

Written evidence submitted by Dr Lucy Series (MCAB32)

This evidence is submitted by Dr Lucy Series, a Wellcome Research Fellow and Lecturer in Law at the School of Law and Politics, at Cardiff University. Dr Series is an expert on the Mental Capacity Act 2005 (MCA) and the deprivation of liberty safeguards (DoLS). Her research and evidence has been cited by the House of Lords Committee on the MCA and the Law Commission in their proposals for reforms to the law. She has given expert evidence to the National Institute for Health and Care Excellence for the 2018 NICE guidelines on mental capacity and decision making and to the Parliamentary Joint Committee on Human Rights in their recent inquiry into the DoLS. She was a member of the Equality and Human Rights Committee for the recent Independent Review of the Mental Health Act 1983 (MHA). She is a member of the Law Society's Mental Health and Disability Committee. She has worked with the World Health Organisation and the United Nations on issues relating to legal capacity and disability human rights.

Dr Series is submitting this evidence in her capacity as a researcher, not on behalf of any other organisation or group. She can be contacted on SeriesL@cardiff.ac.uk

Reform of the deprivation of liberty safeguards

The Mental Capacity Act 2005 deprivation of liberty safeguards (MCA DoLS) are in urgent need of reform: they do not adequately protect human rights,¹ they are overly complex, they do not cover all the areas where safeguards are required, and supervisory bodies are unable to cope with the scale of applications following the Supreme Court's ruling in *Cheshire West*.² The DoLS need replacing with a framework that *better* protects human rights, which *reduces* complexity, and with a reasoned and plausible allocation of resources to ensure the new framework can be delivered.

Unfortunately, the speed with which the Mental Capacity (Amendment) Bill is progressing through Parliament is making it extremely difficult for stakeholders to give these important and complex issue the scrutiny, thought and consultation they deserve.

Disability rights

It is disappointing that the government has not brought forward the Law Commission's proposals to amend the MCA to enable a person to formally nominate chosen supporters, and placing particular weight on the wishes and feelings of the person in making best interests decisions.³ These proposals were well supported at consultation⁴ and would have brought the MCA into closer alignment with the UN Convention on the Rights of Persons with Disabilities (CRPD). The impression is that important rights have been sacrificed to the goal of pushing the Bill through Parliament as fast as possible.

The purpose of the safeguards

The Liberty Protection Safeguards (LPS) must protect human rights across a wide range of settings and circumstances. They will apply both for a person who (perhaps counter-intuitively) is expressing contentment with their living arrangements, to a person who is actively objecting, and for a large number of

¹ House of Lords Select Committee on the Mental Capacity Act 2005, *Mental Capacity Act 2005: post-legislative scrutiny* (HL Paper 139, 2014); Law Commission, *Mental capacity and deprivation of liberty: A consultation paper* (Consultation Paper 222, 2015).

² NHS Digital, 'Mental Capacity Act (2005) Deprivation of Liberty Safeguards, (England) 2016/17, Official Statistics' (2017) <<http://digital.nhs.uk/catalogue/PUB30131>> accessed 3 January 2019.

³ Law Commission, *Mental Capacity and Deprivation of Liberty* (Law Com No 372, 2017) Recommendations 31 and 40.

⁴ Law Commission, *Mental Capacity and Deprivation of Liberty - Consultation Analysis* (2017) <http://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/>

people for whom it is difficult to say with any certainty whether they are ‘objecting’ or content. They will apply in very restrictive settings such as ‘mental health establishments’ (e.g. assessment and treatment units, psychiatric hospitals etc), but they will also apply in care homes, supported living, children’s homes, residential schools, and even private family-based care.

Broadly speaking the LPS will serve two main functions. Firstly, they must ensure that, in line with the requirements of the European Convention on Human Rights (ECHR), any deprivation of liberty is necessary,⁵ that less restrictive measures are always considered – including alternatives to institutionalisation,⁶ that people with mental disabilities are afforded ‘the greatest possible personal freedom’ to facilitate integration (or re-integration) into society, scaling down any deprivation of liberty where appropriate,⁷ and that protective measures reflect the wishes and feelings of the person as far as possible⁸. Secondly, they must deliver effective safeguards in cases where the person or those close to them object to the arrangements. This will be the case for an estimated 25% for LPS.⁹ The LPS authorisation processes must provide ‘guarantees of independence’ that effectively ‘counterbalance’ the broad powers vested in health and social care professionals.¹⁰ In cases where the cared-for person or those close to them object to the arrangements, robust and *accessible* rights of appeal to the Court of Protection are a vital safeguard. This remains one of the weakest areas under the DoLS and in this Bill.

Authorisation and review procedures

There must be fair and proper procedures to ensure the authorisation conditions are met and continue to be met for the duration of any deprivation of liberty.

The Bill places new responsibilities on health bodies. In general, this is a sensible reallocation of responsibilities and should go some way to helping local authorities with the current backlog. However, there are concerns about independent hospitals acting as responsible bodies because of financial conflicts of interest.¹¹ A government amendment will require a review by an Approved Mental Capacity Professional (AMCP) in all cases where an independent hospital is a responsible body. This may offer some safeguards against conflicts of interest, but much will depend on the arrangements for securing an AMCP and ongoing review of the situation. There should be further consultation on guidance in the Code on this.

Care home arrangements

The Lords’ amendments to the Bill giving responsible bodies discretion to arrange assessments themselves or entrust this to care homes, and requiring ‘appropriate experience and knowledge’¹² for those undertaking medical or mental capacity assessments or the ‘necessary and proportionate’ determination, improve on earlier iterations of the Bill. However, it is difficult to assess these without a draft Code and impact assessment indicating in what proportion of cases the government anticipates care providers would continue

⁵ *Witold Litwa v Poland* (App no 26629) [2000] ECHR 141.

⁶ *Stanev v Bulgaria* (App no 36760/06) [2012] ECHR 46.

⁷ *Hiller v Austria* (App no 1967/14) [2016] ECHR 1028.

⁸ *Mihailovs v Latvia* (App no 35939/10) [2013] ECHR 65.

⁹ This estimate was provided by the Association of Directors for Adult Social Services to the Law Commission, and has been adopted by the government for its impact assessment for the Bill. Law Commission, *Impact Assessment: Mental Capacity and Detention* (LAWCOM0055, 2017). Department of Health and Social Care, *Mental Capacity (Amendment) Bill: Impact Assessment* (2018).

¹⁰ *IN v Ukraine* (App no 28472/08) [2016] ECHR 565, para 81.

¹¹ Arguably, however, even NHS hospitals may have these following the 2012 reforms which introduced a quasi-market into healthcare.

¹² Sections 18(2) (medical and mental capacity determinations) and section 19(3) (necessary and proportionate determination).

to undertake this role, and who they envisage being responsible for these assessments. It is unclear whether care providers will be resourced for the administrative costs of arranging these assessments, and paying for any additional assessments required. The detail of the 'prescribed connection' regulations will be important.

Charges for LPS assessments and administration

There is a risk that the costs of assessments and administration will be passed on to the cared-for person, either by care providers or even potentially by NHS medical professionals (since nothing in the NHS charging regulations prohibits this). The Bill should clearly prohibit charging the person for assessment or administrative costs for the LPS. Care providers, clinicians and public bodies must be appropriately resourced.

Less restrictive alternatives

It is implicit in the 'necessary and proportionate' test and assessments of the person's mental capacity to consent to the arrangements¹³ that less restrictive alternatives, or alternatives that the person may prefer, are considered. Nothing in the Bill explicitly requires evidence of how these were considered for each determination. Where the assessments are undertaken by the same professionals responsible for making decisions under the Care Act 2014 about how a person could be supported, they are likely to have oversight of possible alternatives, but this is much less likely to be the case for self-funders, and also for assessments or determinations undertaken by care home managers (or, in some cases, hospitals). The Bill should explicitly require the responsible body (section 15), care home managers (section 16) and to consider less restrictive alternatives, and for this to form part of the authorisation record (section 24). It is important that there is *transparent* consideration of alternatives to the arrangements, in particular so that family and friends, or other professionals, can highlight any options that have *not* been considered.

Pre-authorisation review by an Approved Mental Capacity Professional

The 'proportionate' approach to reviews by an independent AMCP recommended by the Law Commission and adopted in this Bill is necessary in view of the volume of applications following *Cheshire West*. However, there are a number of situations where there is a heightened risk of human rights violations and excessively restrictive care where an AMCP review is not required under the Bill.

The Bill requires an AMCP review in situations where 'it is reasonable to believe that the cared-for person does not wish to reside in that place' or 'it is reasonable to believe that the cared-for person does not wish to receive care or treatment at that place.'¹⁴ In essence, the arrangements will only trigger proper independent scrutiny if the person is regarded as objecting. For many people this will in itself be hard to identify, and many people will be unable to object because of communication impairments, sedation, institutionalisation or even fear of rocking the boat. Some people will not have families to help identify behaviour that may signal objection.

At a minimum there should be a statutory requirement for an AMCP review wherever:

- The person is already subject to a regime under the MHA, or the purpose of the arrangements is to secure treatment for mental disorder in a mental health establishment (see below for further discussion of the MHA interface);
- There is frequent use of physical restraint, medication to control behaviour, or seclusion;

¹³ *CC v KK and STCC* [2012] EWHC 2136 (COP).

¹⁴ Schedule AA1, section 21(2).

- There are objections from the person's family or friends (regardless of whether the person is seen as objecting);
- There are restrictions on contact between the person and other named persons, or designed to prevent a person establishing or enjoying personal relationships with others.

This approach reflects the 'higher risk' criteria adopted by the Association of Directors of Adult Social Services (ADASS) to help local authorities prioritise DoLS applications and manage the backlog.¹⁵

There may also be other situations where an AMCP Review is advisable – for example where irreversible decisions to sell a person's home to finance care are made which may prevent them from returning home at a later date, where there is a particularly complex package of care or where a request is received from a concerned third party. A general provision requiring an AMCP Review 'where it would be reasonable for the responsible body to do so', with further guidance in the Code and case law, could help address this and offer flexibility for the future.

'The arrangements'

This Bill distinguishes between the 'arrangements' themselves and the care and treatment enabled by the arrangements.¹⁶ The LPS authorise only the 'arrangements' and not the underlying care and treatment:

Schedule AA1 applies to arrangements enabling care or treatment to be provided; it does not apply to the direct delivery of the care and treatment (this is addressed elsewhere in the MCA: see sections 5 and 6). For example, Schedule AA1 could apply to arrangements to ensure that less restrictive practice is being followed. The delivery of the person's care and treatment at the care home would be governed by section 5 of the MCA¹⁷

It is not immediately obvious how these can be so easily distinguished in practice; this will present serious complications for mental capacity and necessary and proportionate determinations. The Escheresque distinction between 'care and treatment' and 'arrangements to secure care and treatment' is not merely esoteric; consider these cases:

- A person with pica is at risk of choking and so requires continuous supervision and control to prevent them from eating dangerous objects. Is this supervision and control itself the care, or is it merely the arrangements to secure the care?
- A care provider believes that a person lacks the capacity to consent to sex. Accordingly, they impose a regime of continuous supervision and control to prevent them having sex with their partner, which the person objects to. If an Approved Mental Capacity Assessor (or even the Court of Protection) is required to determine the person's mental capacity to consent to the 'arrangements', must they also make a determination as to the person's mental capacity to consent to sex? Can they determine whether the arrangements are 'necessary and proportionate' without a determination of the underlying safeguarding decisions around sexual relationships?

¹⁵ Association of Directors of Adult Social Services, *ADASS TASK FORCE: A Screening tool to prioritise the allocation of requests to authorise a deprivation of liberty* (2016) <https://www.adass.org.uk/adass-priority-tool-for-deprivation-of-liberty-requests/>

¹⁶ The Bill defines 'arrangements' as 'enabling the care or treatment of a person', for example 'to reside in a particular place', 'to receive care or treatment at a particular place' or 'for the means and manner of transport for the cared-for person to, from or between particular places', Schedule AA1 s 2.

¹⁷ Department of Health and Social Care, *Mental Capacity (Amendment) Bill: Explanatory Notes for the as brought from the House of Lords on 11 December 2018 (Bill 303)* (2018) para 33. <https://publications.parliament.uk/pa/bills/cbill/2017-2019/0303/en/18303en.pdf>.

- Following a safeguarding referral concerning self-neglect, a local authority concludes that it is in a person's best interests to place them in a care home, against their will. Arrangements are put in place to prevent them from leaving the care home. Is the capacity assessment and the necessary and proportionate determination merely of the arrangements to prevent them leaving the home, or the underlying decision to place them in the care home?
- Following allegations of abuse by a person's close relative, a care home requires all contact to be supervised and prohibits the person leaving the home with their relative or visiting them in their home. This requires a regime of continuous supervision and control. Should an AMCP or the Court of Protection investigate the safeguarding allegations to determine whether the arrangements are necessary and proportionate, and whether the person has mental capacity to make decisions about contact?

If the underlying care or safeguarding decisions are *not* part of the 'arrangements', and thereby not subject to review under the LPS, then one has to question the point of this entire endeavour. Yet the construction of the 'arrangements' as separate to the care and treatment suggests that what is actually under review must take as its starting point that the underlying decisions concerning care were appropriately made. This is likely to raise questions about the scope of the AMCP's authority and responsibility to review the arrangements, and may also present complications about funding by the legal aid agency for s21ZA reviews.¹⁸

Valid refusals of care and treatment

Unlike the DoLS, the LPS do not explicitly require responsible bodies to consider whether there is a valid refusal by a deputy or attorney empowered to make health and welfare decisions on behalf of the person, nor explicitly prevent them from authorising the arrangements where they do.¹⁹ The Minister has stated that this protection is already contained in section 6(6) MCA, which should form the basis for any care or treatment that the arrangements are intended to secure.²⁰ There is still some scope for legal argument on this, which in part relates to this complex distinction between the 'care and treatment' and the arrangements to secure these.²¹ Ideally the Bill should explicitly prohibit the LPS being used to authorise arrangements that

¹⁸ Notably the legal aid agency has recently taken the approach that 'treatment' decisions, which DoLS authorisations enable, are not part of s21A Reviews: *Briggs v Briggs (No 2)* [2016] EWCOP 53.

¹⁹ The government's Bill removed a paragraph by the Law Commission that would have explicitly prevented responsible bodies authorising arrangements that an appropriately empowered attorney or deputy objected to. See: Draft Schedule AA1 section 15, in Law Commission, *Mental Capacity and Deprivation of Liberty* (Law Com No 372, 2017) p 208.

²⁰ Lord O'Shaughnessy, HL Deb, 22 October 2018, c710.

²¹ There are two specific risks to the powers of attorneys, deputies or advance decisions in relation to the LPS. The first is that there is a distinction between the 'arrangements' (which the LPS authorises) and the underlying care and treatment which the arrangements are intended to secure. Alex Ruck Keene, a highly regarded barrister who worked on the Law Commission's Bill, has observed that it may be the case that an attorney or deputy objects to the 'arrangements' needed to secure the care and treatment, even if they agree that the underlying care and treatment are themselves in the best interests of the person (see footnote for the blog post 'Mental Capacity (Amendment) Bill – highlights of first day of Committee stage' (*Mental Capacity Law and Policy* 6 September 2018) http://www.mentalcapacitylawandpolicy.org.uk/mental-capacity-amendment-bill-highlights-of-first-day-of-committee-stage/#_ftnref1).

The second risk relates to what would happen if the 'necessary and proportionate' test of the LPS began to peel apart from best interests, and authorise deprivation of liberty in circumstances that are not in the best interests of the person. There was a real risk of this when 'risk of harm to others' was potentially within the scope of the Bill, but this risk appears to have been mitigated for now as the Lords voted to insert an amendment that meant that deprivation of liberty could only be authorised when the arrangements are necessary and proportionate in relation to the risk of harm *to the person* themselves (not to others).

an attorney or deputy objects to, and this protection should be extended to the parents of 16 and 17 year olds.

From best interests to ‘necessary and proportionate’

The shift from best interests to a ‘necessary and proportionate’ test may place a greater emphasis on the wishes and feelings of the person, and strengthen threshold criteria for arrangements that conflict with the wishes of the person. Risks of serious legal complications, conflicts with the wider principles of the MCA and the extension of the MCA to become a public protection regime of detention have been minimised by the Lords voting against inclusion of ‘risk of harm to others’ as a basis for detention. However, this may reappear as an issue in a future mental health Bill.

Rights of appeal

Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful. (Article 5(4) ECHR)

Rights of appeal against a deprivation of liberty remain one of the weakest elements of the DoLS and are further weakened by this Bill. The appeal against an authorisation goes to the Court of Protection (under s21ZA), but it relies on a complex and fallible system that places a heavy burden on the person’s friends and family, and which does not adequately protect the person’s rights.

The obligation to support and enable appeals

Article 5(4) is not a mere ‘entitlement’ to appeal against any deprivation of liberty – rather the person must be **supported and enabled** to do so if they wish.²² This support must not rely on the goodwill or discretion of others²³, or require the person to have any particular prospects of success.²⁴ Support to exercise rights of appeal should be based on whether the person wishes, or would wish, to appeal; the Court of Protection has held that ‘there is no place’ for a best interests decision in relation to supporting a person to exercise rights of appeal.²⁵

Recourse to the Court of Protection is not, as has sometimes been characterised in debates on this Bill, a sign of failure. Rather it is a sign that the system is working effectively to place limits on the powers of health and social care professionals to impose a course of action on a person (or their family) against their wishes, without independent judicial oversight. Some of the best DoLS teams around the country routinely facilitate applications to the Court of Protection, even when they are confident that they are acting in the person’s best interests, because it is the person’s right for serious interferences with their rights to liberty and respect for home, family and private life, to be independently adjudicated.

There are numerous examples under the DoLS of people who have been prevented from living in their own homes or with their families, and even where contact with relatives has been seriously restricted, where access to the Court of Protection has come too late in the day. These include the case of Steven Neary – whose father spent a year campaigning for him to be returned home from a ‘positive behaviour unit’ where the local authority had placed Steven against his and his father’s wishes.²⁶ There are cases involving

²² *London Borough of Hillingdon v Neary* [2011] EWHC 1377 (COP).

²³ *Stanev v Bulgaria* (App no 36760/06) [2012] ECHR 46; *Shtukaturov v Russia* (App no 44009/05) [2008] ECHR 223.

²⁴ *Waite v UK* [2002] ECHR 804.

²⁵ *AJ v A Local Authority* [2015] EWCOP 5.

²⁶ *London Borough of Hillingdon v Neary* [2011] EWHC 1377 (COP).

safeguarding allegations found by the Court of Protection to be false²⁷, unproven²⁸ or exaggerated.²⁹ They include a 91 year old retired RAF gunner moved at night into a care home, in his dressing gown, under threats from a social worker to call the police; he was only returned to live in his home (with his cat, Fluffy) after his friend challenged the decision in the Court of Protection.³⁰ The Local Government Ombudsman reports many cases that should have been brought to court sooner; the rate of upheld complaints is higher for the MCA and DoLS than any other kind of social care complaint.³¹ In many of these cases the person was awarded damages for violations of their human rights.

Our research on the Court of Protection demonstrates that the rate of appeal under the DoLS is extremely low – fewer than 1% of authorisations are appealed.³² The government anticipates that this will fall to 0.5% under the LPS.³³ This is a far lower proportion than the 47 appeals or referrals to the tribunal for every 100 detentions under the Mental Health Act 1983.³⁴

There is an unexplained discrepancy between the estimated 30% of people who object to the DoLS authorisation³⁵ and this very small proportion of appeals. In some cases, disputes or objections may be resolved through mediation or adjustments to a package of care that address any concerns. It may also be that in some cases reviews by the supervisory body result in the authorisation being lifted. But overall the evidence indicates that people are not able to exercise rights of appeal when they wish, or would wish, to do so, in accordance with their rights under article 5(4) ECHR.

This has led to very real suffering and trauma³⁶ by people whose rights are violated. *Speedy* rights of appeal are especially important for this largely older cohort of people; our research found that a significant proportion of people died before their case was finally resolved by the Court of Protection.³⁷ Others may lose opportunities to return to live in their homes if their condition deteriorates or their home is sold to pay for care.

The DoLS rely heavily on the cared-for person or those close to them initiating rights of appeal. The expectation is that a ‘relevant person’s representative’ (RPR) – usually a family member or friend - will exercise rights of appeal on the person’s behalf, perhaps with the support of an Independent Mental Capacity Advocate (IMCA). Only as a last resort is the supervisory body expected to ensure the case is

²⁷ *Somerset County Council v MK & Anor* [2015] EWCOP B1.

²⁸ *Milton Keynes Council v RR & Ors* [2014] EWCOP B19.

²⁹ *SR v A Local Authority* [2018] EWCOP 36 .

³⁰ *Essex County Council v RF & Ors (Deprivation of Liberty and damage)* [2015] EWCOP 1.

³¹ Local Government Ombudsman, *The Right to Decide: Towards a greater understanding of mental capacity and deprivation of liberty* (2017). <http://www.lgo.org.uk/information-centre/news/2017/jul/vulnerable-adults-being-let-down-by-poor-social-work-practice>

³² Series L, Fennell P and Doughty J, *Welfare cases in the Court of Protection: A statistical overview* (Cardiff University, Report for the Nuffield Foundation, 2017). <http://orca.cf.ac.uk/id/eprint/118054>

³³ Department of Health and Social Care, *Mental Capacity (Amendment) Bill: Impact Assessment* (2018).

³⁴ Care Quality Commission, *Monitoring the Mental Health Act in 2015/16* (2017). <http://www.cqc.org.uk/content/monitoring-mental-health-act-report>

³⁵ This estimate was provided by the Association of Directors for Adult Social Services to the Law Commission, and has been adopted by the government for its impact assessment for the Bill. Law Commission, *Impact Assessment: Mental Capacity and Detention* (LAWCOM0055, 2017). Department of Health and Social Care, *Mental Capacity (Amendment) Bill: Impact Assessment* (2018).

³⁶ Mark Neary often describes the long-lasting trauma of his son’s unlawful detention, for example see: ‘The Price of Trauma’ (*Love, Belief and Balls* 15 March 2013) <https://markneary1dotcom1.wordpress.com/2013/03/15/the-price-of-trauma/>

³⁷ Out of a sample of 52 DoLS appeals in the Court of Protection we found that 8 people died before a final decision was made. Series L, Fennell P and Doughty J, *Welfare cases in the Court of Protection: A statistical overview* (Cardiff University, Report for the Nuffield Foundation, 2017).

referred to the Court of Protection. Even this fall-back obligation was only firmly established following the *Neary* case³⁸ – it is not an explicit statutory obligation nor clearly stated in the DoLS Code of Practice.

The reported cases, and evidence to the House of Lords Select Committee on the MCA, indicate that friends and family acting in the role of RPR find appeals extremely stressful. One 89-year-old RPR acting for a friend ‘reported feeling that “the full force of the state was battling against her” and that she faced constant suspicion and disadvantage when challenging the local authority’. She described the experience as ‘complex and harrowing’.³⁹ There are also examples of cases where a person’s family supports the deprivation of liberty (having made the arrangements to place the person in the care home themselves), and so are unlikely to assist the person in challenging them in court.⁴⁰ This may particularly affect self-funders whose family manage their property and affairs.

Despite repeated calls to address concerns about cost, accessibility, efficiency and participation in the Court of Protection⁴¹ the Bill does not do this. Instead it deepens the difficulties that will be experienced by a cared-for person or their family wishing to challenge a deprivation of liberty in court.

Rights to information

Article 5(2) ECHR requires information to be provided to the person – or others capable of representing them – about the legal and factual basis for the deprivation of liberty and rights of appeal, in a language that they understand, so that they can exercise rights of appeal.⁴²

Both the DoLS and the MHA set out in statute who is responsible for providing this information to the person and any others representing or supporting them. It places explicit duties on the detaining authorities to take all practicable steps to help them to understand it.⁴³ Surprisingly, this Bill did not contain rights to information when first read in the House of Lords; section 13 on ‘rights to information’ was inserted into the Bill after the government lost a vote in the Lords.

Suggested steps

A government amendment to section 13⁴⁴ would ensure that copies of the authorisation record are given to the cared-for person, any ‘appropriate person’ or IMCA representing and supporting them. It would also require the responsible body to take practicable steps to assist the cared-for person and any appropriate person or IMCA representing them in understanding and exercising the relevant rights. These are important rights, but they do not go as far as is needed.

The government’s amendment on rights to information would remove the requirement under the existing section 13 to inform the person of their rights *prior* to the authorisation process, obligations on IMCAs to assist the person in understanding and exercising the relevant rights, and the obligation on the responsible

³⁸ *London Borough of Hillingdon v Neary* [2011] EWHC 1377 (COP).

³⁹ House of Lords Select Committee on the Mental Capacity Act 2005, *Mental Capacity Act 2005: post-legislative scrutiny* (HL Paper 139, 2014) para 287.

⁴⁰ *AJ v A Local Authority* [2015] EWCOP 5.

⁴¹ House of Lords Select Committee on the Mental Capacity Act 2005, *Mental Capacity Act 2005: post-legislative scrutiny* (HL Paper 139, 2014); Law Commission, *Mental Capacity and Deprivation of Liberty* (Law Com No 372, 2017); Joint Committee on Human Rights, *The Right to Freedom and Safety: Reform of the Deprivation of Liberty Safeguards* (HC 890, HL paper 161, 2018).

⁴² *Van Der Leer v The Netherlands* (App no 11509/85) [1981] ECHR 6; *ZH v Hungary* (App no 28973/11) - Hejud [2012] ECHR 1891; *LM v Slovenia* (App no 32863/05) Chamber Judgment [2014] ECHR 608.

⁴³ MCA Schedule A1 sections 57-59; s132 MHA.

⁴⁴ Listed as amendment 4 in the Marshalled list of amendments for 10 January 2019.

body to ‘ensure that cases are referred to court when the cared-for person’s right to a court review is engaged’ (my emphasis).

There are also no explicit rights to information for a person’s friends or relatives, or lay advocates, who are not acting in the role of appropriate person. Under the DoLS, anybody consulted about the person’s best interests has a right copies of the authorisation information upon request.⁴⁵

Representation and support

Under the DoLS, the responsible body must appoint an RPR to represent and support the person. This is often a relative, but case law has established that it must be a person who is both willing and able to assist the person in understanding and exercising the relevant rights under the DoLS, including rights of appeal.⁴⁶ Where there is nobody appropriate to undertake this role, for example a person has no friends or relatives, or they would be able to maintain contact with the person, or be willing and able to help them understand and exercise the relevant rights, then a paid RPR must be appointed. If the person or the RPR requests an IMCA, the responsible body must appoint one (regardless of the person’s capacity or ‘best interests’). If there is reason to believe that without the support of an IMCA the person and their RPR would not be able to understand or exercise their rights, then an IMCA must also be appointed.

The LPS significantly weakens this framework. The Law Commission had proposed an opt-out scheme, whereby the majority of people would have qualified for an IMCA. However, the Bill adopts an opt-in scheme based on the person’s capacity and best interests. A flow diagram in Appendix A (below) sets out the complex arrangements for appointing an ‘appropriate person’ (the successor to the RPR) and IMCAs under the Bill. This scheme would mean that a person had no automatic right to request support from an IMCA – it would depend upon whether they had the capacity to request one, and also on whether they already had an ‘appropriate person’. Nothing in the scheme requires ‘appropriate persons’ to maintain contact with the cared-for person, or requires the appointment of an IMCA if the appropriate person is failing to adequately represent and support the person (as the DoLS do). The Bill introduces best interests assessments by the detaining authorities into safeguards that are supposed to act as a counterbalance to their power. It is easy to imagine circumstances in which care providers and responsible bodies are so confident that it is in a person’s best interests to be deprived of their liberty, even if the person or their relatives object, that they regard it as *not* in the person’s best interests to be represented and supported by someone who might challenge their decision.

The Bill should provide clear entitlements to request an IMCA for the cared-for person and their representative, the appropriate person. The appropriate person should be required to maintain contact with the cared-for. In circumstances where there is no appropriate person, or the appropriate person is either unwilling or unable to properly represent and support the person, an IMCA should automatically be appointed unless the person does not want their support. Best interests decisions and capacity assessments should play no part in access to these essential safeguards, because this would interfere with a person’s rights of appeal and compromise this counterweight against the broad powers vested in health and social care professionals under the MCA.

⁴⁵ Schedule A1, section 57.

⁴⁶ *AJ v A Local Authority* [2015] EWCOP 5.

Responsibility of the responsible body to enable appeals

Following the case of Steven Neary, when it became apparent that the DoLS placed too great a burden on family and friends to exercise rights of appeal, the Court of Protection concluded that ‘there is an obligation on the State to ensure that a person deprived of liberty is not only entitled but enabled to have the lawfulness of his detention reviewed speedily by a court.’⁴⁷ Under the DoLS the process is convoluted and unclear as so many players bear responsibility for initiating appeals: the primary responsibility lies with the RPR, then an IMCA must ‘expedite’ the application if the RPR has failed to do so, and if these have failed to support an appeal then the supervisory body must apply to the Court of Protection themselves.⁴⁸ This is an extremely complex system, which risks the person’s rights of appeal falling between each of the parties assuming that another will take responsibility for the application.

A more straightforward approach would be to place a clear statutory duty on the responsible body to ensure that applications to the Court of Protection are made when the person’s article 5(4) rights are ‘engaged’. The role of family (as ‘appropriate persons’) and IMCAs would then be the ‘backstop’ position. The responsible body is much more likely than family to understand the relevant guidance and case law on when rights of appeal are ‘engaged’. They should be aware of whether alternative means to resolve any dispute are likely to be successful, and unlike the person’s family, friends, and even IMCAs, responsible bodies have ready access to in-house legal advice, and skilled and experienced MCA professionals. The Code of Practice, and developments in case law, can provide guidance to responsible bodies on when these rights of appeal are ‘engaged’. This would be far more transparent and less complex and *ad hoc* than the current system.

At present, section 13(5) of the Bill as it was brought forward from the Lords, places a duty on responsible bodies ‘ensure that cases are referred to court when the cared-for person’s right to a court review is engaged.’ However, this provision would be removed by the government’s amendment to section 13.

Several opposition amendments tabled as of 11 January would strengthen the duty on the responsible body to promote appeals, including amendments 17, 40 and 41.

Reform of the Court of Protection

There are serious concerns about cost, delay, access to justice, and rights of participation in the Court of Protection.⁴⁹ These must be addressed in order to comply with our international human rights obligations, and to deliver an accessible and efficient system of appeals that is based around the needs of disabled people and their friends and families. This requires a full, transparent and accessible public consultation on the Court of Protection, which lies beyond the timescales of this Bill. We need cross-party commitment to securing this. Concerns about cost and efficiency in the Court of Protection cannot serve as reasons to ration fundamental rights of appeal.

Mental health detention and interface with the MHA

The LPS applies in hospital settings where the MHA also applies, and some people in the community may be subject to both the MHA and the LPS (as they currently are under the DoLS).

⁴⁷ *London Borough of Hillingdon v Neary* [2011] EWHC 1377 (COP).

⁴⁸ *AJ v A Local Authority* [2015] EWCOP 5.

⁴⁹ Series L, Fennell P and Doughty J, *The Participation of P in Welfare Cases in the Court of Protection* (Report for the Nuffield Foundation, Cardiff University, 2017) <https://orca.cf.ac.uk/cgi/users/home?screen=EPrint%3A%3AView&eprintid=74014>; Series L, Fennell P and Doughty J, *Welfare cases in the Court of Protection: A statistical overview* (Cardiff University, Report for the Nuffield Foundation, 2017) <http://orca.cf.ac.uk/id/eprint/118054>.

There were 4,670 DoLS applications from mental health establishments in England in 2017-18.⁵⁰ Of those that were ‘completed’ (i.e. the local authority completed the required assessments), the majority were people with dementia, with a substantial proportion of people with learning disabilities and ‘other’ mental health needs (most likely autism). Supervisory bodies authorised 1660 detentions in ‘mental health establishments’ in 2017-18, but in 305 cases found that the qualifying requirements are not met, indicating approximately 16% of all completed applications from mental health establishments were found by assessors not to meet the DoLS qualifying requirements.⁵¹

Extremely complex rules govern the interface between the MCA and the MHA. For a person who is deprived of their liberty in hospital for treatment for mental disorder, the DoLS cannot be used where a person is objecting (meaning the MHA must be instead), but where a person is not objecting then either the MHA or the DoLS can be used.

The Law Commission had proposed that the LPS should not be used for mental health detention (except for limited circumstances where the MHA cannot be used). This was partly because the MHA offers much stronger safeguards – including second opinions for medical treatments where the person lacks capacity, stronger rights for the ‘nearest relative’ to object to detention or discharge the patient, automatic referrals to the tribunal and free after-care to facilitate discharge. It was also because of the desire to reduce the complexity of this interface.⁵² The Bill, however, replicates this extremely complex interface and if recent proposals by the chair of the Independent Review of the MHA are adopted, even more people would be subject to the LPS than currently are under DoLS.⁵³ The fairness of denying people with dementia and learning disabilities the stronger safeguards of the MHA is questionable, and should be the subject of further consultation before a mental health bill is introduced.

In the meantime, people subject to the LPS are likely to be regarded as not objecting, meaning they are unlikely to qualify for a review by an AMCP. This is extremely problematic. Mental health detention is one of the most restrictive (and arguably dangerous) forms of detention under the LPS scheme. It contains some of the most complex assessments of the interface between the MCA and the MHA, which at present can only be undertaken by a professional with specialist training and qualifications under the MHA. DoLS assessors often find that the qualifying requirements are not met in mental health establishments. There are very serious risks of unlawful detention and excessive restrictions in these settings. An AMCP review should be required in every case where the arrangements are to secure inpatient treatment for mental disorder.

⁵⁰ NHS Digital, *Mental Capacity Act 2005, Deprivation of Liberty Safeguards England, 2017-18* (2018) <https://digital.nhs.uk/data-and-information/publications/statistical/mental-capacity-act-2005-deprivation-of-liberty-safeguards-assessments/annual-report-2017-18-england>

⁵¹ This analysis is based on data released to me by NHS Digital under the Freedom of Information Act 2000. I have written in more detail about this issue, and provided links to this data from NHS Digital, here: Lucy Series, ‘Psychiatric detention under the Mental Capacity Act 2005’ (*The Small Places* 3 January 2019) <https://thesmallplaces.wordpress.com/2019/01/03/psychiatric-detention-under-the-mental-capacity-act-2005/>.

⁵² Law Commission 372 (2017) 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.’ The reason for the ‘learning disability’ exemption is because the MHA cannot be used for people with a learning disability whose behaviour is *not* associated with ‘abnormally aggressive or seriously irresponsible conduct’.

⁵³ Wessely S and others, *The independent review of the Mental Health Act: Interim report* (2018) <https://www.gov.uk/government/publications/independent-review-of-the-mental-health-act-interim-report>.

For those in the community subject to an MHA regime, the interface can also throw up extremely complex issues. A person wishing to challenge restrictions may have to mount separate challenges under the LPS and the MHA. In the words of Mr Justice Peter Jackson, it is 'a truly unhappy state of affairs that the law governing the fundamental rights and welfare of incapacitated people should be so complex... 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'.⁵⁴ Nobody should have to appeal to two separate courts and navigate the complex entanglements of two separate legal regimes to assert their rights. Any consultation on the future of the MHA should aim to ensure that to the greatest extent possible nobody should be simultaneously subject to the MHA and the LPS.

A statutory definition of deprivation of liberty

Several stakeholders, and the Joint Committee on Human Rights, have recommended that the Bill adopt a statutory definition of deprivation of liberty. Stakeholders hope that this will reduced legal uncertainty, clarify the application of the test, and address concerns about it applying in domestic settings. Perhaps some stakeholders mistakenly believe Parliament can effectively reverse *Cheshire West*.

I have enormous sympathy with the desire for legal certainty and I have serious concerns about applying a framework like the LPS in family-based care. However I am not convinced that a statutory definition of deprivation of liberty will serve either of these functions. I believe this may lead further litigation on the meaning of deprivation of liberty with the added complication of the constitutional and legal status of a Parliamentary definition if it conflicts with the approach taken by the courts (domestic, or European).

If the purpose of a statutory definition of deprivation of liberty is to *describe* the current status of case law (the 'acid test'), then the proper place for this is the Code of Practice. If the purpose of a statutory definition is to *fix* the meaning, then this simply cannot be done. For better or worse, the meaning of article 5 ECHR is ultimately determined by the courts. This means that whatever definition of deprivation of liberty is proposed by Parliament, the courts may take a different view. If this happens there will if anything be even less certainty for disabled people and families about their rights, and for professionals, public bodies and care providers about their responsibilities and potential liability. This is precisely why the Law Commission recommended *against* a statutory definition of deprivation of liberty for the MCA; if it were too narrow, then public bodies would end up having to apply to the Court of Protection for authorisation or could potentially face challenges under the Human Rights Act 1998 for unlawful deprivation of liberty, because there would be a 'gap' in protection under the LPS.⁵⁵

The only way *Cheshire West* can be changed without a serious constitutional mess ensuing is for this matter to be revisited by the Supreme Court.

One option, suggested by the Joint Committee on Human Rights, that could address many concerns about the scope of the LPS, the resources implications and some of the more counter-intuitive results of *Cheshire West* would be for Parliament to legislate for what is known as the 'subjective element' of deprivation of liberty. This means when a person is regarded as giving a legally valid consent to their arrangements, which means they cannot constitute a deprivation of liberty.⁵⁶ The JCHR proposed a definition of 'valid consent' which would have meant that if a person were 'capable of expressing their wishes and feelings (verbally or otherwise)', they had 'expressed their persistent contentment with their care and treatment arrangements'

⁵⁴ *C v Blackburn and Darwen Borough Council* [2011] EWHC 3321 (COP).

⁵⁵ Law Commission, *Mental Capacity and Deprivation of Liberty* (Law Com No 372, 2017) para 5.37.

⁵⁶ *Storck v Germany* (App no 61603/00) [2005] ECHR 406.

and ‘there is no coercion involved in the implementation of the cared-for person’s care and treatment arrangement’, then subject to this being confirmed in writing by two professionals (one independent of the person’s care) then this should be treated as a legally valid consent to the arrangements, meaning there would be no deprivation of liberty.⁵⁷

This approach would help address concerns that following *Cheshire West* ‘deprivation of liberty’ is being found in settings where a person is not only not objecting but is actively expressing a desire to live there. This would distinguish a case where a person truly is living ‘happily’ with their family (such as the case of MIG in *Cheshire West* or even HL or Steven Neary when they live in their own homes with their carers), from cases where a person is actively objecting, or else is frequently restrained or otherwise coerced, or it is unclear from their behaviour whether they are ‘content’.

This would be a radical break with the current approach to consent under the MCA, but it finds support under the CRPD which calls for a broader approach to legal capacity, based on the ‘will and preferences’ of the person. It would, however, require proper stakeholder consultation – not least with organisations representing disabled people. This does not appear to be possible within the rushed timescales of this Bill, but it might be in the future (for example, as part of a future consultation on the interface between the MCA and the MHA).

The government’s proposed statutory definition of deprivation of liberty

Understandably, given widespread stakeholder calls for a statutory definition of deprivation of liberty, the government has tabled an amendment on the ‘Meaning of deprivation of liberty’. This purports to define the meaning of article 5(1) ECHR for the MCA. It is presented as if it is a *description* of the existing approach by the courts. Yet the definition proposed differs from the existing domestic and European court rulings in important ways, and it is likely that this would lead, almost immediately, to further litigation by lawyers acting for people left unprotected by this definition.

The definition states that:

- (2) A person is not deprived of liberty in a particular place if the person is free to leave that place permanently.
- (3) A person is not deprived of liberty in a particular place if—
 - (a) the person is not subject to continuous supervision, and
 - (b) the person is free to leave the place temporarily (even if subject to supervision while outside that place).
- (4) A person is not deprived of liberty if—
 - (a) the arrangements alleged to give rise to the deprivation of liberty are put in place in order to give medical treatment for a physical illness or injury, and
 - (b) the same (or materially the same) arrangements would be put in place for any person receiving that treatment.

⁵⁷ Joint Committee on Human Rights, *Legislative Scrutiny: Mental Capacity (Amendment) Bill* (Twelfth Report of Session 2017–19, HC 1662 HL PAPER 208, 2018) p 10 -13.

(5) A person is free to leave a particular place for the purposes of subsections (2) and (3) even if the person is unable to leave that place provided that if the person expressed a wish to leave the person would be enabled to do so.

Regarding paragraphs 2 and 3, a great deal hinges on what ‘freedom to leave’ in paragraph 5 is taken to mean. In most cases where a person is considered to lack the mental capacity to make decisions about where they live, or their ability to keep themselves safe when leaving their place of residence temporarily, then their ‘freedom to leave’ will depend on the best interests decisions of third parties. It will also engage protective obligations under human rights law and the duty of care; care providers themselves may be in breach of these if a person was simply allowed to leave at will, without some scrutiny of where they were going, why, with whom and for how long.

It is easy, in circumstances where a person is *not* requesting to leave, to maintain that if they did so they would be enabled to. This was the case in the original Bournemouth case, where the hospital maintained that if HL asked to leave he would be permitted to; Lord Steyn and the European Court of Human Rights described this as a ‘fairy tale’⁵⁸, and found that he was deprived of their liberty. In the *Cheshire West* case itself, the local authority maintained that if either MIG or MEG were actively unhappy where they were living, then alternative living arrangements would be found⁵⁹, yet the Supreme Court found that they were deprived of their liberty.

With regards leaving accommodation on a temporary basis, in the cases of MIG, MEG and P in *Cheshire West* they frequently left their accommodation to go on outings, with support, yet were still regarded as deprived of their liberty. In the landmark case of *Stanev v Bulgaria*⁶⁰, Mr Rusi Stanev was ‘permitted’ to go on trips and outings (on his own), but the European Court of Human Rights found that he was still deprived of his liberty because this still required his seeking *permission* from the care facility first. Many patients detained under the MHA are granted temporary leave of absence.

The key issue in all these cases is that ultimately it is not solely the person’s own decision to leave (temporarily or permanently); their ‘freedom to leave’ is subject to the discretion of others with obligations to ensure the person’s safety, however much those others might hope or intend to exercise that in accordance with the person’s wishes.

The approach taken to medical treatment in paragraph 4 appears to be based on the Court of Appeal decision in *R (Ferreira) v HM Senior Coroner for Inner South London*.⁶¹ Whilst it is understandable that professionals (and the courts) would wish to limit the scope of article 5 in cases where a person is receiving ordinary medical treatment and ‘happens’ to lack capacity, I have reservations about how this would apply in cases where the person or their family objects to the treatment and admission. I suspect it would not take long before a person who has been admitted to hospital for a treatment that they or their relatives oppose challenges this approach. It seems to me doubtful that the European Court of Human Rights (or even the appellate courts here) would find intelligible the argument that a person who is actively objecting to inpatient treatment is not deprived of their liberty because the treatment is for a *physical* and not a *mental* disorder. There is also a risk of discrimination that those who are less mobile, and therefore less in need of additional measures to restrict their movement, would be less likely to qualify for this definition.

⁵⁸ *HL v UK* [2004] ECHR 720, paras 46, 87.

⁵⁹ *Surrey County Council v MEG & MIG v Anor* [2010] EWHC 785 (Fam) para 225.

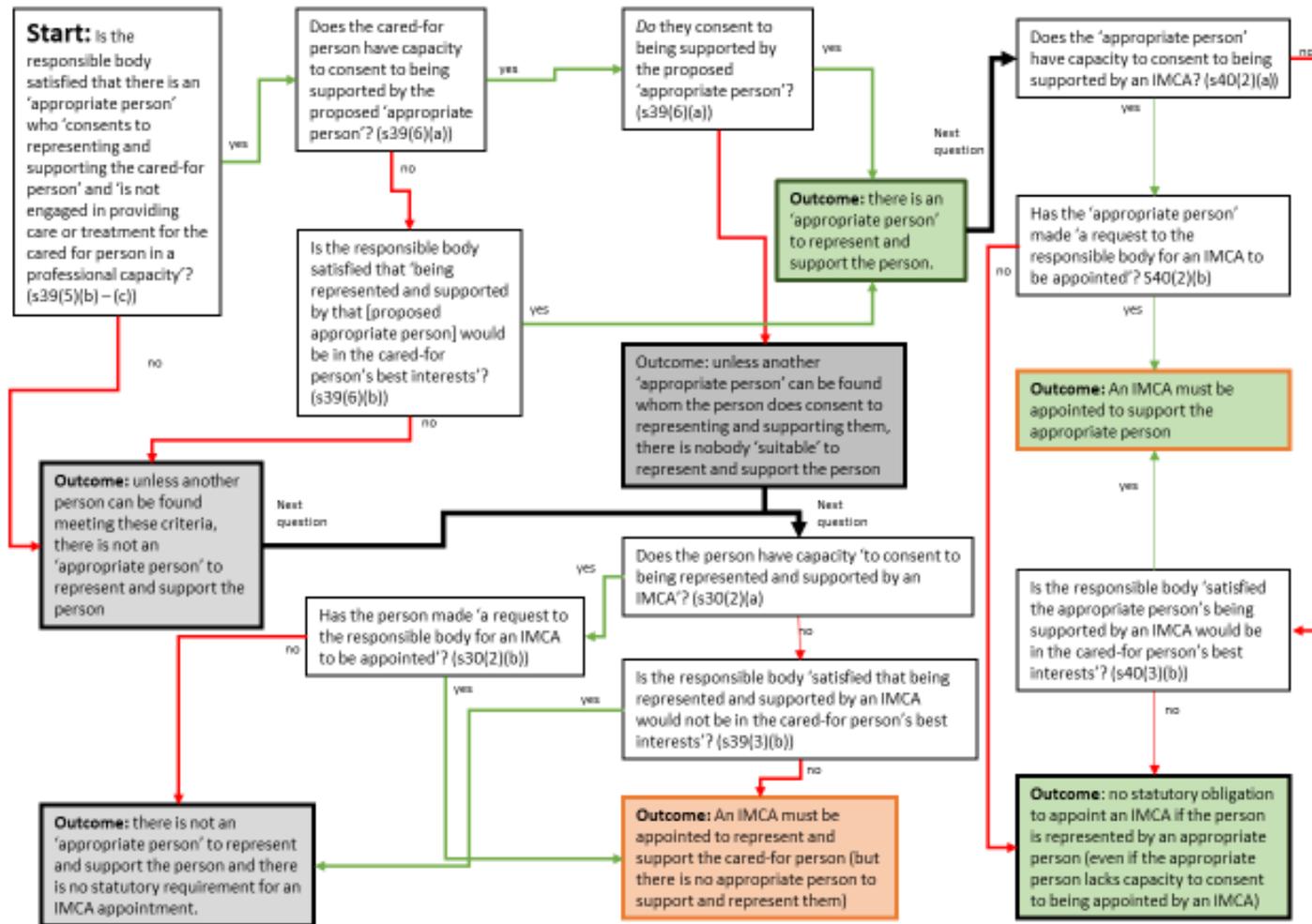
⁶⁰ (App no 36760/06) [2012] ECHR 46.

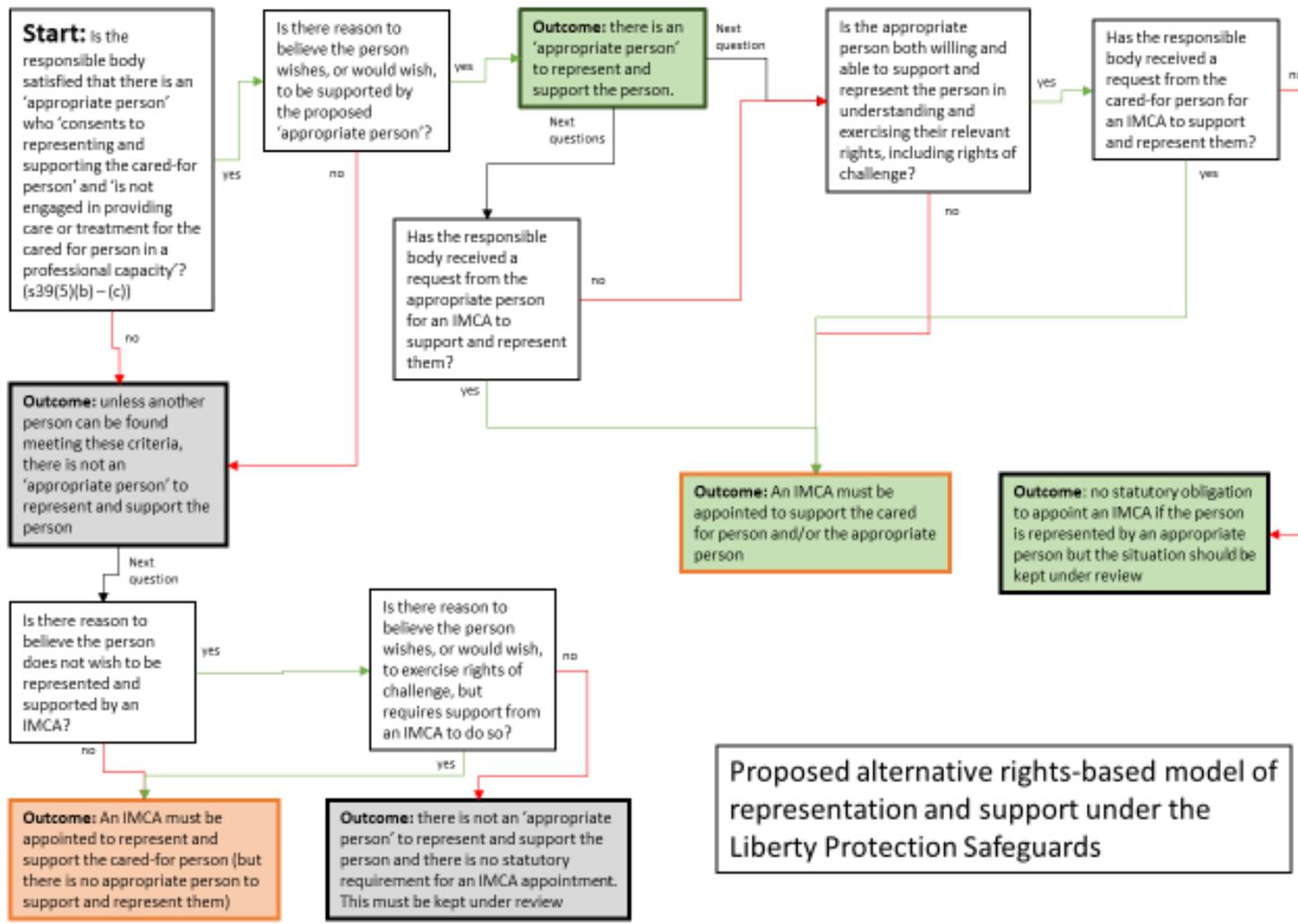
⁶¹ [2017] EWCA Civ 31.

For these reasons, I have serious reservations about the entire project of a statutory definition of the 'objective' element of deprivation of liberty, and believe the particular definition proposed would in very swift order be challenged in the courts and give rise to serious legal and constitutional complications, and further uncertainty.

January 2019

Appendix A: Flow diagram of representation and support under the Mental Capacity (Amendment) Bill





Proposed alternative rights-based model of representation and support under the Liberty Protection Safeguards