

Written evidence submitted by Roger Laidlaw, Social Worker and Deprivation of Liberty Safeguards Coordinator (MCAB35)

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1. A brief word about my background and relevant experiences

2. I am a social worker who has worked with adult groups, mostly with older people and people with dementia-type illnesses. I am Approved Mental Health Professional and thus make decisions within the scope of the Mental Health Act. I have worked as a DoLS Coordinator since a few months after the introduction of the scheme in 2009. I have worked to train student Approved Mental Health Professionals about the so-called 'interface' with the Mental Health Act and have trained DoLS Best Interest Assessors. More importantly, I have trained and, through these contacts, have also listened to the experiences of care home managers, front-line social workers and other care managers. I respond to their inquiries about the DoLS scheme and conundrums about the assessment of decision-making ability and considering 'best interests' every working day and am thus familiar with weaknesses in practice, blind spots and the competing pressures that may distract and obstruct them. Since 2014, I have been involved in discussions about managing the vast increase in required assessments with peers and Welsh Government staff. I am one of the administrators for the largest Facebook discussion group for professional users of the Mental Capacity Act. I would not presume to speak for other members but am thus aware of the themes from discussion on the site. I've responded to every opportunity to comment on the need for change from the Law Commission's consultation to the Parliamentary Joint Committee on Human Rights and the Wessely Review of the

Mental Health Act. I have lobbied members of the House of Lords during the earlier stages of the passage of the Bill.

3. I work for a South Wales local authority but write here in a personal capacity.
4. I was initially disappointed by the Bill introduced in the Lords but have been impressed by the work of legislators from all parties in considering changes to improve the operations of its provisions and will send this briefing widely. I am aware that as a DoLS bureaucrat, I could be seen as having a vested interest in the current set of arrangements and I am aware that some observations made by professionals and experts in response to suggested changes in the law affecting vulnerable people (such as this Bill and the Wessely review of the Mental Health Act) can sometimes be thinly veiled statements about a preference for the continuing with current arrangements after all! I stress my view that there must be change and further, that since there are finite opportunities of time and focus this needs to be taken seriously. I am concerned that this could be a wasted opportunity that saddles the sector with further unwieldy arrangements while the necessary shift in the culture of professionals and providers to the improve the lives of vulnerable people never happens and the concepts of least restriction and supported decision-making receive only lip service. I hope my suggestions below are constructive. I'd be happy to clarify points raised.
5. **Statutory definition of deprivation of liberty – further legal jeopardy?**
6. I believe the Law Commission was sensible and pragmatic in not seeking for the proposed legislation to give a statutory definition of a deprivation of liberty in its final report. Ultimately, the definition must be consistent by the definition given in case law by the European Court of Human Rights or the UK Supreme Court. This definition may change. Producing a novel statutory definition in too great a degree of detail simply creates the risk that the definition in the Act and the definition given by the Courts could at some future point be at odds. What the sector really does not need is another stately progress of cases through the lower Courts to the Supreme Court to an ultimate hearing with an outcome that could floor the new scheme just as the old one was brought to collapse. I know that legislators can sometimes tussle with judges about who makes the law but respectfully submit that this Bill is not the place for such a contest.
7. I also recognise a temptation to reduce the scale of the logistical challenge for addressing deprivations of liberty by trying to narrow the definition of DoL and thus the numbers of assessments required. I recognise a temptation to try to adjust phrasing to remove this service user group or that one or to confine the definition to certain settings but think this approach is fraught with hazard for future legal challenges. The aim should instead be to make responses to DoL proportionate: all service users facing significant restrictions in care plans should be able to depend on the providers supporting them and professionals currently involved with them giving

a coherent account of the rationale for these restrictions whether or not this meets an arbitrary externally defined legal threshold. I agree that the circumstances of only a minority of service users should require detailed consideration by expert assessors or escalation to the Courts but think a 'cheese paring approach' to excluding people from assessments by legal definition would encourage sophistry and evasion rather than a genuine focus on P's rights and welfare.

8. Update – early impressions about the workability of the DHSC proposed statutory definition of DoL

9. Intended government amendments to the Bill were published on January 9th and indeed do include a proposal about a statutory definition of a deprivation. My impression is that this is incoherent and creates serious issues of liberty for particular service user groups. This is not surprising as there is again no evidence that there has been any serious attempt at consultation with stakeholders about the implications of this formulation.

10. The part of the formulation in the amendment that concerns me most is Clause 3. There is no statement about the role of a person's objecting to care arrangements in determining whether there is a deprivation of liberty. This could create the perverse effect that someone objects to a care arrangement but is denied access to a legal framework through which to challenge it.

11. The suggestion that someone 'is not subject to continuous supervision and free to leave the place temporarily (even if subject to supervision while outside that place)'. This will affect many people with learning disabilities and people with mental health problems discharged to rehabilitation support settings. These residents and tenants may currently be free to come and go with licence from the staff responsible for their care who may be aware of their whereabouts, and indeed be working with other providers of support (such as work schemes and day care) which require their absence. Staff would take action to secure the return of residents if, for instance, they over-stayed a time of return from day care or a visit to community amenities. Learning to exercise liberty by developing travel skills and exercising responsibility about return may be part of the therapeutic package. People in this group would currently fall within the definition of a deprivation of liberty and the protection of the law is important.

12. Briefly, how would such a placement be authorised if the person initially objected to it? How would they be returned to the care setting if they absconded? There is no reference to any legislative framework that might accomplish either aim. Claims of the role of assertions of 'necessity' in authorising detention and the assumed special insight and authority of professionals and service providers in applying extra-legal restrictions were effectively dispensed with by the 2014 Supreme Court judgment.

13. The proposal that a person is not deprived of liberty if 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 the same (or materially the same) arrangements would be put in place for any person receiving that treatment', is also seriously flawed. In addition to the complexity of determining what is 'materially' the same treatment, the proposal contains no positive means of authorising care over someone's objection. This is obnoxious in human rights terms because there is therefore also no means of contesting effective detention. This simply creates a new gap, similar to the so called 'Bournemouth gap' which stimulated original drafting of the DoLS scheme after an adverse judgment in the European Court of Human Rights. This is actually worse because this is a legal lacuna created not by a case law decision, but by the deliberate drafting of legislation supposedly intended to improve the scheme.

14. There are particular problems for people with mental health problems who may be in secure accommodation. Taken in conjunction with the recent outcomes of the PJ¹ and MM² cases heard in the High Court which respectively indicate that MHA s 17A Community Treatment Orders and conditional discharges for offenders with mental health problems confirmed by the Home Office do not implicitly authorise or justify deprivations of liberty in restrictive discharge care plans. Indeed the lack of any clear means of authorising a deprivation of liberty outside hospital under the Mental Health Act, planning care containing restrictions intended to offer rehabilitation to patients who are not in accord with such therapeutic aims or may lack insight into their support needs becomes difficult if not entirely impossible. Producing a lawful careplan that satisfies requirements of proportionality and public safety has become difficult. A consultant psychiatrist with a forensic background spoke to me as recently as Friday and said that, 'People will die in hospital'. His meaning was that patients with patterns of offending related to their mental health conditions who currently could be discharged to care home and supported living settings could remain detained and indeed die of old age waiting for coherent legislative reform.

15. Incompatibility with European Court of Human Rights Case Law

16. Linking a deprivation of liberty exclusively to close supervision at all times contradicts established norms of case law interpretation:

17. In the case *Stanev vs Bulgaria*³, Mr Stanev was deprived of his liberty even though allowed to travel unsupervised from the hostel he was required to live in to a neighbouring village to work. His time away from the care home was subject to controls and restrictions imposed by staff and the lack of direct supervision was not

¹ *Welsh Ministers vs PJ*, UKSC 2018/0037

² *Secretary of State for Justice vs MM*, UKSC 2017/0212

³ [2012] ECHR 46

consider in any way to vitiate the serious interference in his liberty. In both *DD v Lithuania*⁴ and *Kedzior v Poland*⁵, the individuals were allowed outside the residential establishment, but only with permission of, and under the control and supervision of the management of the facility.

18. May I observe that if I, as an averagely informed lay person, can identify these tensions between the proposed wording of the Act and norms of case law interpretation which informed the Supreme Court judgment of 2014 within a few days of reading the proposed amendment, then I have no doubt that eminent lawyers with better insights are now eagerly awaiting the challenges of taking a new generation of cases to the Court of Protection and onwards through various appeals to the higher courts? Considering the means by which the DoLS scheme was brought to the point of collapse, providing such an open invitation to further legal controversy seems a very badly informed response.

19. Can I emphasise?

- **It is not necessary to provide a statutory definition of deprivation of liberty for effective reform to the scheme**
- **Doing so could be seriously counterproductive**

20. **Another approach – the Code of Practice - would a well drafted Code of Practice address the actual issues for implementation better?**

21. I would instead favour robust guidance about the interpretation of deprivation of liberty and other key legal concepts being given in the Code of Practice. The DoLS Code of Practice produced in 2008 and still extant was, quite frankly, feeble and is now badly out of date. Many predictable scenarios about liberty being infringed (admission to a hospital or care home in a crisis, restrictions on contact with supporters in cases where abuse or exploitation is suspected, etc) were simply not addressed at all and were in my view, clearly ducked by the authors of this document. There are still serious gaps (such as whether the DoLS scheme actually gives powers to return absconding residents to care homes) that I assume the authors believed the judges might helpfully fill in.

22. My personal view is that a more clearly drafted document that did not consign any major issues to the box labelled 'too hard' would have been of considerable assistance and, if such document had available for the judges to refer to, might have affected the case law trail to the Supreme Court. The judges do refer to Codes when they address issues and often defer to them as giving insights into the intention of legislators. It is

⁴ [2012] ECHR 254

⁵ [2012] ECHR 1796

mildly amazing that the Code has not been redrafted in the four years since the Supreme Court judgment.

23. A new Code for England and Wales could be bolder in identifying the salient issues. Such a document could be produced in a timely manner. The Law Society produced an accessible and clear guide to case law quickly at the request of the then Department of Health in the wake of the Supreme Court judgement. I note that some circulars about interpretation of legal issues given by the then Department of Health since 2014 have been more categorical and more assertive (though still not always entirely clear!) and that they have been referenced and heeded by judges. There is now a mature body of case law that could be referenced in a Code.
24. I would like to make four suggestions about improving the relevance and ensuring the embedding of a Code of Practice. Please regard this as my distinctive contribution as the observations of the staff member on the other end of the phone to perplexed care home staff and social workers doing their best!
 - a) A commitment to the Code of Practice being reviewed, revised and reissued within three years of the commencement of the new scheme should be made. This aim could be specified in statute and I note several suggested amendments brought in the Lords about reviews of the impact of the scheme after a bedding in period
 - b) The committee of stakeholders and Civil Servants who produce the initial Code should not disband but should continue to meet to review emerging issues within the three-year period
 - c) The British National Formulary, a handbook about medication, has a 'yellow card' notification scheme. Each BNF used to have a tear out card that medical practitioners and pharmacists could complete and return to notify of side effect issues. I daresay much of this notification now actually takes place online. Any new Code could invite responses from practitioners, families and other affected by it to send in notifications about where it is unclear and where its guidance does not cover situations being encountered in practice. These notifications could be sent to the standing committee noted above.
 - d) The Code of Practice should cover England and Wales uniformly, stating the position in both sub-jurisdictions clearly. No Code should be issued until this can be accomplished. The extant Code only fully addressed the situation in England and exasperated users learned to have to spot the phrase 'in England' in text as a cue that the situation in Wales was not addressed adequately or sometimes at all, leaving them to have to refer to other material. There are circumstances where English care home residents and Welsh hospital patients may be cared for across borders and the matter of which legislative arrangements apply needs to be addressed and described, covering a range of common scenarios. A Code covering both England and Wales is necessary to address these scenarios.

25. Deprivations of liberty in domestic settings – legislative requirement for professionals to consider support at home

26. I've noted above a possible temptation to change the definition of a deprivation of liberty to affect the numbers of assessments required. I recognise that there may be especial reluctance to tackle deprivations of liberty where P resides in their own home or at a family address. The corollary of a requirement to investigate and authorise a deprivation of liberty is that it could be seen that state officials, in effect, have to give tacit permission for someone to remain living in own home care under the care of their family where care may necessarily be restrictive. I fully recognise concerns about disproportionate state interference in this sphere. Nevertheless, I would not recommend trying to change the definition of a deprivation liberty to define this group out of the scope of the scheme and most certainly would not recommend this issue not being addressed with a 'hoping for the best' attitude and not tackled at all.

27. Most people cared for at home will also use resources such as day services or direct payment personal assistants or may have respite stays in care homes and will have care plans that specify restrictions that need to be applied in these settings. I believe trying to exclude support arrangements including family carers would lead to incoherence in the scheme and would attract legal challenge.

28. I believe an effective check to concerns about unduly intrusive assessments could be that the legislation clearly states that living at home should be considered as the first alternative that needs to be considered and which emphasises a positive duty on public authorities to provide the support necessary for people reside with family carers or other lay supporters. The legislation could further specify rights of review and appeal (perhaps in the first instance to an Approved Mental Health Professional) for supporters who believe that this option has been given insufficient consideration.

29. Interface with the Mental Health Act – second class liberty?

30. I am deeply concerned about the risk of differential standards of safeguarding and accountability for hospital patients being treated for mental disorders because of an arbitrary legal definition meaning that some patients will fall under the Mental Health Act while others have a treatment regime and detention authorised by the Mental Capacity Act. For patients in hospital under the MHA regime, recourse to Managers' Hearings and to the Mental Health Tribunal is an immediate and realistic possibility, whereas for patients under the DoLS scheme, recourse to the Court of Protection is a remote and largely theoretical possibility. The Tribunal provides accountability and does change the behaviour of professionals. The suggestion given in Wessely review into the Mental Health Act is that the cleavage between patients detained under new mental health legislation and under a future Mental Capacity Act regime should be whether or not a patient who lacks decision-making ability in relation to treatment for a mental disorder would be 'objecting' to that treatment. This is basically the situation

that currently obtains. The review suggests that the law could be changed to ensure that non-objecting patients cannot ever be detained under the terms of the Mental Health Act, but for the reasons discussed below, I think this is a change that might only apply to a few patients.

31. I have to report widespread reports in informal discussions of current poor practice with some hospital staff and clinicians in effect seeking to 'game' the system with the intention of moving patients to the DoLS scheme in circumstances where those patients, by reason of objection to treatment, are not in fact eligible for this legal status. They are therefore illegally detained. I am very sorry to have to say this but believe it to be true and am surprised that this has not attracted wider comment and concern. My concern is that the Mental Capacity Act Amendment Bill could harden this established pattern of poor practice and be seen to legitimise it.
32. The reasons for this preference for patients being detained under the MCA / DoLS regime may be that public authorities are avoiding future liability for s 117 aftercare funding commitments as patients are not detained under s 3 of the MHA or the determination of staff to evade accountability required by a Mental Health Review Tribunal hearing. I am aware of reports of instances of staff using MHA powers to remove someone to hospital with the detention being ended after a short period with legal responsibility for their continuing detention being transferred to the DoLS scheme even despite what might appear to be continuing objections. This practice is justified by statements to effect that the patient is not or is no longer objecting. Upon more detailed examination, patients may simply be unable to request to leave in clear and articulate terms, may not be asked direct questions about their wishes or it may be that expression of wishes is rationalised away by being described in terms of symptoms such as agitation or confusion. Sometimes and somewhat bizarrely, despite the person's presence in hospital it may be claimed that they are not in fact receiving treatment. What it meant by this is that staff may no longer regard the person's very obvious continuing support needs as an institutional priority.
33. The government's ambition to reduce the numbers of detained patients is laudable and changing the culture of services to person focussed approaches and building therapeutic alliances is entirely necessary. Not detaining people is only valid if their voluntary engagement with treatment is real. It is not valid, and is indeed dangerous to liberty, if the imperative to reduce numbers of detentions creates a class of patients who are in reality 'de facto' and unlawfully detained. This institutional discrimination falls particularly hard certain of people with certain diagnoses: mainly people with learning disabilities and dementia. These are the most vulnerable groups of patients. If not handled extremely carefully, legislation around the so called 'interface' will provide not only an incentive but also an effective means of discrimination on the basis of diagnosis and a second-class liberty for some groups of citizens.

34. I recognise that the 'interface' will persist for the foreseeable future and have suggestions about safeguarding patient welfare in this legal landscape. The intention is to reduce incentives to 'game' and exploit inconsistencies at the 'interface' and to introduce requirements for review:

- a) Patients detained in Mental Health treatment units under any future MCA regime should be subject to the same inspection and reporting regime provided by CQC and Health Inspection Wales as for patients detained under MHA provisions
- b) Patients detained under MCA provisions in England should have a statutory right of access to an Independent Mental Health Advocate (IMHA) as is current the case in Wales under the terms of the delegated 'Mental Health Measure'
- c) The legal status of a patient subject to MCA provisions should be subject to automatic review by an Approved Mental Health Professional and / or Approved Mental Capacity Professional after a period following their admission (I would suggest 72 hours). The purpose of the interview with patient, key carers and staff and examination of notes and treatment plans would be to determine whether or not there is an 'objection' to treatment and whether the correct statutory regime is being employed. Patients who have been removed from the provisions of MHA by a Responsible Clinician would also be subject to such a review within the same stated period
- d) A similar review of status could be request at any time by a Mental Health Act Nearest Relative or Appointed Person, any appointed person's representative under the new MCA scheme, from the holder of a Lasting Power of Attorney with Welfare powers, or from an advocate in any statutory role (Independent Mental Capacity Advocate, Independent Mental Health Advocate, advocate acting under the Care Act in England or the Social Services and Wellbeing Act in Wales)
- e) Patients currently detained under the DoLS scheme are also denied access to the Second Opinion Appointed Doctor (SOAD) service. These provisions apply so that treatment plans must be reviewed if a patient has been treated without their capacious consent for stated period. The Wessely Review seeks to positively promote consideration of alternative treatment plans. This could be an onerous commitment and avoiding it might ultimately be found to be another incentive to transfer patients to the MCA treatment regime. All mental health patients, whether subject to the MHA or MCA provisions should be reviewed by a SOAD after the same indicated statutory period. This would remove any suggestion of a perverse incentive and would establish that patients detained under the MCA regime are not receiving less effective clinical care

35. I have noted above that the DoLS Code of Practice was unsatisfactory. Any chapter dealing with the 'interface' in a new Code should be particularly carefully considered, should positively address bad practice by naming and describing it and contain very clear statements about indications for 'objection' to reduce the influence of ingenious and creative interpretations which may be current among staff.

36. I note several amendments introduced in the Lords about ongoing review of the effectiveness of the legislation following implementation and suggestions given by the Law Commission report about conducting research into specific issues, such as supported decision-making to inform future legislation. The Bill could be amended to include a review of current practice at the 'interface'.

37. Powers of the Approved Mental Capacity Professional (AMCaP) - Professional Support and Protection from Undue Influence

38. The Approved Mental Capacity Professional remains a key role in the Bill's proposals. The powers an AMCaP would have are insufficiently specified.

- a) The Law Commission Review noted that the AMCaP could, as the employee of public authority required to make independent decisions that could have implications for the finances of that body and its exposure to legal processes, be vulnerable to pressure from managers asserting institutional priorities. The proposals contained provisions for the arm's length management of AMCaPs and for a nominated officer responsible for training and standards. These recommendations should be incorporated in the Bill
- b) The legislation requires a clear statement that an AMCaP can refuse to authorise a care plan both on the grounds that reports and assessments are insufficient and that a proposed care plan features to high a degree of restriction, and also:
- c) A clear statement that an AMCaP can set conditions intended to reduce restrictions or expedite such aims as a return home,
- d) A clear statement about whether conditions given by AMCaP staff can impose financial implications: maintaining people in care homes and never allowing them out is generally a cheaper model of care than supporting them in accessing the community
- e) That AMCaP staff have a power and responsibility to refer cases to the Court of Protection
- f) That any deadlock when a Responsible Body refuses to accept AMCaP recommendations is a trigger for a referral to the Court of Protection.

39. Care Home Managers coordinating assessments – too much responsibility for a group under extreme pressure?

40. The role of care home managers in the new scheme was novel and had not been canvassed in the Law Commission report. In principle, I would support such arrangements if the training were resourced properly (half a day's training was suggested as being sufficient) and safeguards were introduced in relation to quality and conflicts of interest. In the event, these suggestions were simply an ill-considered rabbit pulled out of a hat to shift onerous responsibilities off the books of the public sector without elementary thought being to feasibility or consequences, revealing a flippant attitude to the liberty of vulnerable people. The claim that care home managers already produce documents equivalent to such assessments and this would thus avoid duplication was both a categorical error and revealed that the Department

of Health and Social Care had failed to consult with sector stakeholder. Homes' care plans are generally a prosaic list of tasks and requirements and defensive risk management plans and are not statements about how achievable liberties can be sought.

41. The statement above does not diminish my awareness of the importance of the provider service care plan to promoting liberty nor my respect for care home managers as a group of professionals. As noted above, I interact with care home staff every working day. Sadly, many of them are sufficiently distant from these considerations to remain completely unaware as to the proposed new responsibilities. Staff who are more involved are fearful and apprehensive.
42. Care home managers are members of a quasi-profession in crisis. There is high staff turnover and there are many vacant posts. Adding these responsibilities to the daily list of priorities will not help improve quality in the sector and may in fact accelerate the departure and inhibit the entry to the role of effective staff who understand the important nature of these responsibilities.
43. My main concerns are:
 - a) The obvious conflict of interest for a care home manager tasked with maintaining full beds occupancy and thus a healthy revenue stream and taking steps to expedite reductions in restriction that may have financial implications (additional staff to support people in trips away from the care home) or even the loss of revenue completely as through competent exercise of their responsibilities about ensuring care is only 'necessary and proportionate', a person is returned to their own home or discharged to a less restrictive care setting.
 - b) Incoherence in the scheme resulting in varying standards. Care home managers will be responsible for coordinating assessments for people receiving care in registered settings whereas no responsibility is specified for people in supported living settings that may closely resemble care home settings and it is only assumed that social workers and other care managers will exercise a similar coordinating role in other settings and in circumstances where people reside in their own homes or with family members. The quality of assessments and statements about support may be variable. The multiple pathways by which assessments may be coordinated and arrangements 'authorised' will do nothing to reduce the 'bureaucracy' that was apparently such an obnoxious feature of the DoLS scheme and the point noted above about obvious conflicts of interest might mean that some assessments are simply conducted with less zeal in search of achievable liberty
 - c) The issue of funding assessments is not explicitly addressed in the legislation. Public authorities will be keen to dispense with this commitment and transmit it elsewhere and I prophesy much bickering about this issue. It is possible, because it is not forbidden, that care homes may try and surcharge residents for assessments being

undertaken. In principle, is the idea of people paying to have their fundamental human rights recognised a sound one?

- d) Amendments have suggested that local authorities could remove assessment responsibilities from a particular home if they were concerned about the standards of reports or I assume because of failure to manage conflicts of interest. If a local authority determined that one home in area should not coordinate assessments, I have little doubt that others would actually clamour for this responsibility to be lifted from them also! Issues about how assessments would be funded would also complicate these considerations. Would public authorities be paying for assessments undertaken on behalf of homes? How would an appropriate scale of charges be agreed?

44. The obvious alternative to care home managers playing a key role in coordinating assessments would be this role being assumed by care managers employed by public authorities to consider, commission and arrange services, whether they are social workers, nurses or even unqualified staff. This group of staff could produce and coordinate such assessments as part of the work of preparing care plans. Staff in the care management role should already be considering issues of consent, the sufficiency of support arrangements and whether restrictions are proportionate and could be reduced in intensity. Care managers have received and continue to receive training in this area and generally receive professional supervision which addresses these issues. This is by no means perfect but is certainly more advanced than the training offered to care home managers. I believe that care managers should be relied upon to produce a primary statement about whether a person is likely to be subject to restrictions amounting to a deprivation of liberty in their care plan and they should be able to include their rationale of why these arrangements are in the person's best interests and cannot be reduced in intensity. I agree and understand that this work won't be undertaken with a sufficient degree of independence to provide a procedural safeguard to authorise any deprivation of liberty. I would envisage that these are the documents which would be considered in the first instance by the Responsible Body. That would demonstrate regard has been given to issues of liberty and would be the documents that identify issues, reasons for additional concern and from which other procedures to consider disputes or objections would depart.

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