



**Law
Commission**
Reforming the law

Mental Capacity and Deprivation of Liberty Summary

**Law Com No 372 (Summary)
13 March 2017**

Summary

1. This is a summary of our final report on Mental Capacity and Deprivation of Liberty, published on 13 March 2017. Pages 1 to 9 summarise our main recommendations and their context. Pages 10 onwards give further detail. Full details are in the report. A glossary explaining some of the terminology used in the report and in this summary is attached at page 27. The purpose of the project was to review the Deprivation of Liberty Safeguards and consider how the law should protect people who need to be deprived of their liberty in order to receive care or treatment and lack the capacity to consent to this. Article 5 of the European Convention on Human Rights (“ECHR”) guarantees the right to personal liberty and provides that no-one should be deprived of liberty in an arbitrary fashion. If a person is deprived of liberty then certain safeguards must be provided, including entitlement to bring legal proceedings to challenge the deprivation of liberty. Such situations also engage an individual’s right to private and family life under Article 8 of the ECHR.
2. The project was announced in 2014. Its first stage led to the publication of a consultation paper in July 2015 setting out provisional proposals for law reform. Following consultation we published an interim statement in May 2016. The publication of our final report marked the completion of the project. These documents, together with an analysis of the consultation responses that we received, are available on the mental capacity and deprivation of liberty project’s page of the Law Commission’s website, at <http://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/>.

THE CASE FOR REFORM

3. More than 12 years ago the European Court of Human Rights gave 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 people who lacked capacity to consent to treatment were being deprived of liberty for the purpose of mental health treatment under the common law principle of necessity rather than under the powers in the Mental Health Act.² The court held that HL was being denied the procedural safeguards demanded by Article 5.
4. As a result of the judgment, the Mental Health Act 2007 added 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”). The DoLS provide for the authorisation of deprivations of liberty by an administrative process and also a means to challenge any such deprivation in court. They apply to hospitals and care homes in which people who lack capacity to consent to their living arrangements are deprived of liberty. They do not apply to deprivations of liberty elsewhere, such as in supported living, shared lives, or private or domestic settings.³ Where deprivation of liberty occurs in those other

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

² The claimant, HL, had been treated at Bournewood Hospital in Surrey.

³ See the glossary for an explanation of these terms.

settings an authorisation currently needs to be (but in practice is usually not) obtained from the Court of Protection.

5. The DoLS have been subject to heavy criticism since their inception. 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”. It concluded that “the legislation is not fit for purpose” and proposed its replacement.⁴
6. In 2014 a decision of the Supreme Court (commonly referred to as “*Cheshire West*”) gave a significantly wider interpretation of deprivation of liberty than had been previously applied in the health and social care context.⁵ This increased considerably the number of people who need to be recognised as being deprived of liberty and requiring safeguards. The implications for the public sector have been significant.⁶
7. Responses to our consultation paper confirmed that the current regime is in crisis and needs 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. A number of responses from families described how distressing and confusing the DoLS process had been for their loved ones. Hospital clinicians told us that the DoLS process delivered no tangible benefits to the person’s treatment plan (particularly in intensive care units and end of life care) and deflected resources away from the provision of care and treatment. Consultees generally 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.
8. Many responses (particularly from NHS bodies and local authorities) pointed to the practical and financial impact of *Cheshire West*, such as the increasing backlog of cases, referrals for authorisation being left unassessed, the legal timescales for authorisations being frequently breached and shortages of people qualified to perform roles under the DoLS provisions. Many local authorities and NHS bodies reported that they are not even considering obtaining authorisation for deprivations of liberty in cases outside hospital and care home settings, or involving 16 and 17 year olds, where the DoLS do not apply.
9. In our view there is 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 also confirmed that the DoLS are not capable of dealing with the increased numbers of

⁴ 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.

⁵ *P v Cheshire West and Chester Council and P and Q v Surrey County Council* [2014] UKSC 19.

⁶ Official figures show 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). In Wales, there was a 16 fold increase in DoLS applications in 2014-15 (the year following the judgment). The figures also show an increasing number of DoLS referrals being left unassessed and statutory time-scales being routinely breached; in England out of the 195,840 DoLS referrals during 2015-16, only 43% were completed within the year, and of those only 29% were completed within the 21 day time-limit set in regulations. See NHS Digital, *Mental Capacity Act (2005) Deprivation of Liberty Safeguards (England): England 2015-16 National Statistics* (2016) and 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).

people considered to be deprived of their liberty following *Cheshire West*. The widespread reports of backlogs, breached statutory timescales and increased workloads mean, in our view, that any notion that the DoLS can be patched up to cope, even in the short term, is unrealistic. Article 5 rights must be practical and effective. It is not acceptable to continue with the current system under which many people's rights have become theoretical and illusory.

10. Our report recommends that the DoLS should be repealed and a new scheme introduced as a matter of pressing urgency. The draft Bill attached to the report contains our recommended replacement scheme, which we have called the Liberty Protection Safeguards. The draft Bill would also amend other parts of the Mental Capacity Act to provide increased protection for people whose rights to respect for their private and family life and their home under Article 8 of the ECHR are at risk, whether or not they risk being deprived of their liberty.
11. We have also recommended that the Liberty Protection Safeguards should be accompanied by the publication of a new Code of Practice covering all aspects of the Mental Capacity Act, including the new scheme.

OVERVIEW OF THE LIBERTY PROTECTION SAFEGUARDS

12. This section provides an overview of how the Liberty Protection safeguards would operate. It is followed by a more detailed explanation of some of the key aspects of the new scheme.
13. Our recommended scheme serves the same essential purpose as the DoLS and where possible we have made use of existing mechanisms and procedures provided by health and social care and mental capacity legislation. People with experience of these areas of law will notice a number of familiar elements. But in designing the Liberty Protection Safeguards we have removed the features of the DoLS that we have identified as being both inherently inefficient and actively detrimental to the interests of people who are deprived of their liberty.
14. As mentioned above, the DoLS do not apply at all to deprivations of liberty in many settings in which people who lack mental capacity to consent to being accommodated are commonly deprived of liberty. Where deprivation of liberty occurs in those other settings an authorisation currently needs to be obtained from the Court of Protection. This is time-consuming and expensive and in practice is usually not done, leaving the person deprived of their liberty unlawfully. Another 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). An authorisation under the Liberty Protection Safeguards could cover deprivation of liberty in any setting and in more than one setting so as to take account of, for example, planned admissions to hospitals and respite care, as well as arrangements for the person's travel between venues.
15. 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.⁷ 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 an unnecessary form-filling obligation; it also means that the formal process of considering whether deprivation of liberty is justified only begins after the decision to subject the person to a deprivation of liberty has already been taken, often by the same local authority.

16. 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, but this procedure was not designed to enable authorisations to be applied for late in the day and we have been told that the paperwork for 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 is true of hospitals in which individuals are deprived of liberty.
17. 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 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 gone over 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. The “best interests assessors” are, however, directed to consider whether the deprivation of liberty is in the person’s best interests. It is not surprising that many 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.
18. It is also 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* illustrate the consequences of such failures.⁸
19. The Liberty Protection Safeguards would dispense with the current carousel-like process in which 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

⁷ The only exception is hospitals in Wales, where the supervisory body for hospital patients is the local health board.

⁸ *Hillingdon LB v Neary* [2011] EWHC 1377 (COP), [2011] 4 All ER 584 and *Essex CC v RF* [2015] EWCOP 1. A summary of these cases can be found at para 1.26 of the report.

liberty that they have already arranged. It would bring forward formal consideration of the justification for a deprivation of liberty so that it occurs before the arrangements are made, rather than only afterwards. It would replace urgent authorisations 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 permissible under our scheme to impose a deprivation of liberty on someone until the proposed arrangements have been authorised.

20. This is designed 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 should impose a discipline on the care and treatment planning process itself.
21. 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 Health Professional in mental health legislation; we intend it to involve similar levels of professional qualification and independence.
22. The requirement of a second assessment by an Approved Mental Capacity Professional applies in cases where it appears that the person does not wish to reside in or receive care or treatment at a particular place or proposed accommodation, or where the arrangements are wholly or mainly for the protection of people other than the person being placed.
23. 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 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 court's 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.
24. Consistently with bringing human rights considerations formally into the initial decision-making process, the responsible bodies 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. 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 make the NHS an active partner in protecting people's Article 5 rights.

25. 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 – the private care or treatment provider will need to apply to the local authority 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 and are not authorised.
26. The table that follows sets out the main elements of the Liberty Protection Safeguards. It is followed by a flowchart describing the procedural steps involved.

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?

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:

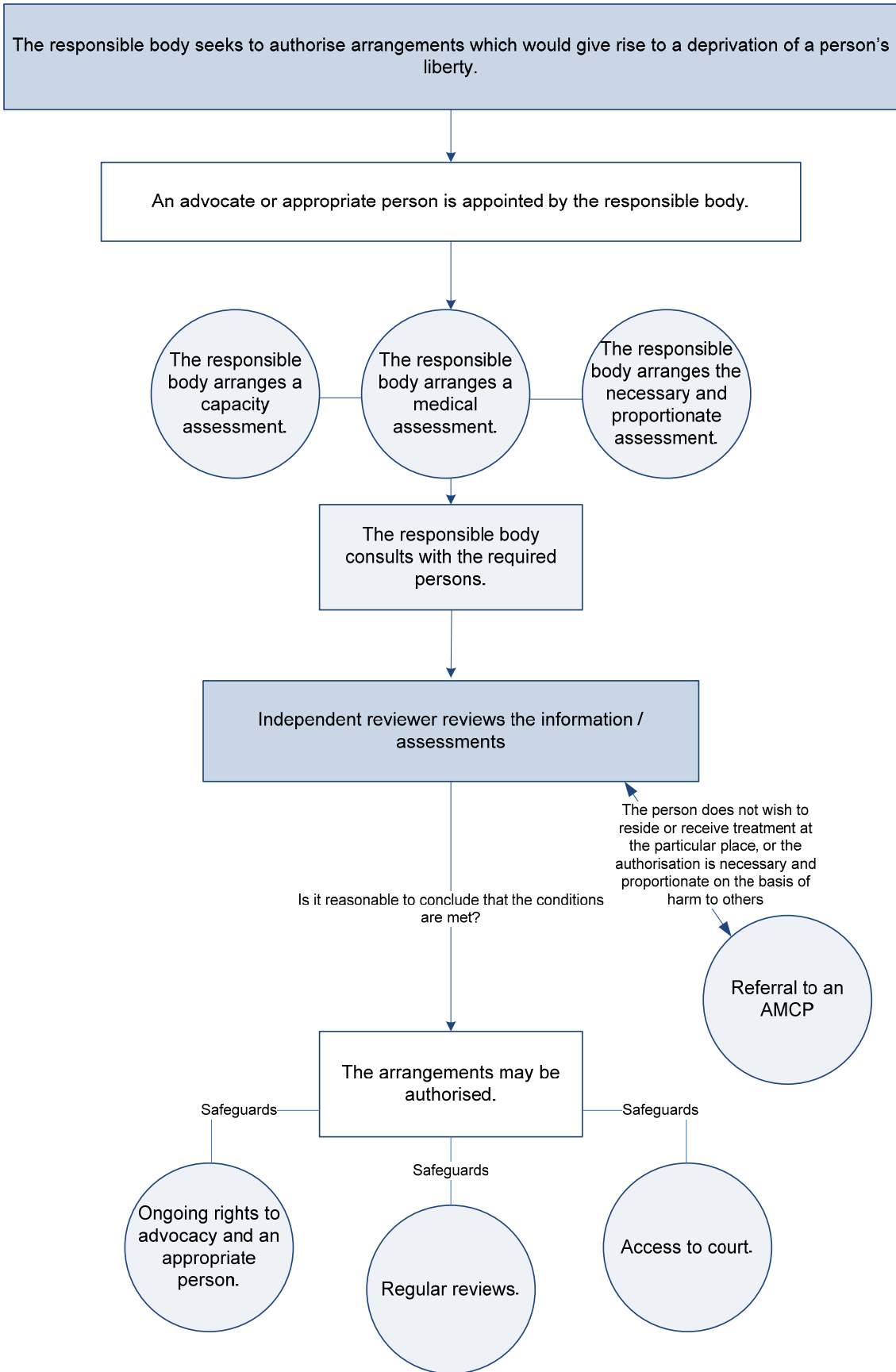
- (1) a donee of a lasting power of attorney; or
- (2) a court appointed deputy.

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 Liberty Protection Safeguards

Summary of steps



27. 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.
28. The Liberty Protection Safeguards would thus reduce bureaucracy and give greater flexibility as to how arrangements are authorised and what arrangements are authorised. Most importantly, they are designed to deliver tangible benefits and improved outcomes for people and their families through a more rights-focused decision-making process buttressed by enhanced liability in civil law for unauthorised deprivation of liberty and accompanied by enhanced rights to advocacy and periodic checks on the care or treatment arrangements.
29. The Liberty Protection Safeguards would operate within a broader set of proposed reforms to improve decision-making across the Mental Capacity Act, not only in relation to people deprived of liberty. All decision-makers would be required to consider a person's ascertained wishes and feelings when a best interests decision is taken. In the case of actions taken pursuant to a number of important best interests decisions, professional providers of care or treatment would be unable to rely on the defence to liability provided by section 5 of the Act unless a written record of the decision-making process has been prepared. The record must confirm (amongst other matters) that a formal capacity assessment has been undertaken and rights to advocacy have been implemented. The cases to which this applies are decisions to move a person into particular accommodation, to restrict their contact with others or to administer certain types of medical treatment to them. This discipline would help to ensure proper consideration, in advance of the decision being made, of the necessity of (for example) removing a person from their home and placing them in a care home in the name of their best interests. These wider reforms are integral to the overall approach that we set out in the Bill and explain in the report.
30. The remainder of this summary gives further details of our recommendations.

THE SCOPE OF THE LIBERTY PROTECTION SAFEGUARDS

The arrangements that can be authorised

31. Our new scheme would extend beyond hospitals and care homes, obviating the need for deprivations of liberty in other settings to be authorised by the Court of Protection. The Liberty Protection Safeguards are not limited to specific forms of accommodation or residence; they encompass any situation where Article 5(1)(e) is potentially engaged and focus on arrangements that give rise to a deprivation of liberty. The types of arrangements that may be authorised are set out in the table above.
32. The term “arrangements” is intentionally broad. It would include arrangements to return a person to a specified place (or places) if they had absconded or wandered off and to authorise arrangements in community settings such as day centres. The intention is that decision-makers be clear and precise about the particular arrangements that are being authorised and not authorise arrangements in vague and broad terms.
33. An authorisation can have effect immediately, or up to 28 days later. Our intention is that arrangements should be authorised in advance of being put in place. Except in urgent and emergency cases, not doing so will give rise to civil (and possibly criminal) liability.
34. We consider it important that the Liberty Protection Safeguards should 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. This is important so as to balance the right to liberty arising under Article 5 ECHR and the rights of individuals and their families to respect for their private and family life arising under Article 8 ECHR.

16 and 17 year olds

35. Most of the Mental Capacity Act applies to people aged 16 and over; however, the DoLS only apply to adults aged 18 and over. The current legal framework for the deprivation of liberty of 16 and 17 year olds (which includes secure accommodation under section 25 of the Children Act 1989, detention under the Mental Health Act 1983 or a court authorisation) provides an inadequate basis for dealing with many young people who lack mental capacity and need to be deprived of their liberty. Section 25 of the Children Act has a punitive quality which makes it inappropriate for the vast majority of cases within this group. Unless detention under the Mental Health Act is appropriate for them, an application must be made for a court 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. 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.
36. We are therefore recommending that the Liberty Protection Safeguards should apply to people aged 16 and above. The extension of the Liberty Protection Safeguards to 16 and 17 year olds would allow deprivations of liberty to be authorised in a much more efficient and straightforward manner than at present, 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.

37. The concern we expressed in the consultation paper about the use of parental consent to authorise what would otherwise be a deprivation of liberty for 16 and 17 year olds was shared by consultees. We remain of the view that Article 5 safeguards should not be denied to young people on the basis of parental consent to their confinement. The current legal position is that a parent cannot consent to what would otherwise give rise to a deprivation of liberty of a 16 or 17 year old.⁹ Despite our support for this position, we have decided not to codify it in the draft Bill by expressly prohibiting parental consent. It is possible that the position may alter in the future as a result of domestic or Strasbourg case law and we would want the Liberty Protection Safeguards to be able to accommodate the effect of any future judgments.

THE RESPONSIBLE BODY

38. The Liberty Protection Safeguards are designed to establish a stronger link between the commissioning of the arrangements and consideration of whether deprivation of liberty is justified. This means that the body responsible for arranging the care or treatment should (to the extent that this is practicable) be responsible for considering requests for authorisations, commissioning the required assessments and then giving the authorisation.
39. We also recognise the importance of legal certainty in identifying the responsible body. The draft Bill provides for the following three criteria to be applied to identify the responsible body in any case:
- (1) if the arrangements or proposed arrangements are being carried out primarily in a hospital, the responsible body is the “hospital manager” (which would in most cases be the trust that manages the hospital in England or the local health board in Wales);
 - (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 local health board in Wales; and
 - (3) otherwise the responsible body is the “responsible local authority”.
40. It is also necessary to identify which local authority will be the “responsible” local authority for any given case. In most cases this will appropriately be the authority that is meeting the person’s needs under the Care Act 2014, Children Act 1989 or Social Services and Well-being (Wales) Act 2014. In any other case 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.

⁹ *Birmingham City Council 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 publication.

THE CONDITIONS FOR AUTHORISATION

41. 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.

The capacity assessment

42. The DoLS require that in order for a standard authorisation to be granted 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".¹⁰ This does not, in our view, get to the heart of the issue under Article 5. It is not the 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 require that the person lacks capacity to consent to the arrangements which would give rise to a deprivation of the person's liberty. This also permits the authorisation of arrangements that do not relate to residence in a particular place, such as those for visits to day centres and transport between places.
43. 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 3.¹¹
44. Many consultees also commented on the difficulties that currently occur when a person has fluctuating capacity. It was pointed out that strict application of the existing law is impracticable, requiring a continuous cycle of discharges followed by fresh DoLS assessments when the person temporarily regains capacity and then loses it again. In practice health and social care professionals tend to adopt a pragmatic approach, based on the *DoLS Code of Practice*, which suggests that an authorisation can remain in place where the regaining of capacity is likely to be temporary and an authorisation will be required again within a short period of time.
45. In our view, it is not acceptable for the legislative framework simply to ignore fluctuating capacity, exposing health and social care professionals and those authorising a deprivation of liberty to significant legal risk. The Liberty Protection Safeguards should provide expressly for fluctuating capacity. Our draft Bill builds on the position set out in the *DoLS Code of Practice*. We think this is justifiable given 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. A risk of harm may be continuously present in cases of fluctuating capacity owing to the risk of a person losing the ability to keep themselves safe whilst at large on their own.

¹⁰ Mental Capacity Act, sch A1, para 15.

¹¹ These are explained in chapter 3 of our report.

46. 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 the periods of capacity are likely to last only for a short period of time, the person remains at all times “of unsound mind” for the purposes of Article 5 and the authorisation of the arrangements remains necessary and proportionate.

“Unsoundness of mind”: the medical assessment

47. The mental health requirement under the DoLS is that the person is suffering from a “mental disorder” within the meaning of the Mental Health Act. This is intended to ensure that the person’s circumstances fall within of Article 5(1)(e) of the ECHR, which permits deprivation of liberty on the basis that a person is “of unsound mind”.
48. We have concluded that the Liberty Protection Safeguards should not retain the existing mental health requirement under the DoLS, as this would make their scope 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).¹² Consultees also provided us with examples of patients who would not be considered mentally disordered for the purposes of the Mental Health Act but would be of unsound mind for the purposes of Article 5. We have therefore concluded that the best approach is for the new scheme to apply on the basis of unsoundness of mind. Though this term is not in keeping with modern psychiatric terminology and social attitudes towards people with mental health problems, it is being used purely a matter of drafting to ensure that the Liberty Protection Safeguards have the same scope as the relevant provisions of Article 5.
49. In order to comply with the Strasbourg case law, the Liberty Protection Safeguards require unsoundness of mind to be confirmed by a medical assessment. The Bill creates a regulation-making power to specify which professionals can undertake this assessment, providing the flexibility to respond to evolution of the case law requirement of “objective medical expertise”.

Whether the arrangements are necessary and proportionate

50. Under the DoLS, the “best interests requirement” is that deprivation of liberty is in the person’s best interests, is necessary, and is a proportionate response to the likelihood of the person suffering harm and the seriousness of that harm. This combines 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 are a requirement of Article 5(1)).
51. However, at consultation we were told that there is some degree of confusion over the role of the best interests decision generally, and in particular when it comes to deprivations of liberty. 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.

¹² *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 giving rise to severe learning disabilities.

52. We have concluded that the problem is that the best interests requirement in reality adds nothing to the consideration of whether a 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. The best interests decision is therefore based on a notional “choice” between the person staying at home in an unsafe environment and the care home placement. Given that a DoLS assessor cannot compel the local authority or NHS to fund the domiciliary care, 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).
53. As well as adding nothing to the assessment in the vast majority of cases, the DoLS best interests requirement adds a complication in the small number of cases where 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”) requires assessors to conclude, somewhat artificially, that the person’s own interests include not harming someone else and thereby (for instance) becoming subject to civil or criminal proceedings.
54. We have therefore tied the authorisation of arrangements 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 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; or
 - (2) the likelihood of harm to other individuals if the arrangements were not in place and the seriousness of that harm.
55. This 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. It does not remove best interests from the process of formulating the arrangements as a whole. A 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 (discussed at paragraph 99 below). These reforms are intended to ensure that best interests considerations are fully addressed, before arrangements giving rise to a deprivation of liberty are put into effect, and as part of a documented process.
56. Furthermore, considering whether a deprivation of liberty is proportionate involves considering whether there is a less intrusive alternative. This is particularly important where the arrangements 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. Like the current law, our draft Bill does not allow authorisation to be refused on the grounds that additional funding ought to be provided to enable less intrusive arrangements. But the requirement of proportionality requires a robust approach to challenging assumptions upon which decisions have been taken.

57. For example, social services departments frequently conclude that a person needs such a high level of care that placement in an institution is the only affordable option. The principle of proportionality requires an assessment of whether this conclusion takes sufficient account of the importance to the person of remaining at home with a lower level of care, even if this is at the cost of some greater degree of risk. The draft Bill provides that cases where (in broad terms) a person objects to the proposed arrangements, this must be referred to an Approved Mental Capacity Professional (see below). Authorisation could be refused if the Approved Mental Capacity Professional was not satisfied that deprivation of liberty under the proposed arrangements would be proportionate. Those proposing the arrangements could be invited to consider allocating the available funding differently so as to provide a lower but still acceptable level of care and enable the person to remain at home.
58. In cases of risk of harm to others, our approach would remove the element of artificiality we have referred to, making the process more transparent. It is necessary in the public interest for a deprivation of liberty to be possible where a person who lacks capacity is a source of risk to others. Public protection is not currently among the purposes of the Mental Capacity Act, which are directed primarily at the empowerment of individuals and their protection from risks to themselves, but we consider it preferable for the protection to be provided under our scheme rather than to set up separate legal machinery. However, there are similar existing powers in the Mental Health Act, which provides for the detention of people with a mental disorder on the basis of public protection. The draft Bill therefore requires decision-makers in cases mainly involving risk of harm to others to consider whether it would be more appropriate for an application to be made under sections 2 or 3 of that Act, so as to ensure that the Liberty Protection Safeguards are not used in cases where detention under the Mental Health Act is more appropriate. These cases too must be referred to an Approved Mental Capacity Professional.

The required consultation

59. Under the DoLS the determination that it is in the best interests of a person for them to be detained is made by reference to section 4 of the Mental Capacity Act, which includes a duty to consult as far as it is “practical and appropriate”. We consider it very important to ensure that full consultation takes place before arrangements can be authorised under the Liberty Protection Safeguards. The draft Bill creates an express duty to consult, where practical and appropriate:
- (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.

Conflicting decision of a donee or deputy

60. The “no refusals” requirement under the DoLS provides that a standard authorisation cannot be given if it would conflict with a valid decision of a donee of a lasting power of attorney or a court-appointed deputy, or where the person has made a valid advance decision to refuse all or part of the proposed treatment. The draft Bill sets out with more precision which decisions should operate as a bar to the granting of an authorisation. It precludes an authorisation which would conflict with a valid decision of a donee or a deputy as to where the person should reside or receive care or treatment. It does not automatically bar an authorisation where a donee, a deputy or the person (through an advance decision) is refusing all or part of the care or treatment plan which the arrangements are intended to enable. This is because 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. Instead, the assessor would need to consider whether it could be said to be necessary and proportionate to authorise the arrangements in view of the terms of the refusal.
61. The draft Bill also expressly confirms the current position that a donee or deputy cannot consent on behalf of a person to what would otherwise be a deprivation of their liberty.

Independent review

62. There is a need for operational independence given that in many cases the assessments will be undertaken by members of the team responsible for the person’s care or treatment. 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.¹³ The Liberty Protection Safeguards require an “independent review” to be carried out in all cases in order to confirm that it is reasonable to conclude that the conditions for an authorisation are met, or (in certain cases) to refer the case to an Approved Mental Capacity Professional. No one who is involved in the day-to-day care or treatment of the person can act as the reviewer or the Approved Mental Capacity Professional.
63. In cases which are not referred to an Approved Mental Capacity Professional the reviewer is required to certify personally that it is reasonable to conclude that the conditions for an authorisation are met. They must review the information available to the responsible body and determine whether or not the responsible body’s decision to authorise arrangements is a reasonable one to come to on the basis of that information.

Approval by an Approved Mental Capacity Professional

64. Under the DoLS the best interests assessor plays a key role. We have built upon this in creating the role of Approved Mental Capacity Professional, and giving that role a specific focus on the approval of arrangements giving rise to deprivation of liberty. In our view the existing requirement of a separate best interests assessment in every case is simply no longer sustainable, given the large number of people now considered to be deprived of their liberty following *Cheshire West* and taking into account that the Liberty Protection Safeguards will extend to 16 and 17 year olds and those deprived of liberty

¹³ *IN v Ukraine* App No 28472/08 at [81].

otherwise than in hospitals and care homes. We have therefore concluded that the only practical alternative is to focus this role on certain defined cases. In reaching this conclusion we have borne in mind that all those deprived of liberty will benefit from safeguards including rights to seek a review of the care or treatment arrangements, rights to advocacy and an appropriate person, access to the Court of Protection and other reforms aimed at ensuring that decisions are taken in a thorough, documented process.

65. In our view the cases where a greater degree of oversight is required are, first of all, those where the arrangements are contrary to the person's wishes. The draft Bill therefore requires a referral to be made to an Approved Mental Capacity Professional where it is reasonable to believe that the person does not wish to reside or receive care or treatment at a particular place. Secondly, we consider that there must be a referral to an Approved Mental Capacity Professional where arrangements are regarded as necessary and proportionate wholly or mainly by reference to the likelihood and seriousness of harm to others. In all other cases there would be a power to refer cases to an Approved Mental Capacity Professional.
66. Where a referral is made, the Approved Mental Capacity Professional's role is to determine whether or not they must approve the arrangements. The Approved Mental Capacity Professional is required to meet with the person unless it is not practicable or appropriate to do so, and can consult other key individuals in the person's life. The written approval of the Approved Mental Capacity Professional would enable the authorisation of arrangements by the responsible body.
67. Local authorities would be responsible for the approval of Approved Mental Capacity Professionals and for ensuring that there are sufficient numbers of persons approved. A local authority could only approve a person to act as an Approved Mental Capacity Professional if the person meets requirements prescribed in regulations. The regulation-making power allows, amongst other things, bodies such as the Health and Care Professions Council and Care Council for Wales to be prescribed to approve courses for Approved Mental Capacity Professionals. The Liberty Protection Safeguards do not specify which professionals could or could not undertake the new Approved Mental Capacity Professional role; this would be a matter for the Governments.
68. The Liberty Protection Safeguards aim to put Approved Mental Capacity Professionals in a similar position to Approved Mental Health Professionals. They would act "on behalf" of the local authority but would be independent decision-makers who could not be directed to make a particular decision.

AUTHORISATIONS

Authorisation record

69. The Liberty Protection Safeguards require the responsible body to produce an "authorisation record" and specify the information that must be included, such as details of the arrangements authorised and of why the conditions for an authorisation have been met. Copies of the record must be given as soon as reasonably practicable to the person they relate to and to others who need to see it so as to equip them to carry out their role (most obviously, an advocate or appropriate person). In practice, we anticipate that the record will be attached to any statutory care plan (for example, under the Care Act or the Social Services and Well-being (Wales) Act) maintained in relation to the person, but it will not, in law, form part of it.

Effect of authorisations

70. 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. The second is to afford a statutory defence to the members of staff individuals concerned who are doing the actual acts of detaining. We did not consult specifically on the effect of an authorisation, but it was evident that there was some confusion on this subject.
71. We have therefore sought to simplify the effect of an authorisation under the Deprivation of Liberty Safeguards. Under the draft Bill an authorisation does not provide statutory authority to deprive a person of their liberty; instead, a new section 4AA of the Mental Capacity Act would provide a defence to civil or criminal liability in respect of acts done pursuant to an authorisation. This defence does not cover the provision of medical treatment or restricting contact with third parties, since “arrangements” cannot extend to these matters. This is so that care and treatment providers cannot be given power to do things that go beyond effecting a justified deprivation of liberty, unless they have the power under the general law. The provision of medical treatment can attract the defence under section 5 of the Mental Capacity and admission of visitors can be controlled using the general powers of an occupier of premises.

Duration, cessation and renewal

72. Under the DoLS the maximum duration of a standard authorisation is 12 months. Any further authorisation must be applied for afresh. A standard authorisation remains in place until it expires or is terminated following a formal review.
73. In order to mitigate the significant cost of repeat DoLS assessments in cases of people with life-long and stable diagnoses, the draft Bill would provide that an authorisation can last for an initial period of up to 12 months and can be renewed for a second period of up to 12 months and thereafter for an indefinite number of periods of up to three years. The draft Bill would introduce a mechanism for renewal, rather than fresh authorisation, allowing the responsible body to renew an authorisation if it reasonably believes that:
- (1) the person continues to lacks 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 would be any significant change in the person’s condition during the renewal period.
74. The draft Bill also provides for an authorisation to cease before its expiry date as soon as it is no longer justified, without the requirement of a formal review process. An authorisation ceases to have effect if the responsible body determines that it should or if the body knows or ought reasonably to suspect that:
- (1) the person has, or has regained capacity, to consent to the arrangements;
 - (2) the person is no longer of unsound mind; or
 - (3) the arrangements are no longer necessary and proportionate.
75. An authorisation is suspended, but revives again afterwards, if the person to whom it relates is admitted to hospital under the Mental Health Act for not more than 28 days.

76. The draft Bill would protect members of staff who are not in a position to know that an authorisation has terminated early or been suspended; they would continue to have a defence to liability except where they know or ought to know otherwise.

SAFEGUARDS

Reviews

77. Article 5 provides that the lawfulness of continued confinement depends upon the person remaining of unsound mind. It follows that any scheme which authorises deprivation of liberty must include a mechanism to ensure that the person's mental state is kept under appropriate review by the detaining authority.
78. The Liberty Protection Safeguards would allow flexibility in the review process. The responsible body is required to set out in the authorisation record its proposals for reviewing the authorisation of arrangements, by way of fixed dates or prescribed intervals. The draft Bill would require a responsible body to keep an authorisation under review generally, putting the responsible body in a position to undertake a review at any time in between the planned review dates if circumstances change. There would be a duty to hold a review:
- (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 the Mental Health Act;
 - (3) if the person to whom it relates becomes subject to requirements arising under the Mental Health Act; or
 - (4) if the responsible body becomes aware of a significant change in the person's condition or circumstances.
79. 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 regulations. The draft Bill does not specify the process for carrying out a review. We consider this would be better dealt with in the new Code of Practice.

Independent advocacy and an appropriate person

80. The DoLS provide for an Independent Mental Capacity Advocate and a "relevant person's representative" in a number of circumstances. We remain strongly committed to advocacy and support when arrangements are being proposed or authorised under the Liberty Protection Safeguards.
81. We have imported into the Liberty Protection Safeguards the role of the appropriate person under the Care Act. A responsible body proposing to authorise arrangements under the Liberty Protection Safeguards must determine whether there is someone who would be an appropriate person to represent and support the person to whom the arrangements would apply. An "appropriate person" cannot be someone who is engaged in providing care or treatment to the person in a professional capacity or for remuneration. If there is a person who could appropriately act as the person's representative and supporter, they must be appointed to act as such unless they do not consent, or the person whom they would represent and support does not consent or (if that person lacks capacity to give or withhold consent) it would not be in their best

interests to be represented or supported by that other person. The appropriate person replaces the relevant person's representative under the DoLS.

82. The draft Bill also provides that an Independent Mental Capacity Advocate must be appointed if a responsible body "proposes to authorise arrangements" and also throughout the period of the authorisation. Where there is no appropriate person appointed, the role of the advocate is to "represent and support" the person who is the subject of the arrangements. An advocate must be appointed 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. Where there is an appropriate person, the responsible body must appoint an advocate to support and assist the appropriate person in undertaking their role, unless the appropriate person does not consent. This is intended to ensure that advocacy is provided automatically and on an opt-out rather than an opt-in basis.

Rights of legal challenge

83. 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 judicial body, 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.
84. 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. In particular we identified concerns that the Court of Protection is too slow and costly and failed to guarantee the effective participation of the person. There was strong overall support amongst consultees for the introduction of a tribunal jurisdiction, with strong support in particular for a multi-member composition along the lines of the First-tier Tribunal when it hears cases under the Mental Health Act. 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.
85. In our view, the arguments are finely balanced. The potential advantages of a tribunal system include accessibility, informality, speedy decision-making and multi-member panels including non-legal (such as medical) expertise. 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 jurisdiction of the Court of Protection.
86. The Government is undertaking a programme of reform of courts and tribunals. The judicial landscape is likely to alter over the next few years in ways that we cannot predict. We do not know what procedures will operate in the Court of Protection and other parts of the courts and tribunals system as a result of it. Our draft Bill 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. We recommend that, in tandem with the programme of reform, the Government should 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 the desirability of including medical expertise within the panel deciding the case.

Monitoring and reporting

87. 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. The prescribed bodies are the Care Quality Commission in England and, in Wales, the Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales.
88. In our view it is essential that the Liberty Protection Safeguards provide for an effective and comprehensive monitoring scheme. But we also think it important to ensure that the level of oversight is proportionate to the risks posed and can deliver efficiencies. The draft Bill gives the Secretary of State and Welsh Ministers regulation-making powers to require prescribed bodies to monitor and report on the operation of the new scheme. This would provide flexibility, enabling the Governments to continue to provide for the current prescribed bodies to undertake the role and/or to prescribe other bodies, for instance Ofsted and Estyn in respect of some or all 16 and 17 year olds, or 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.

INTERFACE WITH THE MENTAL HEALTH ACT

89. 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.
90. In our view, the “fusion” of mental health and mental capacity legislation potentially represents the future direction for mental health law reform in England and Wales. The introduction of such “fusion law” in Northern Ireland provides an opportunity to review mental health law in England and Wales with a view to the possible introduction of mental capacity-based care and treatment for mental as well as physical disorders. Our report urges the UK and Welsh Governments to take that opportunity. In the absence of fusion, we have sought to simplify the notoriously complex interface between the current DoLS and the Mental Health Act.
91. There are two aspects to our recommendations. First, we recommend that the Liberty Protection Safeguards should not apply to arrangements carried out in hospital for the purpose of assessing or treating mental disorder. Instead, the relevant provisions of the Mental Health Act (or equivalent compulsory provisions such as the Criminal Procedure (Insanity) Act 1964) might be appropriate. A complicating factor here is the so-called “learning disability exclusion” under the Mental Health Act, which has the effect that a person can be detained under section 2 of the Act for the assessment or treatment of a learning disability, but cannot be subject to other provisions of the Act (such as detention under section 3) unless the disability is “associated with abnormally aggressive or seriously irresponsible conduct”. The Department of Health has already stated its

intention to reconsider this matter. 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.

92. There are also some rare cases where a patient is detained under the Mental Health Act but needs additional further treatment for a purely physical disorder which is unrelated to his or her mental disorder (and therefore not covered by Mental Health Act powers), and that treatment has to be delivered in circumstances which give rise to a deprivation of liberty. The Liberty Protection Safeguards could be used to authorise any additional arrangements made for the purpose of that treatment which give rise to a deprivation of liberty.
93. Secondly, the Department of Health has confirmed its intention to undertake further work in relation to the “community” powers of the Mental Health Act (those exercisable in relation to patients not currently detained in hospital), following engagement with stakeholders. In the meantime we have drafted the legislation to maintain, as far as possible, the current legal position; the Liberty Protection Safeguards could be used to authorise arrangements giving rise 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 they could not be used to authorise arrangements which are inconsistent with any requirement, condition or direction applying under one of these powers.

PLACING THE PERSON AT THE HEART OF DECISION-MAKING

94. The draft Bill contains a number of wider reforms of the Mental Capacity Act. These would 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.

The place of wishes and feelings in best interests decisions

95. 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. The best interests check-list requires the decision-maker to consider, amongst other matters, the person’s past and present wishes and feelings. But there is no hierarchy between the various factors. The consultation paper argued that the law fails to give sufficient certainty for decision-makers, and highlighted failures by public authorities to give sufficient recognition to the person’s wishes and feelings. A majority of consultees agreed. We were told that health and social care professionals and the Court of Protection often failed to consider the person’s wishes and feelings, and that the concept of best interests was often interpreted in a medical and paternalistic sense.
96. The draft Bill would amend the Mental Capacity Act to require that the decision-maker must, first of all, “ascertain, so far as is reasonably practicable” the person’s wishes and feelings. It further requires that, in making the best interests determination, the decision-maker “must give particular weight to any wishes or feelings ascertained”. The draft Bill also places additional requirements on professionals to explain their decisions not to give effect to a person’s wishes and feelings, in the context of restrictions of the defence to civil and criminal liability under section 5 the Mental Capacity Act. These are described below.

Section 5 acts: additional limitations

97. The consultation paper provisionally proposed separate schemes of “supportive care” and “restrictive care”. The supportive care scheme would have applied to people lacking capacity to consent to arrangements made for them where the arrangements fell short of giving rise to a deprivation of liberty. This was with a view to ensuring that proper assessments take place, care planning arrangements are adhered to, and the need for more restrictive forms of care and treatment is prevented or at least delayed. The reforms were intended to protect Article 8 rights, especially at a point in time when (for example) a person was being placed in a care home and lacked capacity to consent to the move.
98. The supportive care scheme received the backing of a majority of consultees. 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. It was reported that currently the presumption of capacity under section 1 of the Act 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. However, concerns were raised about the resource implications of supportive care.
99. The draft Bill seeks to achieve the underlying objectives of supportive care without the resource implications of a separate formal scheme. Specifically the draft Bill would restrict the availability of the defence contained in section 5 of the Mental Capacity Act; where someone acting in a professional capacity or for remuneration does an act pursuant to a “relevant decision”. The defence would not be available unless a written record has been made of the “required information”.
100. A relevant decision for these purposes is:
- (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.
101. The information to be recorded is:
- (1) the steps taken to establish that the person lacks capacity;
 - (2) the steps taken to help the person to make their own 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 the person’s wishes, feelings, beliefs or values ascertained wishes and feelings for the purposes of the best interests determination and, if the decision conflicts with them, an explanation of the reason for the 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.

Supported decision-making

102. Supported decision-making is the process of providing support to a person whose decision-making ability is impaired to enable them to make their own decisions wherever possible. 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 a decision before they are treated as lacking capacity to make that decision. A number of common law jurisdictions have introduced, or are moving towards, formal supported decision-making schemes set out in legislation. At consultation, a majority supported our proposal to establish a similar scheme. Many argued that this would secure greater compliance with the UN Convention on the Rights of Persons with Disabilities,
103. The draft Bill therefore provides a regulation-making power of the Secretary of State and the Welsh Ministers to establish supported decision-making schemes. 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”.

OTHER MATTERS

Advance consent

104. Advance consent refers to the ability of a person to consent in advance to specific care or treatment arrangements that would otherwise give rise 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 not be engaged.
105. The draft Bill would enable a person to give advance consent to specified arrangements that would (but for that consent) give rise to a deprivation of liberty. The principle that people should be able to make decisions which will endure in the event of future incapacity is already recognised in law, and it is right that people should be able 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.
106. The draft Bill provides that a person aged 16 and over, who has capacity to do so, may consent to “specified arrangements” being put in place at a later time, enabling the care or treatment of the person, which in the absence of consent would give rise to a deprivation of liberty. The person must clearly articulate the particular arrangements to which they are consenting. In line with the law on advance decisions to refuse treatment, advance consent would remain valid unless:
- (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.

Interim and emergency deprivation of liberty

107. We have referred above to the current unsatisfactory state of affairs regarding urgent authorisations under the DoLS. Our draft Bill takes a different approach, authorising deprivation of liberty in particular situations but only for the purpose of providing of life-sustaining treatment or taking action believed necessary to prevent a serious deterioration in the person's condition.
108. The amended section 4B of the Mental Capacity Act would apply while a decision is being sought from the Court of Protection as to whether a person may be deprived of their liberty, while a responsible body is determining whether to authorise arrangements, or in an emergency where there is no time to invoke any legal machinery.

Unlawful deprivation of liberty

109. 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.¹⁴
110. 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 to intervene where it knows or ought to know that a deprivation of liberty is taking place. 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.
111. The draft Bill therefore provides that where care or treatment arrangements are put in place by, or on behalf of, a "private care provider" (defined as, broadly speaking, the managers of private care homes and independent hospitals) which give rise to a deprivation of liberty (and have not been authorised), the person may bring civil proceedings against the private care provider. The care provider would not be liable if it reasonably believed that the arrangements did not give rise to a deprivation of liberty or that the deprivation of liberty was authorised.

Amendment of the Coroners and Justice Act 2009

112. Where a person dies while under a DoLS authorisation (or if their deprivation of liberty has been authorised by the Court of Protection) 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".¹⁵
113. 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

¹⁴ 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.

¹⁵ This provision has been amended by the Policing and Crime Act 2017, s 178. At the time of publishing the report, the amendment had not been commenced.

to issues over whether the deceased's body should be taken to the official mortuary rather than by the family's preferred funeral director.

114. The draft Bill would therefore amend the Coroners and Justice Act 2009 so as to remove people subject to deprivations of liberty authorised under the Liberty Protection Safeguards from the duty to hold an inquest. However, we also think that additional safeguards will be needed to ensure that any deaths which are attributable to a lack of care do not go unnoticed.
115. 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. Those reforms would provide the necessary safeguards. If the Department of Health decides not to introduce them, other 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.

Glossary of terms

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.
Care Act	Care Act 2014.
Cheshire West	<i>P v Cheshire West and Chester Council and P and Q v Surrey County Council</i> [2014] UKSC 19.
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.
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.
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.
Interim statement	Law Commission, <i>Mental Capacity and Deprivation of Liberty: Interim Statement</i> (2016).
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.
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.
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.