



Court of Protection  
Practitioners Association

**SUBMISSION TO HOUSE OF COMMONS  
PUBLIC BILL COMMITTEE**

**MENTAL CAPACITY (AMENDMENT) BILL**

**JANUARY 2019**

## CoPPA

We are a multi-disciplinary organisation which works towards providing education/training, multi-disciplinary perspective on policy and issues of practice affecting the Court of Protection. We are a fused group of practitioners across 'health and welfare' and 'property and affairs': this is useful for our members as it ensures that we reinforce within our training the core principles of the Act which cut across disciplines. CoPPA has over 800 members who cover a broad base of disciplines. This enables us to raise the knowledge base of each field as to the practice, law and policy issues for the other. Our membership includes social workers, experts, medical practitioners, mental health treating clinicians, solicitors, barristers, financial deputies, IMCAs, other advocates amongst others.

The objectives of the Association are: -

1. The development and strengthening of the practice of the Court of Protection, Mental Capacity and Mental Health Law in the jurisdiction of England and Wales.
2. To provide a forum for discussion of matters of common interest.
3. To ascertain and represent views of members in relation to their professional interests.
4. To protect and promote the efficiency of Courts in England and Wales in dealing with matters relating to the Court of Protection.
5. To further the understanding and development of the Court of Protection and Mental Capacity and Mental Health Law.
6. To develop the facility in England and Wales for the conduct of cases in the Court of Protection.
7. The advancement of education of the public and in particular but without limitation to work, to further and improve the knowledge and practice of all persons involved and interested in the law and practice relating to the Court of Protection and mental health and capacity issues.
8. To consult and/or make representations, in so far as it may be

desirable, with the legislature, executive and judiciary concerning matters pertaining to mental capacity law and policy, mental health law and policy and the Court of Protection and those who administer it.

9. To promote best practice by means of high quality training, and the dissemination of information and know-how, to encourage bench marking; through the provision of seminars, conferences and meetings for the discussion of legal and practice issues affecting vulnerable adults and young persons, who may lack capacity to make decisions for themselves, their family and carers.

In furtherance of these aims each region aims to hold at least five seminars/debates/socials a year in their area and we arrange a national conference annually. We represent our members as follows: we hold three positions on the ad hoc Rules Committee. We are invited to attend the Court Users Group at the RCJ and committee members attend other Court user groups in each region.

We have an Executive Committee with the following officers.

Jakki Cowley, Advocate: Chair  
Simon Burrows, Barrister: Vice Chair  
Kate Edwards, Solicitor (Founder): Treasurer  
Eleanor Keehan, Barrister: Secretary  
Lorraine Cavanagh, Barrister  
David Hilton, Solicitor  
Mathieu Culverhouse, Solicitor  
Melanie Varey, Solicitor  
Arianna Kelly, Barrister  
Genevieve Powrie, Solicitor  
Kayleigh Smith, Solicitor

We have seven regional committees who each have a chair, vice chair, treasurer and Secretary these are:

1. Northwest (executive committee administers this region)

2. Yorkshire and Humberside (Francesca Gardner, Barrister, Chair)
3. South West (Hannah Taylor, Solicitor, Chair)
4. East Midlands (Lauren Crow, Solicitor, Chair)
5. London and the South East (Katie Scott, Barrister, Chair)
6. West Midlands (Nageena Khalique QC, Chair)
7. North East (Kimberley Fryer, Solicitor, Chair)
8. Wales (Gavin Knox, Solicitor, Chair)

The sub-committee who drafted this submission was comprised of:

**Mathieu Culverhouse**

**Arianna Kelly**

**Lorraine Cavanagh**

**Simon Burrows**

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## **Introduction**

1. CoPPA responded to the Law Commission's consultation process and broadly concurs with its conclusions and recommendations. The Government introduced into the Bill procedural shortcuts without any statutory consultation, and setting aside much of the evidence based rationale for the Law Commission's proposals. The primary areas in which the Government sought to depart from the Law Commission's recommendations were:
  - (a) The removal of the provision for an Independent Mental Capacity Advocate as of right unless the cared for person opts out;
  - (b) Introducing a role for the care home manager in the assessment of both the capacity of the cared for person and whether the proposed care is "necessary and proportionate". This enhanced status of the care home manager extended to determining whether a cared for person may access essential safeguards. Advocacy is one such example;
  - (c) The removal of the procedural protection that the Mental Capacity Act 2005 ought not to be the vehicle for the authorisation of detention of a person whose mental health had deteriorated.
  
2. For the avoidance of doubt CoPPA did not, and does not, support the removal of these procedural protections and safeguards, nor the introduction of the enhanced role for the care home manager. Whilst the amendments and further consultation have gone some way to remedying the defects introduced by the Government, they have not, CoPPA respectfully submits, gone far enough.
  
3. This brief submission focuses mainly on the proposed statutory definition of deprivation of liberty. Further brief comments on other aspects of the Mental Capacity (Amendment) Bill are set out at the end of this document.

## Proposed Statutory Definition of Deprivation of Liberty

4. It is understood that the proposed amendments on the Bill are not yet complete. However, in the amendments filed as of 9 January 2019, it is noted that an amendment has been tabled to provide for a statutory definition of a deprivation of liberty. CoPPA would offer the following submissions in respect of this amendment:
5. This amendment is of considerable concern to CoPPA members, as the definition of a deprivation of liberty it is of central importance to the rights of individuals lacking capacity. CoPPA would agree with the submissions of Dr Lucy Series that a measure of such fundamental importance as this should only be considered following robust consultation with stakeholders and legal advisors, rather than as a very late addition to the bill.
6. CoPPA would echo the Law Commission's view on the reasons that a statutory definition of a deprivation of liberty is inherently problematic. The Commission noted that, while the statute cannot redefine the scope of Article 5 ECHR, it can create a lacuna if the statutory definition fails to encompass the full scope of Article 5:

*5.37 Some responses called for a statutory definition of deprivation of liberty which was narrower than that set by the acid test. In our view, this would be misguided. The meaning of deprivation of liberty reflects our ECHR obligations under Article 5, and is based on Strasbourg case law (which must be taken into account by the domestic courts under section 2 of the Human Rights Act 1998). **If our draft Bill set a narrower statutory definition of deprivation of liberty, the courts would continue to apply the test as they perceive it to have been set down by the Supreme Court based on the evolving Strasbourg case law. This would almost certainly mean that the new scheme would be incomplete; it would not cover everyone being deprived of liberty within the meaning of Article 5, and a court authorisation would be needed for***

*those individuals. The greater the mismatch between any statutory definition and the definition given by the courts, the greater the number of people in respect of whom (more expensive and cumbersome) court authorisation would be required. We therefore consider that the best option is to continue to tie the definition of deprivation of liberty to the ECHR, not least because the definition continues to be subject to considerable evolution in case law. (emphasis added)*

CoPPA agrees.

5. The difficulties caused when a statutory regime does not provide a mechanism for authorising Article 5 deprivations of liberty are currently seen in the expensive and cumbersome process for authorising deprivations of liberty for children. Without a statutory process for authorising these deprivations of liberty, all authorisations must take place by means of an application to the court, at far greater expense and time relative to a DoLS Standard Authorisation.
6. The proposed definition states that *'references to deprivation of a person's liberty have the same meaning as in Article 5(1) of the Human Rights Convention.'* If this were the case, the further statutory definition would have no purpose. The definition instead appears to be an attempt to define the meaning of Article 5(1) by stating that *'accordingly, a person is not deprived of liberty in any of the circumstances described in subsections (2) to (4).'* However, as described below, the statutory definition does not appear to be in line with interpretations of Article 5 by the courts.
7. As a result, it would appear likely that the proposed definition will lead to additional questions of, and litigation over, whether a person would fall within the range of deprivations of liberty which may be authorised by means of the LPS, or whether the person's deprivation of liberty would need to be authorised by a separate application to the court.
8. This is of particular concern because it appears that the statutory definition, as drafted, covers only a subset of Article 5 deprivations of

liberty as defined by courts. Courts have repeatedly stressed that a deprivation of liberty arises out of the concrete situation of the person. In *Cheshire West*, the Supreme Court echoed the findings in *HL v United Kingdom* that the key features in determining whether a deprivation of liberty exists are whether *“the person concerned “was under continuous supervision and control and was not free to leave.”* This finding has been explicitly endorsed by both the Supreme Court and the European Court of Human Rights.

9. It is noted that Lady Hale divided the question of whether a person was objectively deprived of his liberty into two parts: whether the person is subject to continuous supervision and control and whether the person is free to leave. She found that the elements were separate and that both were required for an objective deprivation of liberty to exist:

*A person might be under constant supervision and control but still be free to leave should he express the desire so to do. Conversely, it is possible to imagine situations in which a person is not free to leave but is not under such continuous supervision and control as to lead to the conclusion that he was deprived of his liberty. [para 49]*

10. Prior to *Cheshire West*, there were profound disagreements as to the precise nature of a deprivation of liberty, and CoPPA would take the view that the Supreme Court’s definition gave considerable clarity on this issue. A statutory definition of deprivation of liberty would seem unnecessary after that decision. It is open to the Supreme Court (sitting as the full court) to revisit this definition if a credible legal argument can be constructed to challenge it. To date, despite the best efforts of many skilled lawyers, no such challenge has been sufficiently credible to deconstruct this settled law.
11. CoPPA members have observed that post-*Cheshire West*, Court of Protection cases involving deprivations of liberty have focused far more on the welfare of vulnerable people rather than spending time and resources determining whether a deprivation of liberty exists. It is our

collective experience that the Supreme Court has brought certainty to the task of recognising a detained person.

12. It is the experience of CoPPA members that, in practice, within the overarching definition provided, deprivations of liberty can take a wide variety of forms. People receiving restrictive forms of care differ greatly in their own needs and care plans are rightly tailored to those needs to ensure that care is not unduly restrictive. In close cases where it is necessary to determine whether a deprivation of liberty exists, consideration is given to the totality of restrictions upon the person and often belies simply categorisation.

13. As drafted, the amendment attempts to create a subset of people whose deprivations of liberty would fall outside of the LPS scheme, namely where *'the person is not subject continuous supervision and the person is free to leave the place temporarily (even if subject to supervision while outside that place).'*

14. If a person is not subject to continuous supervision and control, he or she would not fit within the *Cheshire West* definition of an Article 5 deprivation of liberty. However, the statutory definition appears to contemplate that a person would not fall within its definition of a deprivation of liberty if the person:

- a. Is compelled to live at a particular place;
- b. Is continuously controlled there, but not continuously supervised; and
- c. Is supervised at all times upon leaving the place.

15. It is the experience of CoPPA members that many people who are deprived of their liberty may have periods of time during which they have privacy in their accommodation, or have trips out of their accommodation with staff, family members or sometimes without supervision for brief periods of time. Another scenario which is not uncommonly seen in cases of restrictive care is that people are not

forcibly prevented from leaving the place detained if they attempt to do so, but are followed by carers who supervise them in the community to ensure their safety, and also to ensure their return to their accommodation. Such a set of facts may fall outside of the statutory definition, but it would appear that such a person is still, in fact, subject to continuous supervision and control and not free to leave his or her place of residence and thus remains deprived of his or her liberty for the purposes of Article 5.

16. In close cases, the question of whether restrictions on a person rise to a deprivation of liberty may be challenging. CoPPA would note the findings of the European Court of Human Rights in *Stanev v Bulgaria* (2012) EHRR 22 (partially quoting *Guzzardi v Italy*) that the distinction between a restriction on liberty and a deprivation of liberty *'is merely one of degree or intensity, and not one of nature or substance....the process of classification into one or other of these categories sometimes proves to be no easy task in that some borderline cases are a matter of pure opinion...In order to determine whether someone has been deprived of his liberty, the starting point must be his concrete situation and account must be taken of a whole range of criteria such as the type, duration, effects and manner of implementation of the measures in question.'*

17. There have been many cases which have considered whether individuals who were subject to intensive care and treatment regimes with some elements of unescorted leave have been considered to be deprived of their liberty:

- a. *Stanev v Bulgaria* (2012) EHRR 22, as summarised in *Cheshire West*: *'The applicant in Stanev had spent many years in a social care home...the court also considered that (i) the objective requirement of deprivation of liberty was met because he had been kept at the home, in a mountain region far from his home town, needing permission to go out to the nearest village and leave of absence to visit his home, entirely at the discretion of*

*the home's management which kept his identity papers and managed his finances, and accordingly "he was under constant supervision and was not free to leave the home without permission" (para 128)'.*

- b. *Kędzior v Poland* (App. No. 45026/07) [2012] ECHR 45026/07: In determining whether an objective deprivation of liberty existed, the court considered that the requirement for permission to leave the placement was central.
- c. In the Upper-Tier Tribunal decision in *PJ v A Local Health Board* [2015] UKUT 480 (AAC), Charles J considered the question of whether a person with unescorted leave was subject to a deprivation of liberty. PJ was subject to 15-minute observations, and was generally supervised in the community. PJ had unescorted leave subject to a number of conditions. In considering whether the arrangements for his care constituted a deprivation of his liberty, Charles J found that: *'the fact that a person may have unescorted leave in the community does not mean that he is not deprived of his liberty if the leave is regulated and controlled, and he is not free to leave in the sense of removing himself permanently in order to live where and with whom he chooses.'*
- d. *W City Council v Mrs L* [2015] EWCOP 20: Mrs L lived in her own home, where she was effectively locked in. She had three care calls daily, and assistive technology which alerted others if she left the house unescorted so that she could be returned to it. The court found that it was a finely balanced case, but the restrictions were *'not continuous or complete. Mrs L has ample time to spend as she wishes, and the carer's visits are the minimum necessary for her safety and wellbeing, being largely concerned to ensure that she is eating, taking liquids and coping generally in other respects.'*

18. The proposed statutory definition does not appear to align completely with the Supreme Court's definition of deprivation of liberty for the

purposes of Article 5 and this gap would appear likely to trigger further litigation rather than to add clarity to the existing understanding of the term.

19. CoPPA would also highlight s.4 of the definition, which appears to reference the finding of the Court of Appeal in *R (Ferreira) v HM Senior Coroner for Inner South London* [2017] EWCA Civ 31. It is noted that the person to whom this case related, Maria Ferreira, was being treated in an Intensive Treatment Unit and was sedated, intubated and subject to artificial ventilation. She was unconscious for much of her time in hospital. The Court of Appeal concurred with lower courts that Ms Ferreira had not been deprived of her liberty by these arrangements at the time of her death.
20. S.4 of the amendment appears to leave out of the statutory definition of deprivation of liberty a person receiving any treatment for any physical illness or injury if the arrangements are *'the same (or materially the same)'* as arrangements which *'would be put in place for any person receiving the treatment.'*
21. CoPPA would raise concerns that the proposed statutory definition appears to create a significant gap between itself and Article 5 deprivations of liberty. The amendment states on face that it contemplates situations in which *'the arrangements alleged to give rise to the deprivation of liberty'* are put in place for the purposes of medical treatment. It appears to explicitly acknowledge that individuals in this scenario are subject to continuous supervision and control and not free to leave, but nonetheless fall outside of the statutory definition.
22. In the experience of CoPPA members, there are many people lacking capacity who may go into hospital for treatment without requiring attention on an Intensive Treatment Unit or sedation. The fact that treatment arrangements for a person's physical illness may mirror the arrangements for a person with mental capacity is of limited relevance

to whether a person is deprived of his or her liberty, and appears to reintroduce the 'relative normality' test which was explicitly rejected by the Supreme Court in *Cheshire West*. The crucial problem with this amendment is that even if the treatment arrangements are the same for those with or without capacity, a person with capacity is free to accept or reject them, or to discharge him or herself from hospital. A person who is being compelled to accept treatment by means of being detained in hospital and continuously supervised and controlled is, absent the circumstances highlighted in *Ferreira*, deprived of his or her liberty for the purposes of Article 5. For a person with capacity, the detention would almost certainly be unlawful; for a person without capacity, it must be in accordance with a procedure prescribed by law. If no lawful process exists to authorise detentions of this kind because they fall outside of the statutory definition of a deprivation of liberty, hospitals would find themselves either in the position of having to make court applications to lawfully detain patients, or breaching their Article 5 rights and denying them the protection of the Convention.

23. In summary, this amendment appears to create a lacuna in the statutory process for authorising Article 5 deprivations of liberty, as was predicted by the Law Commission in its report. Where the scope of Article 5 protections have been (and will continue to be) defined by the court, CoPPA would query the benefit of introducing a statutory definition of a deprivation of liberty. A statutory definition creating any lacuna between itself and Article 5 would only add costs to the authorisations of deprivation of liberty, or else leave vulnerable people subject to unauthorised state detention. CoPPA would urge against the adoption of this amendment and encourage any further consideration of this issue to follow robust consultation with stakeholders and legal advisors.

### **Rights to information**

24. CoPPA welcomes the proposed amendment to paragraph 13 of Schedule AA1 to the extent that it provides for the cared-for person, their “appropriate person” and their IMCA to be provided with a copy of the authorisation record. However, CoPPA notes that the proposed amendment to paragraph 13 omits the provision currently contained at paragraph 13(5) of the Bill, which places a duty on the responsible body to refer cases to court where the cared-for person’s right to a court review is engaged. This is an unconscionable omission in our respectful opinion. It is emphasised that, pursuant to Article 5(4) ECHR, all people who are detained are entitled to take proceedings to determine the lawfulness of his or her detention. Such proceedings are currently taken as a matter of course for those detained under the Mental Health Act 1983, and the rights of those detained under the DoLS are no lesser. The State (as detaining authority) is under a positive duty to promote the Article 5 and 8 rights of the cared for person. That includes affording to them, and making accessible, the inherent procedural protection within each Article of the Convention. The promotion of these Convention rights extends to raising, on their behalf, legal challenge to their confinement; this Convention obligation ought to be enshrined in the domestic legislation. The most exquisitely vulnerable in society are the cared for persons who will fall under the protection of this legislation. It is not acceptable for the legislation not to clearly signpost the state and the cared for person as to the division of responsibilities and their rights.

25. In CoPPA members’ experience, such a provision is needed in order to ensure that cared-for person’s Article 5(4) rights are respected in circumstances where the responsible body is aware of the need to refer a case to court and no other party has done so or is likely to do so. For detained individuals with mental impairments or illnesses, the process of bringing proceedings may be prohibitively difficult, and they may not be able to exercise their Article 5(4) rights without assistance in doing so. An example of a case where this issue arose is that of *AJ*

*(Deprivation Of Liberty Safeguards) [2015] EWCOP 5* (see further below).

### **Triggers for review by Independent Mental Capacity Professional**

26. These are far too narrowly drawn in the current proposals. The mere consideration of whether there are reasonable grounds to believe that a person may object to their care arrangements is not sufficient to protect of the rights of persons who lack the capacity to know whether or not they should in fact object to their care arrangements. An illustrative example is that of a profoundly disabled for person, who is in bodily restraints for the majority of the day but is compliant and feels safe in them. Such a person may not be considered to be objecting or likely to object to that care regime. Nevertheless, they may not know that the type of restraint being used has not been considered optimum clinical practice for many years. The cared-for person may not know that they have a right to require the relevant statutory body to develop a far less restrictive regime. CoPPA members have direct experience of such a case, in which the cared-for person had no family or friends. That case was initially submitted to the Court of Protection for a paper review, as the person appeared not to object to their care arrangements. Such a case would not engage the independent assessment of the cared for person by an AMCP on current definitions. This cannot be right. The current narrow definitions in the Bill would deprive another cared-for person in this situation the basic procedural protection of an independent review by a suitably qualified person. No fiscal savings can properly justify such a state of affairs.

27. When cast against such real-life examples, the potential for objection to one's care arrangements is an arbitrary measure for such an important procedural protection. Communication impairment may prevent a person from making known their objection, as may impaired memory. Our members have extensive experience of cared-for persons who have very real and valid objections to their confinement when in a more

lucid interval, but may not be able to express those to any great effect when they are disorientated in time and place.

28. There are other more appropriate and procedurally protective triggers for a pre-authorisation review by an AMCP which ought to be included in the Bill:

- (a) Where a person has restrictions in their care plan which impairs their ability to exercise a capacitous area of decision making;
- (b) Where the care plan contains restrictions upon their contact with named persons and/or family members;
- (c) Where the person is prescribed sedating medication and/or is subject to physical restraint and/or seclusion otherwise than rarely;
- (d) Where a person has been placed away from their home into a non-community setting;
- (e) Where the arrangements are to secure treatment in hospital for a mental disorder (regardless of whether the premises are private or NHS).

29. Only if the triggers are widened for the independent assessment of cared for people will there be protection of the rights of some of the most vulnerable members of our society.

### **Identification of cared-for person's objections carried out by care home manager**

30. Paragraph 17(1)(f) of Schedule AA1 provides that the decision of whether an AMCP should be appointed will be based on a determination by the care home manager as to whether P is objecting. In CoPPA members' experience the question of whether a cared-for person is in fact objecting is not always straightforward. Furthermore, an unhappy cared-for person will very often be reluctant to express their unhappiness about their care arrangements directly to the person responsible for providing that care. CoPPA members routinely see cared-for people express different views to people that they understand

to be independent, such as their IMCAs or to Best Interests Assessors, than to care staff. Additionally, the current mechanism places care home managers in the difficult position of determining whether further costs should be incurred by their commissioning local authorities by the appointment of an AMCP. The current provisions of the Bill give rise to the very real possibility of a cared-for person being denied the full protection provided by the scheme on the basis of a flawed determination of whether they are objecting to their care arrangements.

### **Capacity and Medical Assessments**

31. It is noted that under the new scheme, capacity and medical assessments are to be carried out by a person who appears to the care home manager or responsible body “to have appropriate experience and knowledge”. Capacity assessments ought to fall outside of the scope of this provision. They are a specialist piece of work which requires a suitably qualified person to undertake it, at the very least with prescribed qualifications.
32. An assessment of a lack of capacity to make decisions is the gateway to the jurisdiction of the Mental Capacity Act. Accurate and careful assessment of the same is essential to protect the autonomy of the cared for person. A declaration that an adult lacks capacity in specific domains is a significant intrusion into the life of that adult and ought to be predicated on sound and intellectually robust evidence.
33. Under the current DoLS regime the equivalent assessments must be carried out by professionals with certain prescribed qualifications. In the experience of CoPPA members, even with this requirement of the existing scheme, assessments vary significantly in quality and are often found by the court to be flawed. CoPPA therefore suggests that at the very least the new scheme should require capacity and medical assessments to be carried out by persons with qualifications equivalent

to those prescribed under the existing DoLS regime. CoPPA does not support the managing authority being the body who undertakes these assessments. There is a significant potential for a conflict with the interests of the cared for person. In our experience capacity assessments are all too often outcome led i.e. based on an assumption that a foolish or unreasonable decision is conclusive evidence of a lack of capacity.

### **“Necessary and proportionate” assessment**

34. The role of “necessary and proportionate” assessor as set out at paragraph 19 of Schedule AA1, appears to be analogous to the role of Best Interests Assessor under the existing DoLS regime. This role is central to the existing scheme and is one of the few aspects of the existing scheme which has attracted widespread praise. It is noted that under the proposed new scheme the selection of the person making this assessment is to be determined on the basis of their appearing to the care home manager or responsible body “to have appropriate experience and knowledge” to make the determination. The existing DoLS regime specifies the professional qualifications required of a Best Interests Assessor and similar provision must be included in respect of the equivalent role under the new scheme.

### **Pre-authorisation review other than by AMCP**

35. The Bill as currently drafted does not set out any minimum professional qualifications for a person conducting a pre-authorisation review where the review is not carried out by an AMCP. Whilst the Bill specifies that the person carrying out the pre-authorisation review must not have a “prescribed connection” with the care home, or be involved in the “day-to-day” care of the cared for person, this still leaves significant scope for such reviews to be carried out by persons who are not truly independent of the detaining authority, such as persons, whilst not

involved in the “day-to-day” care themselves, may be responsible for managing or supervising those who are.

36. This gives rise to a significant scope for situations arising where the cared-for person is in fact objecting to the care arrangements, but is reluctant to say so to the care home manager, or a care home manager has either failed to recognise or failed to report the cared-for person’s objections to the responsible body.

37. CoPPA would note that the responsibilities placed on care home managers are heavy, potentially beyond their professional experience and place them in a conflicted position with their commissioning bodies. It is noted that:

- a. Many care homes are operating at the limits of their capacity and would not have staff to conduct extensive reviews. It is unclear at present what additional funding they would receive to conduct these assessments.
- b. In the experience of CoPPA members, a central question which often arises in determining whether a person’s detention is ‘necessary and proportionate’ is what other options are available for a person’s care and support, and what the risks and benefits of those options are. While care home managers may be able to address the nature of care provided within their facility, it would seem inappropriate for them to opine on the strengths and weaknesses of other placements, or other forms of care.
- c. Finally, many care homes have large numbers of people placed by local authorities, who may be primary ‘consumers’ of the care home’s services. Care home managers may feel – accurately or not – that their commissioning bodies will take a negative view on their referring people for further assessment, thwarting the operation of the system.

38. In such circumstances the authorisation would fall to be determined on the basis of assessments carried out by unqualified persons, and reviewed by unqualified persons. An authorisation will have been granted with no input from a person equivalent to the Best Interests Assessor under the current DoLS regime. Particularly in the event that there may be problems in the overall provision of care within a placement, the lack of a qualified, independent assessor to review the cared-for person's detention may leave the person without any effective protection from inappropriate care. Given that the Best Interests Assessor's role was one of the few successful aspects of the DoLS regime, this appears to be a significant omission from the new Bill.

#### **Renewal of authorisations**

39. CoPPA notes that the process for renewal of authorisations is significantly less robust than that for initial authorisations, and that the risk of an authorisation being granted without the involvement of a suitably qualified professional is significantly higher at the renewal stage.

40. At the renewal stage there is no requirement for a capacity, medical or "necessary and proportionate" assessment to be carried out by a person who appears to the care home manager or responsible body "to have appropriate experience and knowledge", but simply that the authorisation conditions continue to be met, that the cared-for person's condition is unlikely to materially change during the renewal period and that consultation has been carried out. In cases where the person is residing in a care home the responsible body may rely on the care home manager to provide a statement to this effect. Thus, at the renewal stage, there is not even the (already flawed – see above) requirement of an assessment by a person who appears to have the appropriate experience and knowledge.

41. Whilst the provision of reviews under paragraph 35 of Schedule AA1 go some way to addressing this concern, the provisions of paragraph 35 are themselves also significantly flawed. It appears that the reviewer will not be independent and will be either the responsible body or the care home manager; the difficulties in care home managers fulfilling this role would appear only to be exacerbated upon reviews. Whilst paragraph 35 does provide for the involvement of an AMCP at the renewal stage in certain circumstances, the responsible body or care home manager will once again act as “gatekeeper” to this function, as they will make the determination of whether the cared-for person is objecting to their care arrangements.

42. Furthermore, it appears that the input of an AMCP will only be available at the renewal stage where no AMCP was involved at the pre-authorisation stage, thus denying cared-for persons the benefit of a review by an AMCP where they objected to their care arrangements at the initial authorisation stage and continue to do so at the renewal stage.

43. CoPPA members would also note their own experiences that placements which were once in a person’s best interests may cease to be in the person’s best interests as the person’s needs change. Alternatively, changes in leadership or staff in a placement may also lead to changes to the manner in which the person is cared for. Particularly for individuals who do not have involved family members or advocates, a review may be the only independent consideration of a person’s care needs. The proposed system appears to offer considerably less protection to vulnerable people than the current system.

### **Appointment of Independent Mental Capacity Advocate**

44. CoPPA notes that under the proposed scheme, in circumstances where the cared-for person lacks the capacity to consent to the

appointment of an IMCA, the appointment of an IMCA is to be subject to a best interests test. CoPPA submits that this is not an appropriate way of determining access to support to enable the cared-for person to challenge their detention, and that access to an IMCA should be on an opt-out rather than an opt-in basis.

45. We note that the provisions relating to the appointment of an IMCA do not apply where the responsible body is satisfied that there is an “appropriate person” who would be suitable to represent and support the cared-for person. This presumes that the “appropriate person” will in fact represent and support the cared-for person to exercise their relevant rights. However, this will not always be the case, as was demonstrated in the case of *AJ (Deprivation Of Liberty Safeguards) [2015] EWCOP 5*, in which an 88-year-old woman was represented by the husband of her niece, who failed to take steps to assist her to exercise her rights, in circumstances where he had an interest in her remaining in a care home. This could be remedied by requiring the responsible body to be satisfied that the “appropriate person” will assist the cared-for person to exercise their relevant rights, and for an IMCA to be appointed where the responsible body is not so satisfied.

### **Conditions attached to authorisation**

46. CoPPA notes that paragraph 13(3)(c) of Schedule AA1 of the Bill as passed by the House of Lords refers to “any conditions to which the authorisation is subject”. This would appear to raise the possibility of authorisations being granted subject to certain conditions, this being a useful feature of the existing DoLS regime. However, no further mention is made of this possibility elsewhere in the Bill, and it is noted that the wording at paragraph 13(3)(c) is not included in the proposed amendment to paragraph 13 referred to above. CoPPA would suggest that the ability to attach conditions to an authorisation should continue under the LPS scheme and would urge against the proposed

amendment to paragraph 13 of Schedule AA1 for that reason, and for those set out above.

### **Arrangements for treatment of mental disorder in hospital**

47. CoPPA notes that under the provisions of paragraphs 21 and 48 of Schedule AA1 as currently drafted, persons who will be subject to arrangements that aim to secure treatment for mental disorder in a hospital are unlikely to benefit from a pre-authorisation review by an AMCP, as any such persons who object to their care arrangements would not be subject to the scheme and their care arrangements would instead be governed by the Mental Health Act. Given that, regardless of a lack of objections, this category of cared-for persons is amongst the most vulnerable to whom the scheme would apply, CoPPA would urge that an amendment be made to secure the provision of a pre-authorisation review by an AMCP in all circumstances where such arrangements are contemplated.