care or treatment at, that place.
- (3) In sub-paragraph (2) “conflicting decision” has the same meaning as in paragraph 35(4).

Suspension

- 41 (1) An authorisation is suspended if the cared-for person to whom it relates is admitted to hospital pursuant to Part 2 or section 131 of the Mental Health Act.
- (2) A suspension of an authorisation comes to an end on the earlier of –
- (a) the cared-for person’s discharge from hospital, or
 - (b) the end of the period of 28 days beginning with the day on which the cared-for person was admitted to hospital.
- (3) While an authorisation is suspended the arrangements to which it relates are treated as no longer authorised (but see sub-paragraph (5)).
- (4) If a suspension of an authorisation comes to an end for the reason mentioned in sub-paragraph (2)(b), the authorisation of the arrangements to which it relates ceases to have effect.
- (5) A suspension of an authorisation is to be ignored for the purposes of paragraph 37(9).

PART 5

APPROVED MENTAL CAPACITY PROFESSIONALS

Duty of local authority to approve Approved Mental Capacity Professionals

- 42 Each local authority must make arrangements –
- (a) for the approval of persons to act on its behalf as Approved Mental Capacity Professionals for the purposes of this Act,
 - (b) for the appointment of an individual to manage the conduct and performance of persons approved as Approved Mental Capacity Professionals, and
 - (c) to ensure that there are sufficient numbers of persons approved as Approved Mental Capacity Professionals for its area for the purposes of this Schedule.
- 43 The person appointed under paragraph 42(b) must report to –
- (a) the director of adult social services for the local authority that made the appointment, or
 - (b) the director of social services for the local authority that made the appointment.
- 44 A local authority may only approve a person to act as an Approved Mental Capacity Professional if the person meets the requirements prescribed in regulations made by the appropriate authority (see paragraph 45).

Approved Mental Capacity Professionals: requirements

- 45 (1) The appropriate authority may by regulations –
- (a) prescribe the criteria which must be met for a person to be eligible for approval as an Approved Mental Capacity Professional;
 - (b) prescribe matters which a local authority must or may take into account when deciding whether to approve a person as an Approved Mental Capacity Professional;
 - (c) provide for a prescribed body to approve courses for persons who are, or who wish to become, Approved Mental Capacity Professionals;
 - (d) prescribe the period for which a person may be approved as an Approved Mental Capacity Professional;
 - (e) prescribe any conditions which must be met (or continue to be met) for a person to act (or continue to act) as an Approved Mental Capacity Professional;
 - (f) prescribe the circumstances in which and the manner in which a person's approval as an Approved Mental Capacity Professional may be suspended or terminated.
- (2) Regulations under sub-paragraph (1)(a) may include criteria relating to qualifications, training or experience.
- (3) Regulations under sub-paragraph (1) which contain provision described in paragraph (f) must include provision conferring rights of appeal from decisions to suspend or terminate approval as an Approved Mental Capacity Professional.

- (4) The “appropriate authority” means –
- (a) where the Approved Mental Capacity Professional is to be approved to act on behalf of a local authority whose area is in England, the Secretary of State, and
 - (b) where the Approved Mental Capacity Professional is to be approved to act on behalf of a local authority whose area is in Wales, the Welsh Ministers.

Referral to an Approved Mental Capacity Professional

- 46 (1) Where this Schedule provides for a case to be referred to an Approved Mental Capacity Professional the referral is to be made to an Approved Mental Capacity Professional approved by the responsible local authority.
- (2) The “responsible local authority” has the meaning given by paragraph 11 (and for this purpose references in paragraph 11 to the cared-for person means the cared-for person to whom the referral to the Approved Mental Capacity Professional relates).

PART 6

APPROPRIATE PERSONS TO REPRESENT CARED-FOR PERSONS

- 47 (1) If a responsible body proposes to authorise arrangements under this Schedule in respect of a cared-for person, the responsible body must determine whether there is a person –
- (a) who would be an appropriate person to represent and support the cared-for person on matters arising under this Schedule that affect the cared-for person, and
 - (b) who is not engaged in providing care or treatment for the cared-for person in a professional capacity or for remuneration.
- (2) If the responsible body determines that there is a person meeting the description in paragraph (1), the responsible body must appoint that person to represent and support the cared-for person on matters arising under this Schedule, unless –
- (a) the person does not consent to being so appointed,
 - (b) the cared-for person has capacity to consent to being represented and supported by that person but the cared-for person does not so consent, or
 - (c) the cared-for person lacks capacity to consent to being represented and supported by that person and the responsible body is satisfied that being so represented and supported would not be in the cared-for person’s best interests.
- 48 (1) This paragraph applies at any time when –
- (a) arrangements are authorised under this Schedule in respect of a cared-for person,
 - (b) there is no appropriate person appointed for the cared-for person under paragraph 47 or this paragraph, and

- (c) any appointment of an independent mental capacity advocate for the cared-for person under section 38A(2) has ceased to have effect.
 - (2) If the responsible body determines that there is, at that time, a person meeting the description in paragraph 47(1) to represent and support the cared-for person on matters arising under this Schedule, the responsible body must appoint that person to represent and support the cared-for person on those matters unless –
 - (a) the person does not consent to being so appointed,
 - (b) the cared-for person has capacity to consent to being represented and supported by that person but the cared-for person does not so consent, or
 - (c) the cared-for person lacks capacity to consent to being represented and supported by that person and the responsible body is satisfied that being so represented and supported would not be in the cared-for person’s best interests.
- 49 (1) The function of an appropriate person is to represent and support the cared-for person in matters arising under this Schedule that affect the cared-for person.
- (2) The appropriate authority may by regulations make further provision about how that function is to be discharged, including provision about –
 - (a) challenging, or providing assistance for the purpose of challenging, any decision on matters arising under this Schedule;
 - (b) facilitating the cared-for person’s involvement in those decisions;
 - (c) enabling the cared-for person to exercise the right to make an application to court and the right to request a review under paragraph 38(2).
- (3) “Appropriate authority” means –
 - (a) the Secretary of State, where the responsible body in relation to the relevant cared-for person is an English responsible body, and
 - (b) the Welsh Ministers, where the responsible body in relation to the relevant cared-for person is a Welsh responsible body.
- 50 (1) The appropriate authority may make regulations as to the appointment of appropriate persons.
- (2) The regulations may include provision –
 - (a) that a person may act as an appropriate person only in such circumstances, or only subject to such conditions, as may be prescribed;
 - (b) for the appointment of a person as an appropriate person to be subject to approval in accordance with the regulations.
- (3) “Appropriate authority” has the same meaning as in paragraph 49.

PART 7

MONITORING AND REPORTING

- 51 (1) The appropriate authority may by regulations make provision for, and in connection with, requiring one or more prescribed bodies to monitor, and report on, the operation of this Schedule.
- (2) The regulations may include provision giving a prescribed body authority to –
- (a) visit any place where arrangements authorised under this Schedule are being, or will be, carried out, and
 - (b) meet with cared-for persons.
- (3) The regulations may also include provision requiring any of the following to disclose prescribed information to a prescribed body –
- (a) a person who is, or who has at any time been, a responsible body;
 - (b) any person responsible for the delivery of care or treatment pursuant to arrangements which are authorised under this Schedule.
- (4) The “appropriate authority” means –
- (a) in relation to the operation of this Schedule in relation to England, the Secretary of State, and
 - (b) in relation to the operation of this Schedule in relation to Wales, the Welsh Ministers.
- 52 (1) A responsible body must notify the relevant prescribed body if it authorises arrangements under this Schedule.
- (2) The “relevant prescribed body” is the body which has been prescribed in relation to the responsible body in regulations made under paragraph 51.

PART 8

ARRANGEMENTS RELATING TO MENTAL HEALTH

Mental health arrangements

- 53 (1) For the purposes of this Schedule, “mental health arrangements” are arrangements carried out in hospital for the purpose of –
- (a) assessing mental disorder within the meaning of section 1(2) of the Mental Health Act, or
 - (b) subject to sub-paragraph (2), providing medical treatment for such mental disorder.
- (2) Arrangements carried out in hospital for the purpose of providing medical treatment for mental disorder by reason of learning disability which is not associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned are not mental health arrangements for the purposes of this Schedule (and, as a result, are arrangements to which this Schedule applies).

- (3) In this paragraph—
“learning disability” has the same meaning as in section 1(4) of the Mental Health Act;
“medical treatment” has the same meaning as in that Act.

Arrangements conflicting with requirements arising under legislation relating to mental health

- 54 (1) For the purposes of this Schedule arrangements conflict with requirements arising under legislation relating to mental health if they are inconsistent with any of the following—
- (a) a requirement imposed in respect of a person by a guardian exercising the power under section 8 of the Mental Health Act;
 - (b) a condition or direction imposed or given in respect of a person by a responsible clinician exercising the power under section 17 of the Mental Health Act (leave of absence from hospital);
 - (c) a condition specified by a responsible clinician in a community treatment order made in respect of a person under section 17A of the Mental Health Act (for the imposition of conditions, see section 17B of that Act);
 - (d) a requirement imposed by a guardian in respect of a person who is the subject of a guardianship order under section 37 of the Mental Health Act (see section 40 of and Part 1 of Schedule 1 to that Act);
 - (e) a condition imposed by the Secretary of State on the discharge from hospital of a person subject to a restriction order under section 42 of the Mental Health Act;
 - (f) a condition imposed by any of the persons or bodies listed in sub-paragraph (2) when a person is conditionally discharged under section 73 of the Mental Health Act;
 - (g) a condition or requirement arising by virtue of any other enactment prescribed by regulations made by the Secretary of State for the purposes of this Schedule.
- (2) The persons or bodies are—
- (a) the First-tier Tribunal;
 - (b) Mental Health Review Tribunal for Wales;
 - (c) the Secretary of State;
 - (d) the Welsh Ministers.
- (3) In this paragraph “enactment” includes an Act of the Scottish Parliament and any subordinate legislation under such an Act.

SCHEDULE 2

Section 1(5)

MINOR AND CONSEQUENTIAL AMENDMENTS

- 1 The Mental Capacity Act 2005 is amended as follows.
- 2 Omit—

-
- (a) section 16A;
 - (b) section 21A and the italic heading before it;
 - (c) Schedules A1 and 1A.
- 3 In section 35(1) (appointment of independent mental capacity advocates), for “available to” to the end substitute “available to –
- (a) represent and support persons to whom acts or decisions proposed under sections 37, 38 and 39 relate,
 - (b) represent and support cared-for persons for whom a responsible body must appoint an independent mental capacity advocate as a result of section 38A(2), and
 - (c) support appropriate persons for whom a responsible body must appoint an independent mental capacity advocate as a result of section 38A(3).”
- 4 In section 37(3) (provision of serious medical treatment), after “represent” insert “and support”.
- 5 (1) Section 38 (provision of accommodation by NHS body) is amended as follows.
- (2) In subsection (2A) –
- (a) in paragraph (a) –
 - (i) for “section 39A or 39C” substitute “section 38A”, and
 - (ii) after “represent” insert “and support”, and
 - (b) for paragraph (b) substitute –
 - “(b) the arrangements which are authorised or proposed under Schedule AA1 in respect of P include arrangements for P to be accommodated in the hospital or care home referred to in this section.”
- (3) In subsection (3), after “represent” insert “and support”.
- (4) In subsection (4), after “represent”, in both places, insert “and support”.
- (5) Omit subsection (10).
- 6 (1) Section 39 (provision of accommodation by local authority) is amended as follows.
- (2) For subsections (1A) to (2) substitute –
- “(2A) But this section applies only if accommodation is to be provided in accordance with section 117 of the Mental Health Act.”
- (3) In subsection (3A) –
- (a) in paragraph (a) –
 - (i) for “section 39A or 39C” substitute “section 38A”, and
 - (ii) after “represent” insert “and support”, and
 - (b) for paragraph (b) substitute –
 - “(b) the arrangements which are authorised or proposed under Schedule AA1 in respect of P include arrangements for P to be accommodated in the residential accommodation referred to in this section.”
- (4) In subsection (4) –

- (a) after “arrangements” insert “mentioned in subsection (1)”, and
 - (b) after “represent” insert “and support”.
- (5) In subsection (5), after “represent”, in both places, insert “and support”.
- (6) Omit subsection (7).
- 7 In section 40 (exceptions) –
 - (a) in subsection (1) for “, 39(4) or (5), 39A(3), 39C(3) or 39D(2)” substitute “or 39(4) or (5)”, and
 - (b) omit subsection (2).
- 8 In section 41 (power to adjust role of independent mental capacity advocates) in subsection (2), in paragraphs (a) and (b) after “38” insert “, 38A”.
- 9 (1) Section 42 (codes of practice) is amended as follows.
 - (2) In subsection (1) for paragraphs (fa) and (fb) substitute –
 - “(fa) for the guidance of persons exercising functions under Schedule AA1,
 - (fb) for the guidance of appropriate persons appointed under paragraph 47 or 48 of Schedule AA1,”.
 - (3) In subsection (4) for paragraphs (da) and (db) substitute –
 - “(da) in the exercise of functions under Schedule AA1,
 - (db) as an appropriate person appointed under paragraph 47 or 48 of Schedule AA1,”.
- 10 In section 64 (interpretation), in subsection (1) –
 - (a) omit the entry relating to authorisation under Schedule A1, and
 - (b) in the definition of “local authority”, for “Schedule A1” substitute “Schedule AA1”.

Explanatory Notes on the draft Mental Capacity (Amendment) Bill

WHAT THESE NOTES DO

- 1.1 These explanatory notes relate to the draft Mental Capacity (Amendment) Bill, which gives effect to the recommendations made by the Law Commission in its report *Mental Capacity and Deprivation of Liberty*, published in March 2017.¹ They have been produced by the Law Commission in order to assist the reader of the draft Bill and to help inform debate on it.
- 1.2 These explanatory notes set out what each part of the draft Bill will mean in practice, provide background information on the development of policy, and provide additional information on how the draft Bill will affect existing legislation in this area. These explanatory notes are intended to be read alongside the draft Bill. They are not intended to be a comprehensive description of the draft Bill.
- 1.3 Further information on the policy and background to the Law Commission's recommendations is provided in its final report and the consultation paper which preceded the report.²

OVERVIEW OF THE DRAFT BILL

- 1.4 The draft Mental Capacity (Amendment) Bill gives effect to the Law Commission's recommendations for reform of the law concerning people who need to be deprived of liberty to receive care or treatment but lack capacity to consent to being deprived of liberty for that purpose. It does so by amending the Mental Capacity Act 2005.
- 1.5 In particular, the draft Bill entirely replaces the provisions of schedule A1 to the Mental Capacity Act (referred to as the "Deprivation of Liberty Safeguards" or "DoLS"). It introduces a new administrative process for authorising arrangements enabling the delivery of care or treatment which would give rise to a deprivation of liberty; these are contained within a new schedule AA1 to the Act.
- 1.6 The draft Bill also amends the Mental Capacity Act in a number of ways designed to improve decision-making in respect of all those who lack capacity to make particular decisions.
- 1.7 The draft Bill has the same extent as the provisions that it amends. It applies only to England and Wales: see clause 15. The subject matter of the Mental Capacity Act is currently not devolved to the Welsh Assembly and will remain a matter reserved to the United Kingdom Parliament under the Wales Act 2017 (due to come into force in 2018), but some regulation-making powers are transferred to the Welsh Ministers. In line with this approach, a number of provisions provide for regulations to be made by Welsh

¹ *Mental Capacity and Deprivation of Liberty* (2017) Law Com Report No 372.

² *Mental Capacity and Deprivation of Liberty* (2015) Law Commission Consultation Paper No 222.

Ministers in relation to the application of the Mental Capacity Act – as amended by the draft Bill – in Wales.

OVERVIEW

1.8 The draft Bill contains 15 clauses and two schedules, which can be summarised as follows:

- (1) Clauses 1 to 5, and schedule 1 to which clause 1 gives effect, are concerned with arrangements which give rise to a deprivation of liberty. They make provision about the authorisation of arrangements giving rise to a deprivation of liberty and the powers of the Court of Protection in relation to such authorisations. They also confirm expressly that a donee of a lasting power of attorney or a deputy appointed by the Court of Protection cannot consent on a person's behalf to arrangements which give rise to a deprivation of liberty. In addition, the clauses authorise deprivation of liberty for the purpose of life-sustaining treatment in an emergency and provide for the amendment of the Coroners and Justice Act 2009 to exclude arrangements authorised under the draft Bill from the cases in which an inquest is mandatory under that Act.
- (2) Clause 6 contains provisions about consenting in advance to arrangements which amount to a deprivation of liberty.
- (3) Clause 7 makes provision about unlawful deprivation of liberty, enabling a person to bring civil proceedings against a private care provider who has put in place unauthorised arrangements which give rise to a deprivation of the person's liberty. It also makes provision for a defence to such proceedings, for the courts in which proceedings may be brought, the time limit for doing so and the available remedies.
- (4) Clause 8 amends the existing provisions of the Mental Capacity Act on determining what is in a person's best interests so as to place particular weight on the person's ascertained wishes and feelings.
- (5) Clause 9 contains provisions restricting the defence available under section 5 of the Mental Capacity Act to people who act on behalf of a person who lacks capacity. It sets out cases in which additional record-keeping obligations apply to people acting in a professional capacity or for remuneration.
- (6) Clauses 10 and 11 set out provisions regarding the appointment and functions of Independent Mental Capacity Advocates. It requires an appropriate person or Independent Mental Capacity Advocate to be appointed if an authorisation is proposed or made under schedule AA1 and sets out the functions of Independent Mental Capacity Advocates.
- (7) Clause 12 provides for supported decision-making, creating a power for the Secretary of State and the Welsh Ministers to establish by regulations schemes to support persons in making decisions about their personal welfare or property and affairs (or both).

- (8) Clauses 13 to 15 contain supplementary provisions about regulation-making powers, make some minor and consequential amendments to the Mental Capacity Act, and contains provisions about the territorial extent and commencement of the Bill when enacted.
- (9) Schedule 1 contains schedule AA1, an administrative scheme for authorisation of deprivation of liberty for the purpose of enabling care and treatment to be provided to those of impaired capacity.
- (10) Schedule 2 contains the minor and consequential amendments.

NOTES ON CLAUSES

Arrangements etc. giving rise to a deprivation of liberty

Clause 1 – Deprivation of liberty: arrangements which are authorised

- 1.9 Clause 1(2) amends section 4A of the Mental Capacity Act so as to refer to the new schedule AA1 (which is introduced into the Act by clause 1(4) and provides for the authorisation of arrangements which give rise to a deprivation of liberty). It also omits reference to schedule A1, which would no longer provide a means of authorising deprivations of liberty under the draft Bill (and will be repealed under paragraph 2 of schedule 2). The draft Bill does not contain transitional provisions as these are a matter for Government.
- 1.10 Clause 1(3) inserts a new section 4AA, “Authorised arrangements: restriction of liability”. This provides a person carrying out arrangements that are authorised under schedule AA1 with a defence to civil and criminal liability in relation to non-negligent acts done pursuant to the authorisation. Section 4AA and schedule AA1 together do not therefore provide a power to deprive an individual of their liberty; rather, they provide a defence to liability.

Clause 2 – Deprivation of liberty necessary for life-sustaining treatment etc.

- 1.11 Clause 2 amends section 4B of the Mental Capacity Act so as to provide express authority for a person to deprive another of their liberty in three distinct situations:
 - (1) a decision about whether they are authorised to do so is being sought from a court;
 - (2) steps are being taken to obtain authorisation under schedule AA1; or
 - (3) in an emergency.
- 1.12 In each case, the person must reasonably believe that the other person lacks the capacity to consent to the steps being taken. The deprivation of liberty must also, as under the law at present, be justified as necessary either to provide the individual with life-sustaining treatment or to prevent a serious deterioration in their condition. The new power to deprive a person of liberty in an emergency takes the place of the current provision in the DoLS for urgent authorisation.

Clause 3 – Restriction on powers of attorneys and deputies

- 1.13 Clause 3 inserts a new section 29A, “Deprivation of liberty” into the Mental Capacity Act. This expressly prevents a donee of a lasting power of attorney or a deputy appointed by the Court of Protection from consenting on a person’s behalf to arrangements which give rise to a deprivation of liberty, making explicit the position under the current law.

Clause 4 – Rights of challenge

- 1.14 Clause 4(1) inserts a new section 21ZA, “Powers of court in relation to Schedule AA1” into the Mental Capacity Act. It replaces the current section 21A, which is repealed under paragraph 2 of schedule 2. The new section sets out the powers of the Court of Protection in relation to arrangements under schedule AA1 (the reference to “the court” is, by operation of section 64(1) of the Act, a reference to the Court of Protection). The powers largely duplicate the court’s current powers, with the exception of subsection (1) which gives the Court of Protection the power to determine any question in relation to these arrangements, as opposed to a specified list of matters under the existing section 21A(2) and (4).
- 1.15 Clause 4(2) amends section 50(1A) of the Mental Capacity Act to provide that no permission is required for an application to the Court of Protection under section 21ZA by an appropriate person or an Independent Mental Capacity Advocate. This gives those undertaking roles under the new schedule AA1 access to the Court of Protection on a similar basis as those fulfilling roles under the current DoLS.

Clause 5 - Amendment of Coroners and Justice Act 2009

- 1.16 This clause inserts section 48(2A) into the Coroners and Justice Act 2009. This removes arrangements authorised under schedule AA1, by section 4B, or by an order of the Court of Protection under section 16 of the Act from the definition of “state detention” contained in the Coroners and Justice Act 2009. The effect is to exclude arrangements authorised under the Mental Capacity Act from the cases in which an inquest is mandatory.

Advance consent

Clause 6 - Advance consent to certain arrangements

- 1.17 Clause 6 inserts section 26A, “Advance consent to certain arrangements” and section 26B “Effect of advance consent” into the Mental Capacity Act. These provide for a person to consent in advance to specific arrangements to enable care and treatment that would otherwise amount to a deprivation of liberty. In cases where a person has consented in advance to such arrangements, these do not need to be authorised under schedule AA1 because the person’s consent prevents the arrangements amounting to a deprivation of liberty.
- 1.18 The provisions relating to advance consent are similar to those relating to advance decisions to refuse treatment in sections 24 to 26 of the Act, except that they apply to a person aged 16 and over (not 18 as with advance decisions). In order to give advance consent, the person must have capacity to consent to specified arrangements being put in place at a later time which would, in the absence of consent, give rise to a deprivation of liberty (see section 26A subsections (1) to (3)). The person must also clearly

articulate the particular arrangements to which they are consenting. Specific, more detailed requirements for advance consent, in particular cases, may be set out in regulations by the Secretary of State, such as the form in which consent is given and the level of detail required about arrangements (see section 26A subsection (4)).

- 1.19 Subsection (5) sets out the circumstances under which advance consent comes to an end. These largely mirror those relating to advance decisions to refuse treatment, but also include the expiry of a specified period of time. Where the person has not specified a period after which their advance consent comes to an end, it will do so at the end of a period prescribed in regulations to be made under section 26A subsection (5)(b).
- 1.20 The Court of Protection will have the power to declare whether an advance consent exists, is valid, or is applicable to particular arrangements (either proposed or in place) (section 26B subsection (4)).
- 1.21 Clause 6(3) amends section 42(1) so as to include advance consent among the things that the Lord Chancellor must cover in a code of practice.

Unlawful deprivations of liberty

Clause 7 - Unlawful deprivations of liberty

- 1.22 Clause 7 inserts section 4C “Unlawful deprivation of liberty” and section 4D “Section 4C: proceedings and remedies” into the Mental Capacity Act. They provide a route by which individuals deprived of their liberty in private care homes or hospitals could seek redress where steps have not been taken to obtain authorisation under schedule AA1 of the Act and redress is not otherwise available against private care homes or hospitals.
- 1.23 A private care provider is defined in section 4C(4); it is, in essence, the person or body having managerial responsibility for the private care home or hospital. A regulation-making power is included under subsection (4)(d) to enable the class of private care providers to be widened to accommodate new types of establishment in due course.
- 1.24 The purpose of subsection (5) is to ensure that there is no overlap between a claim that can be brought under section 4C and a claim under section 7 of the Human Rights Act 1998 against a public authority (including a claim against a private care provider in circumstances where it is treated as a public authority under section 73 of the Care Act 2014).
- 1.25 A defence to these proceedings is set out in subsection (3) where the private care provider reasonably believed that the arrangements did not amount to a deprivation of liberty or reasonably believed that the arrangements were already authorised.
- 1.26 Subsection (6) excludes the operation of paragraph 40(2) of schedule AA1; this enables a person who is carrying out arrangements which give rise to a deprivation of liberty (e.g. a care worker) to rely on the defence given by section 4AA where that person did not know and could not have been expected to know that the arrangements were no longer authorised.
- 1.27 Those with managerial responsibility for a care home or hospital should not be able to rely on that provision, which is designed to protect individual members of staff, in order

to avoid liability under section 4C. Section 4C(6) removes any possibility of argument that the reference to the deprivation of liberty being authorised by a provision of the Act includes circumstances where the arrangements are treated as authorised under paragraph 40(2). Only the defence in subsection (3) should be potentially available in proceedings under section 4C.

- 1.28 Section 4D enables proceedings to be brought in the county court or in the High Court. They may also be brought in the Court of Protection as part of other Court of Protection proceedings concerning the same person. In line with the rules on proceedings under section 7 of the Human Rights Act 1998, proceedings must be brought within a year from the date in which the arrangements were first put in place or a longer period that the court considers to be equitable in the circumstances. Similarly, *subsection (4)* makes the principles governing compensation under article 41 of the ECHR applicable to awards of damages in proceedings under section 4C.

Best interests

Clause 8 - Best interests

- 1.29 Clause 8 amends section 4(6) of the Mental Capacity Act to place greater weight on a person's wishes and feelings. When making a best interests determination, the decision-maker would be under a duty to ascertain, so far as reasonably practicable, the person's wishes and feelings, beliefs and values in relation to the matter. The decision-maker is then required to give particular weight to any wishes and feelings ascertained. These two duties will apply to all decisions as to what is in a person's best interests under section 4 of the Act.

Acts connected with care or treatment

Clause 9 - Restriction of defence under section 5 of the Mental Capacity Act 2005

- 1.30 Clause 9 inserts section 6A "Section 5 acts: additional limitations", section 6B "Section 6A: relevant decisions" and section 6C "Section 6A: required information" into the Mental Capacity Act.
- 1.31 Section 5 of the Act provides a person ("D") who does an act in connection with the care or treatment of another person ("P") with a defence to any legal liability arising out of P's lack of consent to the act if D reasonably believes that P lacks capacity to consent to the action and that it is in P's best interests. The new sections introduce further conditions for relying on that defence in the case of certain acts. The purpose of this is to provide greater protection to people who lack capacity in the case of acts implementing decisions that constitute more serious intrusions upon rights to private and family life under Article 8 of the ECHR.
- 1.32 Section 6A prevents a person ("D") from relying upon the defence unless a written record is prepared (either by the person or by someone else) containing "the required information". This section only applies if D is acting in a professional capacity or for remuneration; it therefore would not apply to family carers, for example. It also does not apply if D considers that any delay in acting would result in serious harm to P.
- 1.33 Section 6B contains a list of relevant decisions for the purposes of section 6A. In broad terms they are decisions to move individuals from their own homes into types of accommodation specified in regulations, to restrict a person's contact with others and

to administer certain forms of medical treatment. The Secretary of State may amend or add to the list and make necessary consequential amendments to Sections 6A, 6B and 6C. Subsection (11) requires the Secretary of State to consult the Welsh Ministers.

- 1.34 Section 6C sets out the information that must be recorded. In essence it is a record showing that the decision-making processes required by the Act have been carried out properly.

Advocacy and representation

Clause 10 - Appointment of independent mental capacity advocates

- 1.35 Clause 10 repeals sections 39A to 39E of the Mental Capacity Act, which will no longer be relevant as they relate to advocacy in relation to the DoLS. It also inserts section 38A “Arrangements under Schedule AA1”.
- 1.36 Section 38A sets out the circumstances in which an Independent Mental Capacity Advocate must be appointed under schedule AA1. The effect of section 38A, read together with paragraphs 47 and 48 of schedule AA1, is that at all times from the outset of the process of authorisation under the schedule to the point when the authorisation comes to an end, the person is represented and supported either by an appropriate person (such as a family member) or an Independent Mental Capacity Advocate. The only exception to this is where the person has the capacity to consent to being represented by an appropriate person or advocate (as the case may be) and does not consent, or where they lack the capacity to consent and the responsible body considers that the appointment would not be in the person’s best interests.
- 1.37 Subsection (3) also provides for an Independent Mental Capacity Advocate to be appointed to support an appropriate person in discharging their duties. This advocacy duty operates on an opt-out, rather than opt-in basis.

Clause 11 - Independent Mental Capacity Advocates: functions

- 1.38 Clause 11 would replace section 36 of the Mental Capacity Act with a new section 36 “Functions of independent mental capacity advocates”.
- 1.39 Section 36, which applies to all Independent Mental Capacity Advocates appointed under the Mental Capacity Act, is intended to be less prescriptive in its form than the current version of section 36. Rather, it provides the appropriate authority with a regulation-making power to set out how an Independent Mental Capacity Advocate is to discharge the functions of representing or supporting under section 35.
- 1.40 Subsection (2) provides that regulations under subsection (1) may concern challenging, or providing assistance for the purpose of challenging, relevant decisions or facilitating a person’s involvement in relevant decisions (these decisions being defined in subsection (3)).
- 1.41 The provisions of subsection (4) enable regulations under subsection (1) to ensure that the person subject to an authorisation is represented and supported to exercise “relevant rights”. These rights include (under subsection (5)) the right to make an application to court. It may be that such an application needs to be made to a court other than the Court of Protection; this is why subsection (5) refers to court, rather than “the court” (the latter is defined (by section 64(1)) as meaning the Court of Protection).

Supported decision-making

Clause 12 - Supported decision-making

- 1.42 Clause 12 inserts a new section 36A “Supported decision-making” into the Mental Capacity Act. This provides for a regulation-making power to allow the Secretary of State and the Welsh Ministers to establish supported decision-making schemes in relation to personal welfare or property and affairs (or both). It is designed to enable the Secretary of State and Welsh Minister to explore new models of support, reflecting obligations under the United Nations Convention on the Rights of Persons with Disabilities.
- 1.43 The section also describes the people who can be supported under the scheme; the person must be aged 16 or over and have capacity to appoint a person to assist them with the particular decision. It also provides that a supporter must be aged 16 or over (see subsections (2) and (3)). Further requirements for the supporter and decision-maker may be provided in regulations.
- 1.44 Other aspects of the scheme can be specified in regulations; these could include how supporters are appointed, the role of the supporter, the standards which must be met by a supporter, how the cost of the scheme is to be met, and the monitoring of the scheme (see subsection (4)).

Supplemental

Clause 13 - Regulations: procedure

- 1.45 Clause 13 amends section 65 of the Mental Capacity Act, which deals with the making of rules and regulations under the Act.
- 1.46 Clause 13(2) amends section 65 of the Act so as to provide that regulations relating to the section 5 defence or making changes to the definition of “hospital manager” in England are subject to the affirmative resolution procedure (i.e. must be approved in draft by a resolution of each House of Parliament). All other regulation-making powers inserted into the Act are subject to the negative resolution procedure (i.e. can be annulled pursuant to a resolution of either House of Parliament). Clauses 13(3) and (5) make comparable provision regarding affirmative or negative resolutions of the National Assembly for regulations made by the Welsh Ministers.
- 1.47 Clause 13(6) repeals subsections (4A) to (4C), which apply to regulations made under powers in the repealed schedule A1.

Clause 14 - Consequential amendments etc

- 1.48 Clause 14 introduces schedule 2, which contains minor and consequential amendments and is discussed below.

Final

Clause 15 - Extent, commencement and short title

- 1.49 Clause 15 confirms that the draft Bill would extend to England and Wales only, and gives order-making powers relating to commencement, transitional provisions and consequential amendments of other legislation. The draft Bill does not contain

comprehensive commencement, transitional or consequential amendment provisions; these will be a matter for Government.

SCHEDULE AA1 – ARRANGEMENTS ENABLING THE CARE AND TREATMENT OF PERSONS WHO LACK CAPACITY

Overview

1.50 Schedule AA1 provides a procedure, in compliance with the requirements of Article 5 of the ECHR, for authorising the deprivation of liberty of persons over 16 who lack capacity to consent to it in order to enable the delivery of their care and treatment. It provides a replacement for the DoLS. Under schedule AA1, a responsible body (which will, in most cases, be the body actually responsible for delivering care and treatment to the person) will be able to authorise arrangements amounting to a deprivation of the person's liberty in one or more setting of any type. Specified assessments must be undertaken, which must be reviewed by a person operationally independent from those delivering care and treatment. In cases (principally) where the individual is objecting to being cared for or treated at the place(s) in question, an Approved Mental Capacity Professional must have considered the situation. The scheme of schedule AA1 – described in the report as the “Liberty Protection Safeguards” – also provides for rights to representation and support from the outset of the assessment process.

Part 1 – Introductory and Interpretation

Arrangements to which this schedule applies

1.51 Paragraph 1 sets out the arrangements and the persons that are within the scope of the schedule. The schedule applies solely to arrangements for enabling care and treatment to be provided; it does not apply to the actual carrying out of care and treatment (to which section 5 would be relevant). The arrangements could include arrangements to ensure that a person is safely returned to a particular place where they are receiving care and treatment in the event (for instance) that they have wandered from the care home identified in the authorisation.

1.52 The effect of sub-paragraph (1)(c) read together with paragraph 53, is that arrangements for assessing and treating mental disorder that give rise to a deprivation of liberty in a hospital cannot be authorised under schedule AA1. The effect of sub-paragraph (1)(d), read together with paragraph 54, is that arrangements can only be authorised under schedule AA1 if they do not conflict with decisions made by decision-makers under the Mental Health Act (and Scottish or Northern Irish equivalents as prescribed under paragraph 54(1)(g) of Sch AA1) in relation to people who are subject to that legislation but who are not currently detained in hospital, such as those on community treatment orders.

1.53 Paragraph 2 provides examples of types of arrangements to which the schedule could apply. They are not tied (as are the DoLS) to a single location; an authorisation could therefore cover, for example, residence in a care home together with visits to a day centre or hospital.

1.54 Paragraph 4 sets out key definitions for the purposes of the schedule. It does not define “deprivation of liberty”, but by virtue of section 64(5) of the Mental Capacity Act, that would be given the same meaning as in Article 5(1) of the ECHR.

Responsible body

- 1.55 Paragraph 7 identifies the responsible body that is charged with authorising arrangements that give rise to a deprivation of liberty in the case of a particular individual (referred to in the schedule as the “cared-for person”: see paragraph 2(2)). Its sub-paragraphs are arranged so as to prevent overlap between them. The effect of paragraph 7 is that the “hospital manager” (as defined in paragraph 8) is responsible for authorising arrangements in hospitals and a clinical commissioning group or local health board (as defined in paragraphs 9 and 10) is responsible in the case of arrangements carried out through NHS continuing health care. Paragraph 7 also provides that a local authority is the responsible body in all other cases (including care arranged by the local authority and care provided to people paying for their own care – “self-funders” – or in receipt of after-care under section 117 of the Mental Health Act 1983).
- 1.56 Paragraph 8 defines a hospital manager for the purposes of paragraph 7. This is the NHS body that manages an NHS hospital, the person in whose name an independent hospital is registered or, in the small number of cases where there is no registered person (such as some armed services hospitals) the Secretary of State or Welsh Ministers. Sub-paragraph (2) also defines the “relevant national authority” for the purpose of this paragraph as meaning either the Secretary of State or the Welsh Ministers and provides for the relevant national authority to amend the definition of hospital manager for the purpose of this paragraph by regulations (sub-paragraph (3)). The definition is similar, but not identical, to the definition of hospital manager for purposes of the Mental Health Act 1983.
- 1.57 Paragraph 11 identifies which local authority is the responsible body in any given case. In principle, it will be the local authority where the individual is ordinarily resident for social care purposes. However, to cover the case of self-funders, and where a person’s care and support needs are being met under more than one piece of social care legislation, sub-paragraph (5) provides that the responsible local authority is that for the area where the arrangements (or proposed arrangements) provide for the person to reside, or primarily reside in the case of arrangements relating to more than one location.
- 1.58 Paragraphs 12 and 13 define English and Welsh responsible bodies respectively in order (amongst other purposes) to identify whether the relevant regulation-making body is the Secretary of State or the Welsh Ministers.

Part 2 – Authorisation of Arrangements

Authorisation of arrangements: conditions

- 1.59 Paragraph 14 sets out the conditions required to be satisfied for a responsible body to authorise arrangements under this schedule. These include, among other things, the need for a capacity assessment and a medical assessment to have been carried out which confirm the relevant matters (all of the conditions are discussed below). Paragraph 15 prevents the responsible body authorising arrangements which conflict with a valid decision by a donee of a lasting power of attorney or of a deputy appointed by the Court of Protection.

Capacity and medical assessments

- 1.60 Paragraph 17 enables the Secretary of State and Welsh Ministers to set requirements (for example, as to qualifications) to be met by people who carry out capacity assessments and medical assessments. Paragraph 19 allows the same person to undertake both assessments, subject to the requirement of independence under paragraph 29, discussed below. Paragraph 18 makes it clear that a responsible body can rely upon existing assessments, including those prepared for another purpose, so long as it is reasonable to do so. Sub-paragraph (2) sets out the factors that the responsible body must have regard to when considering whether it is reasonable to rely upon the existing assessment. The intention is that an existing assessment can be relied on, provided that it gives a reliable indication of the person's current condition.
- 1.61 Paragraph 20 requires the capacity assessment to address whether the person's capacity to consent to the arrangements which are proposed or in place is likely to fluctuate and, if so, the likely duration of any periods of capacity to consent to the arrangements. This, alongside paragraph 35 of the schedule, means that an authorisation should not automatically cease to have effect on a person regaining capacity where the person's capacity has been assessed as fluctuating and periods of regained capacity are reasonably expected to be brief.

Necessary and proportionate

- 1.62 Paragraph 21 requires an assessment of whether the arrangements are necessary and proportionate having regard to likelihood and seriousness of harm to the person and/or to others if the arrangements were not in place. It must be carried out by a person who appears to the responsible body to have appropriate experience and knowledge to determine the matter. Sub-paragraph (4) is designed to prevent arrangements being authorised wholly or mainly on the basis of likelihood of harm to others if it is more appropriate for an application to be made for the person to be admitted to hospital under section 2 or 3 of the Mental Health Act 1983, which is the primary legislative means of public protection in such cases.
- 1.63 Sub-paragraph (5) provides that if the same person provides the capacity and medical assessment, they cannot also undertake the necessary and proportionate assessment under paragraph 21. This ensures that at least two different people assess the person's circumstances.

Consultation

- 1.64 Paragraph 22 sets out who the responsible body must consult in order to authorise arrangements under this schedule, to the extent that it is practicable and appropriate to do so (sub-paragraph (4)). The consultation requirements vary depending on whether the person is aged 16-17 or is an adult, reflecting the specific legislative frameworks to which minors are subject.

Independent review

- 1.65 Paragraph 23 sub-paragraph (1) excludes people involved in providing the day-to-day care or treatment to the person from carrying out the required independent review. This is intended to provide the degree of operational independence required by Article 5 of the ECHR.

- 1.66 Most cases are concluded by an independent review in which the independent reviewer reviews the relevant information to determine whether it is reasonable for the responsible body to conclude that the conditions for authorisation are met (sub-paragraph (4)). However, sub-paragraph (2) and paragraph 24 require the independent reviewer to refer certain cases to an Approved Mental Capacity Professional. Other cases may be referred to an Approved Mental Capacity Professional if the Approved Mental Capacity Professional agrees to accept the referral (sub-paragraph (3)).
- 1.67 Paragraph 24 sets out the two cases which must be referred to an Approved Mental Capacity Professional. The first case (sub-paragraph (2) of paragraph 24) is where it is reasonable to believe that the cared for person does not wish to reside in or receive care or treatment in the place specified in the arrangements. The second case (sub-paragraph (3)) is where the arrangements are determined to be necessary and proportionate wholly or mainly on the basis of the likelihood and seriousness of harm to others. Paragraph 25 sets out the factors that an independent reviewer must consider when determining if a case falls within paragraph 24(2).

Approval by an Approved Mental Capacity Professional

- 1.68 The Approved Mental Capacity Professional is required to determine afresh whether the conditions are met, reaching their own conclusion on the matter. This is in contrast to an independent reviewer, who reviews whether it was reasonable for the responsible body to conclude that the conditions for authorisation are met, Paragraph 26 provides that if an Approved Mental Capacity Professional considers that the conditions set out in paragraph 14(a)–(d) are met, the Approved Mental Capacity Professional must approve the arrangements and notify the approval in writing to the responsible body.
- 1.69 If the Approved Mental Capacity Professional determines that the conditions are not met, paragraph 27 requires written notice to the responsible body stating that the arrangements have not been approved, giving the reasons why and describing any steps the responsible body can take in order to obtain approval. The Approved Mental Capacity Professional cannot direct that specific steps are taken.
- 1.70 Paragraph 28 sets out what steps the Approved Mental Capacity Professional is required to take in order to make a determination under paragraph 26 or 27. Reviewing the information provided and, where practical, meeting the person are mandatory (sub-paragraph (1)), fresh consultation and other steps are discretionary (sub-paragraph (2)). A person may not act as Approved Mental Capacity Professional if they are involved in the care or treatment of the person in question (paragraph 26(3)).

Assessments: requirement of independent person

- 1.71 The effect of paragraph 29 is that in all cases at least two people who are independent of each other are involved in carrying out the three core assessments of capacity, unsoundness of mind, and necessity and proportionality. The draft Bill does not specify what makes decision-makers independent or not; this is best judged case by case. Examples of situations in which assessors will not be independent of each other are where their professional or other relationship makes them likely to be unduly influenced by each other's views.

Part 3 – Authorisation record

- 1.72 Paragraph 30 requires a responsible body, when it authorises arrangements under this schedule, to produce an authorisation record relating to the person, or revise an existing authorisation record in relation to that person. The reference to “a responsible body” enables authorisation records to travel with the person between different settings, being reviewed and revised as appropriate by successive responsible bodies. Paragraph 31 sets out what the authorisation record must include, and paragraph 32 provides that the responsible body must revise an authorisation record if there is any change to those matters.
- 1.73 Paragraph 33 requires the responsible body to give a copy of the authorisation record, and any revision of it, to the person to whom it relates, to any person the responsible body consulted under paragraph 14(d) in determining whether to authorise the arrangements, and to any other person mentioned in paragraph 22(1)(a) to (e) and paragraph 22(2)(a) and (b) who the responsible body considers ought to receive a copy.

Part 4 – Authorisation: Duration, Review and Suspension

Duration and cessation

- 1.74 Paragraph 34 sets out when an authorisation has effect under this schedule. This is either immediately on the responsible body determining that the conditions for authorisation are met or from a later date specified by the responsible body which is no later than 28 days from the day it determines that the conditions for authorisation are met.
- 1.75 Paragraph 35 sets out when an authorisation ceases to have effect. This is either at the end of a set period of time (defined in sub-paragraph (1)), or (in broad terms) because of a change in the person’s circumstances. The authorisation may either entirely cease to have effect (sub-paragraph (2)-(3)) or be circumscribed so as to ensure that it is not in conflict with new decisions made by a donee or deputy, or a decision-maker under mental health legislation (such as a decision by a guardian as to where the person should live) (sub-paragraphs (4)-(6)).
- 1.76 In any of the cases set out in paragraph 35, the authorisation will cease to have effect (in whole or in part) without formal steps being taken to terminate it. This paragraph is therefore to be read with paragraph 40 which ensures that those who are acting on authorisations which have, in fact, come to an end and neither knew or ought to have known of this fact are protected from liability. Where arrangements cease to have effect, or are suspended (see paragraph 41), paragraph 36 requires the responsible body to take reasonable steps to notify any person who is likely to be carrying out the arrangements that the arrangements are no longer authorised.

Renewal

- 1.77 Paragraph 37 sets out the process by which authorisations can be renewed under the schedule. Sub-paragraph (1) sets out the renewal period for authorisations. It allows a first renewal for up to 12 months and subsequent renewals for up to three years. The conditions for renewal (sub-paragraphs (3) and (4)) are similar to those for initial authorisations. An Approved Mental Capacity Professional must be involved in renewals in cases where referral to them is mandatory ((see sub-paragraphs (4) to (6)).

- 1.78 There is an additional requirement (in sub-paragraph (3)(d)) that the responsible body must reasonably believe it unlikely that there will be any significant change in the person's condition during the renewal period which would affect the person's lack of capacity to consent to the arrangements, their unsoundness of mind or the necessity and proportionality of the arrangements. This is required so as to ensure that lengthy periods of renewal are only set in the case of persons whose condition and circumstances are truly stable.
- 1.79 Sub-paragraph (9) provides that an authorisation which has ceased to have effect cannot be renewed in accordance with this paragraph.

Reviews

- 1.80 Paragraph 38 sub-paragraph (1) requires a responsible body to keep an authorisation under review. The term "a responsible body" refers to the body responsible for the arrangements at any point in time, so that authorisation records travel with the person between different settings, being reviewed and revised as appropriate by successive responsible bodies.
- 1.81 Sub-paragraph (2) provides that a responsible body must also review an authorisation on a reasonable request by a person with an interest in the arrangements which are authorised, if the person to whom it relates becomes subject to mental health arrangements or different Mental Health Act requirements, and if it becomes aware of a significant change in the person's condition or circumstances.
- 1.82 Sub-paragraphs (3) and (4) require a referral to an Approved Mental Capacity Professional in circumstances where the responsible body becomes aware that a case which initially did not appear to call for such approval now does so. The test therefore mirrors that contained in paragraph 25.
- 1.83 Paragraph 39 sets out what the Approved Mental Capacity Professional must do when a case is referred to them on review. The steps broadly correspond to those in paragraph 28.

Authorisation coming to an end early: arrangements to be treated as authorised

- 1.84 Paragraph 40 provides protection for those, such as care workers, who are carrying out arrangements under authorisations which have either ceased to have effect (in whole or in part or have been suspended) but did not know, and could not have been expected to know that this was the case. It deems arrangements in such cases to be authorised for the purposes of the defence provided by section 4AA.

Suspension

- 1.85 Paragraph 41 provides for an authorisation to be suspended where an individual is admitted to hospital for assessment and treatment of mental disorder for a short period of time – up to 28 days – pursuant to part 2 or section 131 of the Mental Health Act 1983. Whilst suspension means that the arrangements to which the authorisation relates are no longer authorised (sub-paragraph (3)), the arrangements will be treated as authorised again if the person is discharged from hospital within 28 days (sub-paragraph (2)). If the person is not discharged within 28 days, the authorisation ceases

to have effect altogether (sub-paragraph 4). The effect of sub-paragraph (5) is that an authorisation can be renewed under paragraph 37 while it is suspended.

Part 5 – Approved Mental Capacity Professionals

Duty of local authority to approve Approved Mental Capacity Professionals

- 1.86 Paragraph 42 requires each local authority to make arrangements for the approval of persons who will act as Approved Mental Capacity Professionals on its behalf and for the appointment of an individual who will manage the conduct and performance of Approved Mental Capacity Professionals. Each local authority would also be required to make arrangements to ensure that there are sufficient numbers of persons approved as Approved Mental Capacity Professionals for its area.
- 1.87 Paragraph 43 provides that a person appointed under paragraph 42(b) to manage the conduct and performance of Approved Mental Capacity Professionals must report to either the director of adult social services or the director of social services for the local authority that made the appointment.
- 1.88 Paragraph 44 provides that a local authority may only approve a person to act as an Approved Mental Capacity Professional if the person meets the requirements prescribed in regulations made by the appropriate authority (the possible contents of which are set out in paragraph 45).

Approved Mental Capacity Professionals: requirements

- 1.89 Paragraph 45 enables the Secretary of State and Welsh Ministers to prescribe in regulations the criteria for approval as an Approved Mental Capacity Professional, matters which a local authority must or may take into account when deciding whether or not to approve a person as an Approved Mental Capacity Professional and the period for which a person may be approved. Sub-paragraph (2) provides that the regulations may include criteria relating to qualifications, training or experience.
- 1.90 Sub-paragraph (3) provides that regulations under paragraph 45(1) which provide for approval as an Approved Mental Capacity Professional to be suspended or terminated must include provision conferring rights of appeal.

Part 6 – Appropriate persons to represent cared-for persons

- 1.91 The effect of paragraphs 47 to 49 of schedule AA1, together with section 38A of the Act, is that at all times from the outset of the process of authorisation under the schedule to the point when the authorisation comes to an end, the person is represented and supported either by an appropriate person (such as a family member) or an Independent Mental Capacity Advocate. The only exception to this is where the person has capacity to consent to being represented by an appropriate person or advocate (as the case may be) and does not consent, or where they lack the capacity to consent and the responsible body is satisfied that the appointment would not be in the person's best interests.
- 1.92 Paragraph 49 provides that the function of an appropriate person is to represent and support the person and empowers the Secretary of State and Welsh Ministers to make further provisions by regulations, including provision about enabling the person to exercise the right to challenge their deprivation of liberty in court.

- 1.93 Paragraph 50 sub-paragraph (1) gives power to make regulations as to the appointment of appropriate persons, including provision that a person may act as an appropriate person only in prescribed circumstances or subject to prescribed conditions, or provide for the appointment of a person as an appropriate person to be subject to approval in accordance with the regulations.

Part 7 - Monitoring and Reporting

- 1.94 Paragraph 51 gives the Secretary of State and Welsh Ministers regulation-making powers to make provision for monitoring and reporting on the operation of schedule AA1. The regulations could prescribe one or more body to undertake this function. The regulations could also confer authority to visit places where arrangements authorised under schedule AA1 are carried out, to meet with persons and to require the disclosure of information. Paragraph 52 requires responsible bodies to notify the monitoring and reporting body, or bodies, of authorisations granted. This is not intended to duplicate Health and Social Care Information Centre's existing role reporting on the DoLS but rather to enable the monitoring and reporting bodies to direct their monitoring appropriately.

Part 8 – Arrangements relating to mental health

Mental health arrangements

- 1.95 Paragraph 53 defines those “mental health arrangements” that cannot be authorised under the schedule (see paragraph 1(1)(c)). These are arrangements carried out in a hospital for the purpose of assessing or treating mental disorder within the meaning of section 1(2) of the Mental Health Act 1983. This does not include treatment for mental disorder by reason of learning disability unless the disability is associated with abnormally aggressive or seriously irresponsible conduct. Arrangements in other cases of learning disability are not mental health arrangements and are not excluded from the scheme.
- 1.96 The effect of paragraph 53, read together with paragraph 1, is that arrangements, which are for the purpose of assessing mental disorder (including any form of learning disability) or treating mental disorder (including learning disability that is associated with abnormally aggressive or seriously irresponsible conduct), fall outside the scheme and only the Mental Health Act may be used to authorise a deprivation of the person's liberty, whether or not the person objects to the arrangements.

Arrangements conflicting with requirements arising under legislation relating to mental health

- 1.97 The effect of paragraph 54, read together with paragraph 1(1)(d), is that where a person is not detained under mental health legislation but is subject to requirements imposed under it, an authorisation under the schedule cannot conflict with those requirements. For example, where a person is subject to guardianship under the Mental Health Act, an authorisation could not be granted under the schedule which provided for a person to reside in a different place to that specified by the guardian.
- 1.98 The power in sub-paragraph (1)(g) read with sub-paragraph (3) enables the Secretary of State to include conditions and requirements arising under other enactments. “Enactments” here include Acts of the Welsh Assembly, Northern Ireland legislation and Acts of the Scottish Parliament. It also includes subordinate legislation.

Schedule 2 – minor and consequential amendments

- 1.99 This schedule makes various minor and consequential amendments to the Act. They are self-explanatory and do not call for comment save for paragraph 6 which has (amongst other effects) that of removing any duplication of duties in respect of the provision of advocates under both the Mental Health Act 1983 and the Care Act 2014 and Social Services and Well-Being (Wales) Act 2014.

Appendix B: ECHR and CRPD compatibility

- 1.1 This appendix outlines our view as to the compatibility of the recommendations set out in this report with both the ECHR and the UN Convention on the Rights of Persons with Disabilities (“CRPD”).

ECHR

Article 5: procedural obligations

- 1.2 Article 5 of the ECHR protects the individual against arbitrary dispossession of his or her right to liberty.¹ Any procedure for the lawful deprivation of a person on the basis of unsoundness of mind must be such as to be able to establish that certain minimum conditions are satisfied.² These are summarised as follows:

- (1) the person must be reliably shown by objective medical expertise to be of unsound mind, unless emergency detention is required. The time at which a person must be reliably established to be of unsound mind is that of the adoption of the measure depriving that person of their liberty as a result of that condition.³ The term “a person of unsound mind” does not lend itself to precise definition, since psychiatry is an evolving field, both medically and in social attitudes. However, it cannot be taken to permit the detention of someone simply because his or her views or behaviour deviate from established norms.⁴ There is no rule that the relevant medical evidence must be supplied by a person independent of the institution where the person is to be detained, although where the expert’s ability to give the necessary evidence is compromised by the facts of a particular clinical relationship, an external expert may be required;⁵
- (2) the person’s mental disorder must be of a kind to warrant compulsory confinement. This can only be justified if other, less severe, measures have been considered and found to be insufficient to safeguard the person of unsound mind.⁶ The deprivation of liberty must be shown to be necessary in the circumstances. It may be necessary not only where the person needs therapy, medication or other clinical treatment to cure or alleviate his or her condition, but

¹ *Engel v Netherlands* (1979-80) 1 EHRR 647 (App No 5100/71) at [58].

² *Winterwerp v Netherlands* (1979-80) 2 EHRR 387 (App No 6301/73) at [39]. This was reiterated in the context of deprivation of liberty in care homes in *Stanev v Bulgaria* (2012) 55 EHRR 22 (App No 36760/06) (Grand Chamber decision) at [145].

³ *OH v Germany* (2012) EHRR 29 (App No 4646/08) at [78].

⁴ *Winterwerp v Netherlands* (1979-80) 2 EHRR 387 (App No 6301/73) at [37].

⁵ *Rivera v Switzerland* App No 8300/06 at [64] and *Nakach v Netherlands* App No 5379/02.

⁶ *Witold Litwa v Poland* (2001) 33 EHRR 53 (App No 26629/95) at [78]. This principle has been expressly reiterated in the context of deprivation of liberty in care homes: see *Stanev v Bulgaria* (2012) 55 EHRR 22 (App No 36760/06) (Grand Chamber decision) at [43].

also where the person needs control and supervision to prevent them, for example, causing harm to themselves or other persons;⁷ and

- (3) because the validity of continued confinement depends upon the persistence of the mental disorder warranting compulsory confinement,⁸ there must be in place a mechanism to ensure that the persistence of such disorder is kept under appropriate review by the detaining authority. We return to the review requirements below in the context of Article 5(4) of the ECHR.

- 1.3 Whilst there has not been extensive jurisprudence upon the procedural requirements relating to the “administrative” deprivation of liberty in the context of Article 5(1)(e), the Strasbourg court has confirmed a need for some degree of operational independence between those charged with delivering care and treatment to a person and those charged with determining whether to authorise a deprivation of liberty under an administrative scheme.⁹
- 1.4 Article 5(4) provides the right to a speedy judicial decision concerning the lawfulness of detention and ordering its termination, if it proves unlawful. It entitles a detained person to bring proceedings for review by a court of the procedural and substantive conditions which are essential for the lawfulness of the deprivation of liberty.¹⁰ The opportunity for legal review must be provided soon after the person is taken into detention and thereafter at reasonable intervals if necessary.¹¹ A person detained for an indefinite or lengthy period is in principle entitled, at any rate where there is no automatic periodic review of a judicial character, to take proceedings “at reasonable intervals” before a court to put in issue the lawfulness of his or her detention.¹² The Strasbourg court has not stated definitively how frequently a patient must be able to exercise this right under Article 5(4). However, in *Herczegfalvy v Austria* it considered that intervals of 15 months and two years were not reasonable, but an interval of nine months was reasonable.¹³
- 1.5 The Strasbourg court has also made it clear that forms of review satisfying the requirements of Article 5(4) may vary from one context to another, and will depend on the type of deprivation of liberty in issue.¹⁴ However, the Article guarantees a remedy that must be accessible to the person concerned and afford the possibility of reviewing compliance with the conditions for a lawful deprivation of liberty. Special procedural safeguards may also be called for, in order to protect the interests of persons who, on account of their mental health problems, are not fully capable of acting for themselves.¹⁵

⁷ *Hutchinson Reid v UK* App No 50272/99 at [52].

⁸ *Winterwerp v Netherlands* (1979-80) 2 EHRR 387 (App No 6301/73) at [39].

⁹ *IN v Ukraine* App No 28472/08 at [81].

¹⁰ *Idalov v Russia* App No 5826/03 at [161].

¹¹ *Molotchko v Ukraine* App No 12275/10 at [148].

¹² *Winterwerp v Netherlands* (1979-80) 2 EHRR 387 (App No 6301/73) at [55], and *Stanev v Bulgaria* (2012) 55 EHRR 22 (App No 36760/06) (Grand Chamber decision) at [171].

¹³ *Herczegfalvy v Austria* 15 EHRR 437 (App No 10533/83) at [77].

¹⁴ *MH v UK* (2014) 58 EHRR 35 (App No 11577/06) at [75].

¹⁵ *Winterwerp v Netherlands* (1979-80) 2 EHRR 387 (App No 6301/73) at [60], *MH v UK* [2013] ECHR 1008 (App No 11577/06) at [79] to [83], and *AJ v A Local Authority* [2015] EWCOP 5, [2015] 3 WLR 683 at [35] and [36].

The Strasbourg court has been careful not to set out precisely what those safeguards might be in any specific case, so long as they make the right guaranteed by Article 5(4) as practical and effective for this particular category of detainees as it is for other detainees. Although providing for automatic review by a court in cases of the detention of a person of unsound mind is one way in which to afford the necessary safeguards, it is not the only way of doing so.¹⁶

- 1.6 Finally, we note that the right under Article 5(4) must be effective, and that this may give rise to a need for legal representation as part of the special procedural guarantees required in cases of deprivation of liberty involving those of unsound mind.¹⁷ The current legal aid provisions relating to applications under section 21A of the Mental Capacity Act reflect the Government's policy intention that the DoLS "are regarded as a particularly strong example of State intervention involving the human rights of a vulnerable individual".¹⁸

Article 8: procedural obligations

- 1.7 Although Article 8 of the ECHR contains no explicit procedural safeguards, it has long been established that it contains implicit procedural requirements; these are aimed at giving a person a degree of involvement in decisions affecting their private and family life that is sufficient to protect their interests, the requisite degree of involvement being calibrated to the circumstances of the case, and the seriousness of the interference with the rights that the article protects.¹⁹ The Strasbourg court has also emphasised the serious nature of the interference with a person's integrity that is inherent in the forced administration of medication and the consequent requirement that any such administration be based upon a law which guarantees proper safeguards against arbitrariness.²⁰ We consider that this principle also encompasses medical treatment given to those who cannot (by reason of lack of the requisite mental capacity) consent to it.

Compliance of the draft Bill with the procedural requirements of Articles 5 and 8

- 1.8 We consider that the draft Bill meets the procedural requirements of Article 5 of the ECHR by ensuring that:
- (1) there is objective medical evidence of the person's unsoundness of mind (recommendation 9);
 - (2) there is consideration of whether the deprivation of liberty is necessary and proportionate (recommendation 10);
 - (3) there is operational independence between those finally charged with determining whether the person should be deprived of their liberty and those concerned with

¹⁶ *MH v UK* (2014) 58 EHRR 35 (App No 11577/06) at [82].

¹⁷ See, for example, *MS v Croatia (No 2)* App No 75450/12 at [152] to [154].

¹⁸ House of Lords Select Committee on the Mental Capacity Act: Report of Session 2013-14: Mental Capacity Act 2005: Post-legislative Scrutiny (2014) HL 139, para 246 (recording the evidence of Lord McNally, the then Minister of State for Justice).

¹⁹ For example, *Moser v Austria* App No 12643/02 at [67], *Shtukaturov v Russia* [2012] EHRR 27 (App No 44009/05) at [88] to [89], and *Lashin v Russia* App No 33117/02 at [80] to [81] and [88].

²⁰ *X v Finland* App No 34806/04 at [220].

their care and treatment (draft Bill, sch 1 (new paras 23(1) and 26(3) of sch AA1 to the Mental Capacity Act));

- (4) there is ongoing scrutiny of whether the person meets the criteria for detention, by virtue of the review obligation, and the requirement that there be an advocate or appropriate person to represent and support the person throughout the life of any authorisation (recommendations 29 and 30); and
- (5) the person is given an effective right to challenge their authorisation before a court which is able to discharge them from detention (recommendation 35).

1.9 The draft Bill also contains further measures to ensure that there is effective protection against arbitrary deprivation of liberty, in particular:

- (1) the regulatory requirements designed to ensure that prescribed bodies can monitor and report on the implementation of the Liberty Protection Safeguards (recommendation 36); and
- (2) where a person has been subject to an unlawful deprivation of liberty, the provisions which ensure that there is a directly effective remedy against private hospital and care home care providers who have not taken the necessary steps to secure authorisation of a deprivation of liberty; this right of action applies in cases where a remedy is not available under the Human Rights Act 1998 (recommendation 45).

1.10 The draft Bill does not, however, prescribe further the steps that must be taken to investigate potential deprivations of liberty in private and family settings, and does not, therefore, purport to interfere in the potentially delicate balance between Articles 5 and 8 of the ECHR in this context.

1.11 We consider that the procedural requirement contained in Article 8 to provide enhanced protection against arbitrariness in the case of serious interferences with personal autonomy are met by:

- (1) providing (within the Liberty Protection Safeguards) for additional scrutiny by an Approved Mental Capacity Professional in cases where a person (broadly) is objecting to being required to reside or receive care or treatment in the place to which the authorisation relates (recommendation 19); and
- (2) ensuring (within the body of the Mental Capacity Act) that particular steps are taken before reliance can be placed upon section 5 of the Act in implementing certain decisions which have a serious impact upon the person's autonomy (recommendation 41).

1.12 Finally, we note that our recommended amendments to section 4 of the Mental Capacity Act, to secure both a greater duty upon decision-makers to ascertain a person's wishes and feelings and then to give them greater weight in the determination of what is in the person's best interests (recommendation 40), respond to the evolving interpretation of the requirements of Article 8 of the ECHR in particular, in the light of Article 12(4) of the CRPD) outlined above.

CRPD

- 1.13 As we noted in the consultation paper, precisely what the CRPD requires in relation to laws that deal with mental incapacity is still not entirely clear.²¹ There has been some debate as to whether the Committee on the Rights of the Persons with Disabilities (the UN body which monitors implementation of the CRPD by States Parties) has sought to impose obligations that are not contained in the CRPD itself. This is particularly so in relation to Article 12 (the right to legal capacity), following the publication of the Committee's General Comment on Article 12.²²
- 1.14 This is not a debate that we can resolve. Moreover, the remit of our project did not extend to a full-scale review of the compatibility of mental capacity law with the requirements of the CRPD, which would be a very much larger undertaking.²³
- 1.15 However, we emphasise the following points.
- (1) The Liberty Protection Safeguards are unlikely to comply with Article 14 of the CRPD as interpreted by the UN Committee, which contends that any deprivation of liberty on the basis of a person's actual or perceived impairment (even where there are other reasons, including their risk to themselves) amounts to unlawful deprivation of liberty.²⁴ However, and as noted in the consultation paper, it is not on its face possible to comply with both Article 5(1)(e) of the ECHR and this interpretation of Article 14 of the CRPD.²⁵ Moreover, we note that the underlying right to liberty contained in the International Covenant on Civil and Political Rights (which the CRPD is intended to ensure is enjoyed equally by all, regardless of disability) is interpreted in a manner much closer to Article 5(1)(e) by the UN Human Rights Committee.²⁶
 - (2) Within the limits of our terms of reference, we have sought to draft legislation that is in the spirit of the CRPD. In particular, we have sought to ensure that wishes and feelings are given a particular weight in best interests decision-making by our recommended amendments to section 4 of the Mental Capacity Act. We have also provided for a regulation-making power enabling a supported decision-making scheme to be implemented. In respect of both of these see chapter 14.

²¹ Consultation paper, paras 3.17 to 3.22.

²² UN Committee on the Rights of Persons with Disabilities, *General Comment No 1: Article 12: Equal Recognition before the Law* (2014). This has been debated, for example, in Essex Autonomy Project reports: *Achieving UNCRPD Compliance* (2014) and *Three Jurisdictions Report: Towards Compliance with CRPD Art 12 in Capacity / Incapacity Legislation across the UK* (2016). See also the decision of the German Federal Constitutional Court in Bundesverfassungsgericht, Beschluss (des ersten Senats) vom 26. Juli 2016 - 1 BvL 8/15.

²³ An indication of the scale of the task can be seen in Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws* (2014).

²⁴ See UN Committee on the Rights of Persons with Disabilities, *Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities* (September 2015), para 6.

²⁵ Consultation paper, para 3.21.

²⁶ UN Human Rights Committee, *General Comment 35 on Article 9 ICCPR* (December 2014) para 19.

Appendix C: Recommendations

Recommendation 1.

The DoLS should be replaced as a matter of pressing urgency.

This recommendation can be found at page 39 (para 4.29) of the report and is given effect by paragraph 2(c) of schedule 2 to the draft Bill.

Recommendation 2.

The Liberty Protection Safeguards should provide for the authorisation of care or treatment arrangements which would give rise to a deprivation of liberty within the meaning of Article 5 of the ECHR. Deprivation of liberty should have the same meaning as in Article 5(1) of the ECHR.

This recommendation can be found at page 47 (para 5.41) of the report and is given effect by schedule 1 to the draft Bill (new paragraphs 1(1)(a) and (b) and 4(1) of schedule AA1 to the Mental Capacity Act).

Recommendation 3.

The Liberty Protection Safeguards should be accompanied by the publication of a new Code of Practice which covers all aspects of the Mental Capacity Act.

This recommendation can be found at page 48 (para 5.41) of the report and is given effect by paragraph 9 of schedule 2 to the draft Bill.

Recommendation 4.

The Liberty Protection Safeguards should enable the authorisation of arrangements which are proposed (up to 28 days in advance), or are in place, to enable the care or treatment of a person which would give rise to a deprivation of that person's liberty. The arrangements that can be authorised should include:

- (1) arrangements that a person is to reside in one or more particular places;**
- (2) that a person is to receive care or treatment at one or more particular places; and**
- (3) arrangements about the means by which and the manner in which a person can be transported to a particular place or between particular places.**

This recommendation can be found at page 57 (para 7.19) of the report and is given effect by schedule 1 to the draft Bill (new paragraph 1(1)(a) and (b), 2(1) and 34 of schedule AA1 to the Mental Capacity Act).

Recommendation 5.

The Liberty Protection Safeguards should apply to people aged 16 and above.

This recommendation can be found at page 62 (para 7.41) of the report and is given effect by schedule 1 to the draft Bill (new paragraph 1(2)(a) of schedule AA1 to the Mental Capacity Act).

Recommendation 6.

The Government should consider reviewing mental capacity law relating to all children, with a view to statutory codification.

This recommendation can be found at page 62 (para 7.41) of the report.

Recommendation 7.

The responsible body, which can authorise arrangements, should be:

- (1) if the arrangements or proposed arrangements are being, or will be, carried out primarily in a hospital, the hospital manager;**
- (2) if paragraph (1) does not apply and the arrangements or proposed arrangements are being, or will be, carried out primarily through the provision of NHS continuing health care, the clinical commissioning group or local health board;**
- (3) if neither paragraph (1) nor paragraph (2) applies, the responsible local authority.**

This recommendation can be found at page 68 (para 8.22) of the report and is given effect by schedule 1 to the draft Bill (new paragraph 7 of schedule AA1 to the Mental Capacity Act).

Recommendation 8.

The responsible body may authorise arrangements if (amongst other requirements) a capacity assessment has been carried out which confirms that the person lacks capacity to consent to the arrangements which are proposed or in place and would give rise to a deprivation of that person's liberty.

This recommendation can be found at page 71 (para 9.10) of the report and is given effect by schedule 1 to the draft Bill (new paragraph 1(2)(b) and 14(a) of schedule AA1 to the Mental Capacity Act).

Recommendation 9.

The responsible body may authorise arrangements if (amongst other requirements) a medical assessment has been carried out which confirms that the person is of "unsound mind" within the meaning of Article 5(1)(e) of the ECHR.

This recommendation can be found at page 73 (para 9.19) of the report and is given effect by schedule 1 to the draft Bill (new paragraphs 1(2)(c), 4(1) and 14(b) of schedule AA1 to the Mental Capacity Act).

Recommendation 10.

The responsible body may authorise arrangements if (amongst other requirements) those arrangements are necessary and proportionate, having regard to either or both of the following matters:

- (1) the likelihood of harm to the person if the arrangements were not in place and the seriousness of that harm; and**
- (2) the likelihood of harm to other individuals if the arrangements were not in place and the seriousness of that harm.**

This recommendation can be found at page 78 (para 9.37) of the report and is effect by schedule 1 to the draft Bill (new paragraphs 14(c) and 21 of schedule AA1 to the Mental Capacity Act).

Recommendation 11.

If the capacity assessment which was relied on for the purpose of authorising arrangements stated that the person's capacity to consent to the arrangements is likely to fluctuate, the authorisation should not automatically cease to have effect provided that the responsible body reasonably believes that the gaining or regaining of capacity will last for a short period only.

This recommendation can be found at page 82 (para 9.58) of the report and is given effect by schedule 1 to the draft Bill (new paragraphs 20, 35(3) and 37(7) and (8) of schedule AA1 to the Mental Capacity Act).

Recommendation 12.

A capacity assessment and a medical assessment must in all cases have been prepared by someone who meets the requirements set out in regulations made by the Secretary of State and Welsh Ministers.

This recommendation can be found at page 85 (para 9.69) of the report and is given effect by schedule 1 to the draft Bill (new paragraph 17 of schedule AA1 to the Mental Capacity Act).

Recommendation 13.

The capacity assessment, the medical assessment and the assessment of whether the arrangements are necessary and proportionate must be provided by at least two assessors. If the assessments are carried out by two assessors, they must be independent of each other – or if there are more than two assessors at least two must be independent of each other.

This recommendation can be found at page 87 (para 9.77) of the report and is given effect by schedule 1 to the draft Bill (new paragraphs 17, 21(5) and 29 of schedule AA1 to the Mental Capacity Act).

Recommendation 14.

The responsible body should be able to rely on a capacity or medical assessment carried out under the Liberty Protection Safeguards on a previous occasion or for any other purpose, provided it is reasonable to do so. In doing so, it must have regard to the length of time that has elapsed since the assessment was carried out, the purpose of the assessment and whether there has been any significant change in the person's condition.

This recommendation can be found at page 89 (para 9.84) of the report and is given effect by schedule 1 to the draft Bill (new paragraph 18 of schedule AA1 to the Mental Capacity Act).

Recommendation 15.

The responsible body may authorise arrangements if (amongst other requirements) it has consulted, unless it is not practical or appropriate to do so:

- (1) anyone named by the person as someone to be consulted;**
- (2) anyone engaged in caring for the person or interested in their welfare;**

- (3) any donee of a lasting power of attorney or enduring power of attorney, and any court appointed deputy;**
- (4) any appropriate person or independent mental capacity advocate;**
- (5) in the case of a person aged 16 or 17, anyone with parental responsibility; and**
- (6) in the case of a person aged 16 or 17 who is being looked after by a local authority, the authority concerned.**

This recommendation can be found at page 91 (para 10.7) of the report and is given effect by schedule 1 to the draft Bill (new paragraphs 14(d) and 22 of schedule AA1 to the Mental Capacity Act).

Recommendation 16.

The responsible body should not be able to authorise arrangements which provide for a person to reside in, or to receive care or treatment at, a particular place, which conflict with a valid decision of a donee of a lasting power of attorney or a deputy appointed by the court.

This recommendation can be found at page 94 (para 10.18) of the report and is given effect by schedule 1 to the draft Bill (new paragraph 15 to schedule AA1 to the Mental Capacity Act).

Recommendation 17.

The Mental Capacity Act should be amended to confirm that a donee of a lasting power of attorney or a court appointed deputy cannot consent on a person's behalf to arrangements which give rise to a deprivation of that person's liberty.

This recommendation can be found at page 95 (para 10.18) of the report and is given effect by clause 3 of the draft Bill.

Recommendation 18.

The responsible body may authorise arrangements if (amongst other requirements) an independent review has been carried out and the person carrying it out has confirmed that:

- (1) it is reasonable for the responsible body to conclude the relevant conditions for an authorisation are met, or**
- (2) the case has been referred to an Approved Mental Capacity Professional and their approval has been obtained.**
- (3) The independent review may not be carried out by a person who is involved in the day-to-day care of, or providing any treatment to, the person.**

This recommendation can be found at page 97 (para 10.26) of the report and is given effect by schedule 1 to the draft Bill (new paragraphs 14(e) and 23 of schedule AA1 To the Mental Capacity Act).

Recommendation 19.

There should be a duty to refer a case to an Approved Mental Capacity Professional if:

- (1) the arrangements that are proposed, or in place, provide for the person to reside in, or receive care or treatment at, a particular place, and it is reasonable to believe that the person does not wish to reside at that place, or receive the care or treatment at that place; or**
- (2) an assessor has determined that the arrangements are necessary and proportionate wholly or mainly by reference to the likelihood of harm to other individuals if the arrangements were not in place and the seriousness of that harm.**

Otherwise, there should also be a power to refer a case to the Approved Mental Capacity Professional if the case is one which is appropriate to be considered by an Approved Mental Capacity Professional and the Approved Mental Capacity Professional agrees to accept the referral.

This recommendation can be found at page 104 (para 10.52) of the report and is given effect by schedule 1 to the draft Bill (new paragraphs 23(3) and 24 of schedule AA1 to the Mental Capacity Act).

Recommendation 20.

The Approved Mental Capacity Professional should be required to approve the arrangements if he or she determines that the conditions for the authorisation of arrangements are met. In doing so, he or she must meet with the person (unless it is not practicable or appropriate to do so), and may consult others and take further steps (including obtaining information or making further enquiries).

This recommendation can be found at page 104 (para 10.52) of the report and is given effect by schedule 1 to the draft Bill (new paragraphs 26 and 28 of schedule AA1 to the Mental Capacity Act).

Recommendation 21.

Each local authority should be required to make arrangements for the approval of persons to act on its behalf as Approved Mental Capacity Professionals, and ensure there are sufficient numbers of persons approved as Approved Mental Capacity Professionals for the purposes of the Liberty Protection Safeguards.

This recommendation can be found at page 109 (para 10.70) of the report and is given effect by schedule 1 to the draft Bill (new paragraph 42(a) and (c) of schedule AA1 to the Mental Capacity Act).

Recommendation 22.

The Secretary of State and Welsh Ministers should be given regulation making powers to prescribe, amongst other matters, criteria which must be met in order for a person to become an Approved Mental Capacity Professional and a body to approve courses.

This recommendation can be found at page 109 (para 10.70) of the report and is given effect by schedule 1 to the draft Bill (new paragraphs 44 and 45 of schedule AA1 to the Mental Capacity Act).

Recommendation 23.

Each local authority should be required to appoint a manager who is responsible for the conduct and performance of Approved Mental Capacity Professionals and is accountable directly to the director of social services.

This recommendation can be found at page 110 (para 10.70) of the report and is given effect by paragraphs 42(b) and 43 of schedule AA1 to the Mental Capacity Act).

Recommendation 24.

The responsible body should be required to produce or revise an authorisation record if it authorises arrangements. This must, amongst other matters, specify in detail the arrangements which are authorised and date(s) from which they are authorised. Copies of the authorisation record must be given to the person and certain other key individuals.

This recommendation can be found at page 113 (para 11.10) of the report and is given effect by schedule 1 to the draft Bill (new paragraphs 30 to 33 of schedule AA1 to the Mental Capacity Act).

Recommendation 25.

Where arrangements have been authorised under the Liberty Protection Safeguards, no liability should arise in relation to the carrying out of the arrangements if no liability would have arisen if the person had had capacity to consent to the arrangements, and had consented.

This recommendation can be found at page 115 (para 11.21) of the report and is given effect by clause 1 of the draft Bill.

Recommendation 26.

An authorisation should last for an initial period of up to 12 months, and be renewed for a further period of up to 12 months and then for further periods of up to three years.

This recommendation can be found at page 121 (para 11.44) of the report and is given effect by schedule 1 to the draft Bill (new paragraphs 35(1)(a) and 37(1) of schedule AA1 to the Mental Capacity Act).

Recommendation 27.

The responsible body should be able to renew an authorisation if it reasonably believes that:

- (1) the person continues to lack capacity to consent to the arrangements;**
- (2) the person continues to be of unsound mind;**
- (3) the arrangements continue to be necessary and proportionate; and**
- (4) it is unlikely that there will be any significant change in the person's condition during the renewal period which would affect any of the matters in (1), (2) and (3).**

This recommendation can be found at page 121 (para 11.44) of the report and is given effect by schedule 1 to the draft Bill (new paragraph 37(3) of schedule AA1 to the Mental Capacity Act).

Recommendation 28.

An authorisation should cease to have effect if the responsible body knows or ought reasonably to suspect that:

- (1) the person has, or has regained capacity, to consent to the arrangements (except in fluctuating capacity cases); or**
- (2) the person is no longer of unsound mind; or**
- (3) the arrangements are no longer necessary and proportionate.**

The authorisation should also cease to have effect if there is a conflicting decision of a lasting power of attorney or a court appointed deputy, or if the authorisation conflicts with requirements arising under legislation relating to mental health (in so far as it relates to those arrangements).

This recommendation can be found at page 121 (para 11.44) of the report and is given effect by schedule 1 to the draft Bill (new paragraph 35(2) and (4) to (6) of schedule AA1 to the Mental Capacity Act).

Recommendation 29.

The responsible body should be required to specify in the authorisation record when it proposes to review the authorisation of arrangements, to keep an authorisation under review, and to review an authorisation:

- (1) on a reasonable request by a person with an interest in the arrangements which are authorised;**
- (2) if the person to whom it relates becomes subject to mental health arrangements;**
- (3) if the person to whom it relates becomes subject to different requirements arising under legislation relating to mental health; and**
- (4) if it becomes aware of a significant change in the person's condition or circumstances.**

This recommendation can be found at page 126 (para 12.19) of the report and is given effect by schedule 1 to the draft Bill (new paragraph 38 of schedule AA1 to the Mental Capacity Act).

Recommendation 30.

If a responsible body proposes to authorise arrangements which would give rise to a deprivation of a person's liberty, it should be required to appoint an independent mental capacity advocate to represent and support the person (if there is no appropriate person appointed) unless:

- (1) the person does not consent to being represented; or**
- (2) if the person lacks capacity to consent, being represented by an advocate would not be in his or her best interests.**

If a responsible body proposes to authorise arrangements which would give rise to a deprivation of a person's liberty and an appropriate person is appointed, the responsible body should be required to appoint an independent mental capacity

advocate to support the appropriate person unless the appropriate person does not consent.

This recommendation can be found at page 135 (para 12.53) of the report and is given effect by clause 10 of the draft Bill (new section 38A of the Mental Capacity Act).

Recommendation 31.

The Secretary of State and Welsh Ministers should have regulation-making powers to make provision about how an independent mental capacity advocate is to discharge the functions of representing or supporting the person.

This recommendation can be found at page 135 (para 12.53) of the report and is given effect by clause 11 of the draft Bill (new section 36 of the Mental Capacity Act).

Recommendation 32.

If a responsible body proposes to authorise arrangements, it should be required to determine if there is an appropriate person to represent and support the person. He or she must not be involved in providing care or treatment to the person in a professional capacity or for remuneration. If there is an appropriate person, the responsible body must appoint them to represent and support the person, unless:

- (1) the person has capacity and does not consent to that appointment; or**
- (2) if the person lacks capacity to consent, and being represented by an advocate would not be in his or her best interests.**

This recommendation can be found at page 135 (para 12.53) of the report and is given effect by schedule 1 to the draft Bill (new paragraphs 47 to 50 of schedule AA1 to the Mental Capacity Act).

Recommendation 33.

The UK Government and the Welsh Government should review the adequacy of the current levels of advocacy provision under the Mental Capacity Act, Care Act, Social Services and Well-being (Wales) Act, Mental Health Act and Mental Health (Wales) Measure 2010.

This recommendation can be found at page 135 (para 12.53) of the report.

Recommendation 34.

In tandem with the “Transforming our justice system” programme, the Lord Chancellor, the Lord Chief Justice and the Senior President of Tribunals should review the question of the appropriate judicial body for determining challenges to authorisations of deprivation of liberty under the Liberty Protection Safeguards. This review should be undertaken with a view to promoting the accessibility of the judicial body, the participation in the proceedings of the person concerned, the speedy and efficient determination of cases and to the desirability of including medical expertise within the panel deciding the case.

This recommendation can be found at page 142 (para 12.81) of the report.

Recommendation 35.

Pending the conclusion of our recommended review of the appropriate judicial body for determining challenges to authorisations of deprivation of liberty under the Liberty Protection Safeguards, the Court of Protection should have jurisdiction to determine any question relating to arrangements which are authorised under the Liberty Protection Safeguards. No permission should be required for any application made for such determination.

This recommendation can be found at page 143 (para 12.81) of the report and is given effect by clause 4 of the draft Bill.

Recommendation 36.

The Secretary of State and Welsh Ministers should be given regulation-making powers to require one or more prescribed bodies to monitor and report on the operation of the new scheme, and make provision for how the prescribed bodies must undertake these functions.

This recommendation can be found at page 146 (para 12.97) of the report and is given effect by schedule 1 to the draft Bill (new paragraphs 51 and 52 of schedule AA1 to the Mental Capacity Act).

Recommendation 37.

The Liberty Protection Safeguards should not apply to arrangements carried out in hospital for the purpose of assessing, or providing medical treatment for, mental disorder within the meaning it is given by the Mental Health Act. But the Liberty Protection Safeguards should be available to authorise arrangements in hospital for the purpose of providing medical treatment where those arrangements arise by reason of learning disability where that disability is not associated with abnormally aggressive or seriously irresponsible conduct.

This recommendation can be found at page 155 (para 13.31) of the report and is given effect by schedule 1 to the draft Bill (new paragraphs 1(1)(c) and 53 of schedule AA1 to the Mental Health Act).

Recommendation 38.

The Liberty Protection Safeguards should not apply to arrangements which are inconsistent with:

- (1) a requirement imposed by a guardian under section 8 of the Mental Health Act;**
- (2) a condition or direction under section 17 of the Mental Health Act;**
- (3) a condition in a community treatment order made under section 17A of the Mental Health Act;**
- (4) a condition or direction in respect of a hospital order under section 37 of the Mental Health Act;**
- (5) a requirement imposed by a guardian under section 37 of the Mental Health Act;**
- (6) a condition in respect of a restriction order under section 42 of the Mental Health Act;**

- (7) a condition imposed when a person is conditionally discharged under section 73 of the Mental Health Act; or**
- (8) a condition or requirement imposed under any other enactment prescribed by regulations.**

This recommendation can be found at page 155 (para 13.31) of the report and is given effect by schedule 1 to the draft Bill (new paragraphs 1(1)(d) and 54 of schedule AA1 to the Mental Health Act).

Recommendation 39.

The UK Government and the Welsh Government should review mental health law in England and in Wales with a view to the introduction of a single legislative scheme governing non-consensual care or treatment of both physical and mental disorders, whereby such care or treatment may only be given if the person lacks the capacity to consent.

This recommendation can be found at page 155 (para 13.31) of the report.

Recommendation 40.

Section 4(6) of the Mental Capacity Act should be amended to require that the individual making the best interests determination must ascertain, so far as is reasonably practicable:

- (1) the person's past and present wishes and feelings (and, in particular, whether there is any relevant written statement made by him or her when they had capacity);**
- (2) the beliefs and values that would be likely to influence the person's decision if he or she had capacity; and**
- (3) any other factors that the person would be likely to consider if he or she were able to do so;**

and in making the determination must give particular weight to any wishes or feelings ascertained.

This recommendation can be found at page 161 (para 14.21) of the report and is given effect by clause 8 of the draft Bill.

Recommendation 41.

If someone acting in a professional capacity or for remuneration does an act pursuant to a relevant decision, the statutory defence under section 5 of the Mental Capacity Act should not be available unless before doing the act he or she has prepared a written record (or one been prepared by someone else) containing required information. The relevant decisions should be those relating to:

- (1) moving the person to long-term accommodation;**
- (2) restricting the person's contact with others;**
- (3) the provision of serious medical treatment;**
- (4) the administration of "covert" treatment; and**
- (5) the administration of treatment against the person's wishes.**

The required information should be:

- (1) the steps taken to establish that the person lacks capacity;**
- (2) the steps taken to help the person to make the decision;**
- (3) why it is believed that the person lacks capacity;**
- (4) the steps taken to establish that the act is in the person's best interests;**
- (5) a description of ascertained wishes and feelings for the purposes of a best interests determination and if the decision conflicts with the person's ascertained wishes, feelings, beliefs or values, an explanation of the reason for that decision;**
- (6) that any duty to provide an advocate has been complied with; and**
- (7) that the act would not be contrary to an advance decision.**

This recommendation can be found at page 167 (para 14.42) of the report and is given effect by clause 9 of the draft Bill.

Recommendation 42.

The Secretary of State and Welsh Ministers should be given the power, by regulations, to establish a supported decision-making scheme to support persons making decisions about their personal welfare or property and affairs (or both).

This recommendation can be found at page 170 (para 14.56) of the report and is given effect by clause 12 of the draft Bill.

Recommendation 43.

A person aged 16 or over who has capacity to do so, should be able to consent to specified care or treatment arrangements being put in place at a later time, which would otherwise give rise to a deprivation of that person's liberty.

This recommendation can be found at page 176 (para 15.24) of the report and is given effect by clause 6 of the draft Bill.

Recommendation 44.

Section 4B of the Mental Capacity Act should be amended to provide that a person may be deprived of liberty to enable life sustaining treatment or action believed necessary to prevent a serious deterioration in the person's condition if there is a reasonable belief that the person lacks capacity to consent to the steps being taken, and:

- (1) there is a question about whether the decision-maker is authorised to deprive the person of liberty and a decision is being sought from the court;**
- (2) a responsible body is determining whether to authorise arrangements which would give rise to a deprivation of P's liberty (and it does not matter if the steps taken by D which deprive P of P's liberty as mentioned in subsection (1) do not correspond to the arrangements which the responsible body is determining whether to authorise); or**
- (3) it is an emergency.**

This recommendation can be found at page 180 (para 15.38) of the report and is given effect by clause 2 of the draft Bill.

Recommendation 45.

A person should be able to bring civil proceedings against the managers of a private care home or an independent hospital when arrangements giving rise to a deprivation of their liberty have been put in place and have not been authorised under the Mental Capacity Act, the Mental Health Act or by an order of a court.

This recommendation can be found at page 183 (para 15.50) of the report and is given effect by clause 7 of the draft Bill.

Recommendation 46.

Section 48 of the Coroners and Justice Act 2009 should be amended to provide that a person is not in State detention if the compulsory detention, to which he or she is subject, arises as a result of arrangements which are authorised under Liberty Protection Safeguards, section 4B of the Mental Capacity Act or a provision of an order made under section 16 of the Mental Capacity Act.

This recommendation can be found at page 187 (para 15.67) of the report and is given effect by clause 5 of the draft Bill.

Recommendation 47.

If the Department of Health decides not to introduce its proposed reform to require a medical examiner or medical practitioner to refer a case to a coroner if the death was attributable to a failure of care, measures should be put in place to ensure that deaths of people subject to the Liberty Protection Safeguards or deprived of their liberty pursuant to an order of the Court of Protection are notified to the coroner.

This recommendation can be found at page 187 (para 15.67) of the report.

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