



House of Commons

House of Lords

Joint Committee on Human  
Rights

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# Legislative Scrutiny: Mental Capacity (Amendment) Bill

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**Twelfth Report of Session 2017–19**

*Report, together with formal minutes  
relating to the report*

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to be printed 24 October 2018*

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## Summary

Society needs robust mechanisms to protect the human rights of vulnerable people, in particular their right not to be detained arbitrarily. A new scheme to provide the legal safeguards required by Article 5 of the European Convention on Human Rights (ECHR) is urgently required; the current Deprivation of Liberty Safeguards (DoLS) scheme is irrevocably broken, as we said in our report *The Right to Freedom and Safety: Reform of the Deprivation of Liberty Safeguards*.<sup>1</sup>

In the case of *Cheshire West*, the Supreme Court decided that the “acid test” for deprivation of liberty is whether a person is under continuous supervision and control and not free to leave, regardless of whether they are content or compliant.<sup>2</sup> Following this judgment, the breadth of this test has meant that as many as 125,630 people are currently unlawfully deprived of their liberty, in breach of Article 5 ECHR.<sup>3</sup> Extending the existing scheme to all those caught by this definition could cost £2bn a year.<sup>4</sup>

The Government has brought forward the Mental Capacity (Amendment) Bill in an attempt to resolve the crisis. The Bill follows the Law Commission’s proposals for a scheme of Liberty Protection Safeguards (LPS), but differs from the proposals in a number of respects.

Most significantly for those living in care homes, responsibility for arranging the assessments required before a deprivation of liberty can be authorised would in future fall to care home managers. The Government has asserted that its proposals provide the assessment process with the degree of independence required by case law relating to Article 5 of the ECHR. We share concerns expressed by stakeholders that, in practice, care home managers will face conflicts of interest that will seriously hinder their ability to make objective assessments.

These concerns are heightened by the fact that the care home manager would be tasked not only with arranging assessments but also with determining whether the cared-for person should have access to either an Approved Mental Capacity Professional (who conducts a more in-depth review) and/or an independent advocate. Both these roles provide important safeguards of the individuals’ rights under Article 5 and decisions about who requires them should be made independently. We propose amendments to the Bill to enhance these safeguards.

Many of those caught by the *Cheshire West* definition are not perceived by their family or professional carers as being ‘deprived of their liberty’. The Committee repeats its call for Parliament to consider including in the legislation a definition of deprivation of liberty in the context of mental capacity law to clarify the application of the Supreme Court’s “acid test”, whilst being mindful of the fact that any definition must comply with Article 5.

1 Joint Committee on Human Rights, Seventh Report of Session 2017–19, [The Right to Freedom and Safety: Reform of the Deprivation of Liberty Safeguards](#), HC 890 / HL Paper 161

2 *Cheshire West and Chester Council v P* [2014] UKSC 19, [2014] MHLO 16

3 Health and Social Care Information Centre Report, [Mental Capacity Act 2005, Deprivation of Liberty Safeguards, England, 2017–18](#), 2 October 2018

4 Law Commission, [Mental Capacity and Deprivation of Liberty](#), HC 1079

A definition on the face of the Bill is important to give cared-for people, their families and professionals greater certainty about the parameters of the scheme and to direct scrutiny and the necessary resources to where it is needed. It is undeniable that any definition in statute may be refined by future case law but, in our view, it is not possible to design and implement an effective system of safeguards without having a clear sense of the scope of such a system.

# 1 Introduction

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## Background to the Bill

1. The Mental Capacity (Amendment) Bill (the Bill) seeks to amend the Mental Capacity Act 2005 (MCA) and introduce a new scheme, the Liberty Protection Safeguards (LPS), to replace the Deprivation of Liberty Safeguards (DoLS).<sup>5</sup> This scheme is intended to provide the legal safeguards required by Article 5 of the European Convention on Human Rights (ECHR) for people who are considered to lack the mental capacity to consent to their care and treatment arrangements, and who are considered in law to be deprived of their liberty.

2. As set out in our report, *The Right to Freedom and Safety: Reform of the Deprivation of Liberty Safeguards*,<sup>6</sup> a new scheme is urgently required. The current DoLS scheme is irrevocably broken. Ever since its inception, the scheme has been widely criticised for being overly bureaucratic and burdensome. In 2014 the Supreme Court in *Cheshire West* decided (by a majority) that a person is subject to “confinement” when the person concerned is “under continuous supervision and control” and “not free to leave”, to be determined “primarily on an objective basis”.<sup>7</sup> It did not matter whether the individuals in this case were content or compliant. Following this judgment, the requirement for authorisation of deprivations of liberty has applied to a far wider group of people than originally envisaged. Consequently, this means a backlog of over 125,630 cases has built up in the DoLS system.<sup>8</sup> As the law stands, these people are currently unlawfully detained.

3. In 2017, at the Government’s request, the Law Commission produced proposals for a new system of safeguards that were intended to establish a proportionate and less bureaucratic means of authorising deprivation of liberty.<sup>9</sup> The Government responded to that report in March 2018 accepting that the current DoLS system should be replaced, and broadly agreeing with the model set out in the Commission’s draft Bill.<sup>10</sup>

4. In our previous report, we examined the Law Commission’s proposals and concluded that they could form the basis of an improved scheme for authorising deprivations of liberty, directing scrutiny to those who need it most. We noted that the Law Commission’s proposals did not address the definition of deprivation of liberty made in *Cheshire West*. Our conclusions were:

- a) The Government should consider establishing more clearly the definition of deprivation of liberty in order to clarify the application of the Supreme Court’s “acid test” and to bring clarity for families and frontline professionals.
- b) The Law Commission’s proposals for independent review of authorisations for deprivations of liberty within the responsible body were compliant with the European Convention on Human Rights and it would be disproportionate to

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5 The Bill was introduced in the Lords on 3 July 2018 and had second reading on 16 July 2018.

6 Joint Committee on Human Rights, Seventh Report of Session 2017–19, [The Right to Freedom and Safety: Reform of the Deprivation of Liberty Safeguards](#), HC 890 / HL Paper 161

7 *Cheshire West and Chester Council v P* [2014] UKSC 19, [2014] MHLO 16

8 Health and Social Care Information Centre Report, [Mental Capacity Act 2005, Deprivation of Liberty Safeguards, England, 2017–18](#), 2 October 2018

9 Law Commission, [Mental Capacity and Deprivation of Liberty](#), HC 1079

10 [Government Response to the Law Commission’s review of Deprivation of Liberty Safeguards and Mental Capacity](#), 14 March 2018

establish a separate review body. Nonetheless, the Code of Practice for those undertaking authorisations must set out clear guidelines to deal with potential conflicts of interest.

- c) The Law Commission's proposals introduced the possibility of providing advance consent to care and treatment arrangements that would otherwise amount to a deprivation of liberty. This is not currently possible under the DoLS scheme. Advance consent for care arrangements should be valid, as long as safeguards were in place to verify the validity of this consent.
- d) We endorsed the enhancement of rights to an independent advocate proposed by the Law Commission. However, we noted the shortage of advocates and recommended the Government should consider appropriate funding arrangements for adequate numbers of advocates. An individual's right to participate in court ought to be contained in statute and responsibility for securing the individual's access to court should be prescribed clearly on the face of the Bill.
- e) The Law Commission proposed that the Lord Chancellor, the Lord Chief Justice and the Senior President of Tribunals should review whether the Court of Protection (CoP) should retain jurisdiction to hear challenges or whether this should be transferred to the First Tier Tribunal (FTT). We suggested a tribunal system had serious merits for consideration.
- f) Legal aid must be available for all eligible persons to challenge their deprivation of liberty, regardless of whether an authorisation was in place.
- g) The Law Commission proposed that the LPS would apply to persons of "unsound mind" to reflect the wording of Article 5. Further thought should be given to replacing "unsound mind" with a medically and legally appropriate term and a clear definition should be set out in the Code of Practice.
- h) The interface between the Mental Capacity Act (MCA) and the Mental Health Act (MHA) caused particular difficulties. The Law Commission proposed maintaining the two legal regimes: the MHA would apply to arrangements for *mental disorders*; the LPS would apply to arrangements for *physical disorders*. We had two concerns. Firstly, this proposal would require assessors to determine the primary purpose of the assessment or treatment of a mental or physical disorder—this is difficult where persons have multiple disorders. Secondly, there would be essentially different laws and different rights for people lacking capacity depending upon whether their disorder is mental or physical.

5. The Bill that is now being considered by the House of Lords departs from the Law Commission's proposals in several significant respects and does not include a definition of deprivation of liberty. This further report examines some of the key elements of the Bill and makes recommendations for amendments to it.

## Overview of the Bill

6. The Bill amends the MCA. It inserts a new Schedule AA1 which would provide for a new administrative scheme for the authorisation of arrangements enabling care or treatment of a person who lacks capacity to consent to the arrangements, which give rise to a deprivation of that person's liberty (the 'Liberty Protection Safeguards'). Under Schedule AA1, a responsible body would be able to authorise arrangements for care and treatment giving rise to a deprivation of a person's liberty in any setting.<sup>11</sup>

7. Under the Bill, before a responsible body can authorise such arrangements, it must be satisfied that three authorisation conditions are met:

- i) the person who is the subject of the arrangements lacks the capacity to consent to the arrangements;
- ii) the person is of unsound mind; and
- iii) the arrangements are necessary and proportionate.<sup>12</sup>

8. A person who is not involved in the day-to-day care of, or in providing any treatment to, the person would also have to carry out a pre-authorisation review to determine whether it is reasonable for the responsible body to conclude that the authorisation conditions are met. In cases where the person is objecting to the proposed arrangements, an Approved Mental Capacity Professional (AMCP) must carry out the pre-authorisation review.<sup>13</sup>

9. The Schedule provides a number of safeguards after an authorisation has been given. These include regular reviews of the authorisation by the responsible body or care home and the right to challenge the authorisation before the Court of Protection.<sup>14</sup> Schedule AA1 would further place a duty on each responsible body to appoint an Independent Mental Capacity Advocate (IMCA) or an appropriate person to represent and support the person when an authorisation is being proposed and while an authorisation is in place.<sup>15</sup>

10. With regard to the relationship between the Liberty Protection Safeguards scheme and the Mental Health Act 1983, in broad terms, patients who are detained under the Mental Health Act 1983 or who are objecting to their treatment, would not be made subject to an authorisation under Schedule AA1. However, the Explanatory Notes state that a person not detained under the MHA could be subject to an authorisation under Schedule AA1 and subject to Mental Health Act requirements, so long as the authorisation does not conflict with those requirements.<sup>16</sup>

11 A responsible body is either a hospital manager, a clinical commissioning group, Local Health Board, or the local authority depending on the circumstances. See [Mental Capacity \(Amendment\) Bill \[HL\], \[Bill 117 \(2017–19\)\]](#), Schedule 1, para 6

12 [Mental Capacity \(Amendment\) Bill \[HL\]](#), Schedule 1, Part 2, para 11

13 The Secretary of State will set out in regulations the criteria for Approved Mental Capacity Professionals, [Mental Capacity \(Amendment\) Bill \[HL\]](#), Part 4, para 33

14 [Mental Capacity \(Amendment\) Bill \[HL\]](#), Schedule 1, para 31; clause 3

15 An appropriate person is a person who is suitable to represent and support the cared-for person, consents to doing so, and is not engaged in providing care or treatment for the cared-for person in a professional capacity. See [Mental Capacity \(Amendment\) Bill \[HL\]](#), Schedule 1, Part 5, para 36(5)

16 [Explanatory Notes to the Mental Capacity \(Amendment\) Bill \[HL\]](#), [Bill 117 (2017–19) –EN]

## 2 Defining deprivation of liberty

11. In our earlier report on this issue, we recommended that Parliament should consider providing a statutory definition of what constitutes a deprivation of liberty in the case of those who lack mental capacity. This is necessary in order to clarify the application of the Supreme Court’s “acid test”, whilst being mindful of the fact that any definition must comply with Article 5 ECHR.<sup>17</sup>

12. There is no statutory definition of deprivation of liberty in the Bill and unless it is amended to include one, the question of what constitutes a deprivation of liberty will continue to be determined by reference to Article 5 ECHR, as interpreted by the Supreme Court in *Cheshire West*.

13. The European Court of Human Rights (ECtHR) has provided that a person is deprived of liberty for the purpose of Article 5 ECHR where the following three elements are present:

- a) Confinement in a particular place for a not negligible period of time (the objective element);
- b) Lack of valid consent (the subjective element);
- c) Attribution of responsibility to the State (i.e. where the State knows or ought to know).<sup>18</sup>

14. In articulating its definition of Article 5 ECHR in a health and social care context, the Supreme Court considered Strasbourg case law, although they noted there was no precise precedent. They decided (by a majority) that a person is subject to “confinement” when the person concerned is “under continuous supervision and control” and “not free to leave”,<sup>19</sup> to be determined “primarily on an objective basis”.<sup>20</sup> It did not matter whether the individuals in this case were content or compliant. As Lady Hale said, “a gilded cage is still a cage.”<sup>21</sup> This judgment set the “acid test” for determining when a person is deprived of their liberty.

15. Following *Cheshire West*, a group of people who were not previously generally considered to be deprived of their liberty for the purposes of Article 5 ECHR are now said to be so. While this may be in accordance with the ‘living instrument’ principle, evidence presented to our Committee by several witnesses raised serious doubts about the application of safeguards to those living in domestic settings. For example, Mark Neary, who has a son with autism, believes that the current definition is too wide as it captures his son, who is living contentedly in his own home. Mr. Neary explained:

“Steven is currently being assessed for whether he is being deprived of his liberty in his own home. Since October 2016, he has had his own place. He is very much king of his castle in his own place. He requires 24/7 support, which is either me or a member of the support team. It was decided last

17 Joint Committee on Human Rights, Seventh Report of Session 2017–19, [The Right to Freedom and Safety: Reform of the Deprivation of Liberty Safeguards](#), HC 890 / HL Paper 161, para 45

18 *Storck v Germany* (Application No. 61603/00) at para 74; *Stanev v Bulgaria* (Application No. 36760/06) at para 117

19 *Cheshire West and Chester Council v P* [2014] UKSC 19, [2014] MHLO 16, paras 49, 63 and 87

20 *Cheshire West and Chester Council v P* [2014] UKSC 19, [2014] MHLO 16, paras 76–87

21 *Cheshire West and Chester Council v P* [2014] UKSC 19, [2014] MHLO 16, para 46

week that Steven is being deprived of his liberty in his own home on two bases: first, that he is not free to leave, because he needs support workers to go with him when he goes to the shop or goes swimming; and, secondly, that he is under constant supervision.

“I find it very difficult to square that one. When I see him going around his everyday life, interacting with his support workers and getting them to make a toasted cheese sandwich for him, that does not feel to me like supervision. That does not feel to me like a deprivation of liberty.”

16. We understand the Supreme Court’s non-discriminatory approach to the meaning of liberty. Nonetheless, there is a danger that a scheme which applies too widely will be so light touch as to reduce protection for those who truly need it. We continue to fear that use of the “acid test” alone, without further clarification, risks (i) perpetuating the current backlog of cases, (ii) making the new scheme unworkable, (iii) infringing the Article 8 rights of cared-for persons and (iv) diverting acutely needed resources away from front-line care which are essential to promote and protect the human rights of cared-for persons.

**17. A definition on the face of the Bill is important to give cared-for persons, their families, and professionals greater certainty about the parameters of the scheme. It would also ensure that scrutiny and resources are deployed where necessary. It is undeniable that any definition in statute may be revised or refined by future case law but, in our view, it is not possible to design and implement an effective system of safeguards without having a clear sense of to whom it should apply.**

18. This issue has been raised in parliamentary debates on the Bill and the Government has indicated that it is open to further discussion on this point.<sup>22</sup>

**19. The Bill does not set out a specific ‘route’ for authorisations for persons living in their own home, however it is understood that it is envisaged that the local authority or clinical commissioning group would carry out the required assessments. We seek further clarity from the Government about how and by whom assessments will be made in domestic settings. It is not clear to what extent the requirements for authorisations would be extended to self-funders who, or whose families, make their own domestic care arrangements.**

## Options for defining deprivation of liberty

### *The ‘causative’ approach*

20. Providing a statutory definition of deprivation of liberty is made difficult by the lack of clarity in Strasbourg case law. The evidence we received to our inquiry suggested two main approaches which are set out below.

21. The first is to further refine the meaning of ‘confinement’ in the context of persons who lack of capacity. Sir Nicholas Mostyn, a High Court judge suggested that this could be achieved by taking a ‘causative approach.’<sup>23</sup> That is to say that an individual is deprived

22 HL Deb, 5 September 2018, [col 1848](#)

23 Written evidence from Sir Nicholas Mostyn ([DOL0012](#)) submitted to the Committee’s inquiry into The Right to Freedom and Safety: Reform of the Deprivation of Liberty Safeguards.

of liberty only where the cause of their confinement is continuous supervision and control (as opposed to their underlying disability or condition). This is the approach that was taken in the case of *Ferreira*—a case concerning life sustaining treatment.<sup>24</sup>

22. One argument in favour of this approach is that it is better aligned to the Strasbourg case law, which mandates a fact-sensitive approach and which, in determining whether someone is deprived of their liberty, takes into account a range of factors such as the intensity of the restrictions in question.<sup>25</sup>

23. This reasoning may also go some way towards limiting the tension between Article 14 UNCRPD and Article 5(1)(e) ECHR. The Committee on the Rights of Persons with Disabilities has considered that Article 14 UNCRPD means that deprivation of liberty on the basis of disability represents arbitrary detention.<sup>26</sup> However Article 5(1)(e) ECHR permits detention of those with ‘unsound mind’ in accordance with a procedure prescribed by law. A fact-sensitive approach may help to navigate a middle ground between these two different approaches.

24. Arguably, it is far from certain that a ‘causative’ test would be any easier than the “acid test” to apply in practice. It may prove difficult for those operating the safeguards to distinguish whether a person’s disability, their medication, or the restrictions deemed to be required because of their condition, is the ultimate cause of the deprivation of liberty. It may also be viewed as discriminatory as it may, at least in practice, result in a different approach depending on the nature of a person’s disability or lack of capacity.

25. In his submission, Sir Nicholas Mostyn also raised concerns about the meaning of “freedom to leave” in the “acid test”.<sup>27</sup> He points to the interpretation given by Sir James Munby in the case of *Re D (A Child)*<sup>28</sup> in which he stated that he considered the Supreme Court to have meant “leaving in the sense of removing himself permanently in order to live where and with whom he chooses” and not merely “leaving for the purpose of some trip or outing.” He felt that this clarification should also form part of the definition.

### ***The ‘valid consent’ approach***

26. An alternative approach is to maintain the unequivocally non-discriminatory approach to confinement set out in the “acid test” but to revisit the second limb of the definition, that of ‘valid consent’. Currently the position is that if an individual is deemed to lack mental capacity, then they have no legal capacity and cannot give valid consent. It has been suggested that a more nuanced approach could be taken that allows for the fact that

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24 *Ferreira v HM Senior Coroner for Inner South London and Others* [2017] EWCA Civ 31

25 Written evidence from Sir Nicholas Mostyn ([DOL0012](#)) submitted to the Committee’s inquiry into The Right to Freedom and Safety: Reform of the Deprivation of Liberty Safeguards.

26 UN Committee on the Rights of Persons with Disabilities, [Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities](#). Adopted during the Committee’s Fourteenth session, held in September 2015.

27 Written evidence from Sir Nicholas Mostyn ([DOL0012](#)) submitted to the Committee’s inquiry into The Right to Freedom and Safety: Reform of the Deprivation of Liberty Safeguards.

28 [\[2017\] EWCA Civ 1695](#) at [22]

it is possible to manifest assent to a situation through words, behaviours or actions.<sup>29</sup> Such an approach would follow that of the ECtHR in the case of *Mihailovs*, which distinguished between *de jure* capacity to consent and *de facto* ability to give valid consent.<sup>30</sup>

27. To ascertain whether or not ‘valid consent’ has been given would involve identifying the individual’s wishes and preferences and, on that basis, determining whether they are content and consenting to their care and treatment. It is important to stress that valid consent could not be deemed to be demonstrated simply by the absence of an objection. It could only be given by evidence of a positive wish to remain in the relevant place and receive care there under the regime in place for them.

28. Such an approach might be judged to be appropriate in situations in which no coercion is being exercised. The ECtHR has considered the presence or absence of coercion as a factor in determining whether an individual is deprived of liberty, but this was not considered in detail in *Cheshire West*.

29. It may also better reflect the spirit of Article 12(2) of the UN Convention on the Rights of Persons with Disabilities (CRPD), which says that “States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.” In General Comment No. 1 on Article 12, the UN Committee on the Rights of Persons with Disabilities emphasised the crucial importance of ensuring that steps are taken to support individuals to exercise their legal capacity, including by means of supported decision-making. That is a process of decision-making which requires support to be given to a person to make their own decisions, and where such is not possible, for any decision to be taken on the basis of the best interpretation of an individual’s known wishes and preferences in respect of that decision.

30. The General Comment on Article 12 is critical of approaches which say that people should only have legal capacity if they have mental capacity. The CRPD Committee says that “perceived or actual deficits in mental capacity must not be used as justification for denying legal capacity”.<sup>31</sup>

31. There are concerns that taking this ‘valid consent’ approach leaves potentially vulnerable people at risk if they are deemed not to be deprived of their liberty. We understand these concerns and stress that we are not advocating an absence of safeguards for those whose care arrangements are restrictive of their liberty. We question whether, for those who are not subject to coercion and are able to express their wishes and feelings, there are not more appropriate ways of providing safeguards, for example through improved adult safeguarding procedures. We recognise, however, that there is difficulty in introducing an arguably contradictory position that the cared-for person does not have legal capacity to consent to their care and treatment due to their lack of mental capacity, but may nevertheless be deemed to consent if they are able to express their wishes and feelings.

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29 Written evidence from Alex Ruck Keene ([DOL0120](#)) submitted to the Committee’s inquiry into The Right to Freedom and Safety: Reform of the Deprivation of Liberty Safeguards.

30 *Mihailovs v Latvia* [2013] ECHR 65

31 Office of the United Nations High Commissioner for Human Rights, Committee on the Rights of Persons with Disabilities, [General Comment 1 on Article 12 \(Equal recognition before the law\)](#), Eleventh Session, 2014

*32. We recognise that these issues are complex and require considerable expertise to ensure that any statutory definition is pragmatic, medically appropriate, non-discriminatory, and compliant with Article 5. Whilst we are mindful of the inherent difficulties, nevertheless, we believe that the lack of a statutory definition may result in persistent problems with the new scheme. We therefore recommend that a workable definition is included in the Bill and consider that the two approaches discussed above are worthy of Parliamentary debate. We suggest the following amendments to ensure that this difficult issue is given the consideration it deserves:*

**Schedule 1, paragraph 2,**

**Amendment 1**

Page 5, line 33, at end insert -

“(1) “For the purpose of paragraph (2)(1)(b), a cared-for person will only be deprived of their liberty if:

- (a) the cared-for person is subject to confinement in a particular place for a not negligible period of time; and
- (b) the cared-for person has not given valid consent to their confinement.

(2) For the purpose of paragraph (2)(2)(a), a cared-for person is subject to confinement where:

- (a) the cared-for person is prevented from removing himself or herself permanently in order to live where and with whom he or she chooses; and
- (b) the dominant reason is the continuous supervision and control to which the cared-for person is subjected, and not the underlying condition.

**Amendment 2**

Page 5, line 33, at end insert -

“(2) For the purpose of paragraph (2)(1)(b), a cared-for person will only be deprived of their liberty if:

- (c) the cared-for person is subject to confinement in a particular place for a not negligible period of time; and
- (d) the cared-for person has not given valid consent to their confinement.

(3) For the purpose of paragraph(2)(2)(b), a cared-for person is deemed to have given their valid consent where:

- (e) the cared-for person is capable of expressing their wishes and feelings (verbally or otherwise);
- (f) the cared-for person has expressed their persistent contentment with their care and treatment arrangements;

- (g) there is no coercion involved in the implementation of the cared-for person's care and treatment arrangements; and
- (h) paragraphs (2)(3)(a) to (c) are confirmed in writing by the two professionals, one of whom must not be involved in the implementation of the cared-for person's care or treatment arrangements.

33. We note that taking such an approach here would have implications for other provisions of the Mental Capacity Act and should in time prompt a wider review of legal capacity.

## 3 Authorisation of arrangements

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### The role of care home managers

34. Under the Law Commission's proposed scheme responsible bodies would have undertaken or arranged the relevant assessments required before a deprivation of liberty can be authorised in all cases. That would have included assessments as to whether (i) the arrangements amount to a deprivation of the person's liberty, (ii) that the person lacks the capacity to consent to the arrangements, (iii) they are of unsound mind, and (iv) that the arrangements for their care and treatment are necessary and proportionate.<sup>32</sup>

35. In a major departure from this, the Bill before Parliament sets out that for those living in care homes, responsibility for assembling the information required would fall to care home managers. This includes consultation with interested parties to ascertain the cared-for person's wishes or feelings, determinations on the capacity of the cared-for persons, and whether the arrangements are necessary and proportionate. They would submit the outcomes of these assessments in a statement to the responsible body which would then review the information and decide whether to authorise the deprivation of liberty.

36. Under the Bill, in cases where it is reasonable to believe that the person does not wish to reside or receive care or treatment in the place provided for by the arrangements, the pre-authorisation review must be carried out by an Approved Mental Capacity Professional (AMCP).<sup>33</sup> In the care home setting it would be the care home manager who would be responsible for ascertaining whether someone is objecting and therefore eligible for the involvement of an AMCP.

37. Similarly, access to an Independent Mental Capacity Advocate (IMCA) for those in care homes would also be gained via the care home manager. Where a person lacks capacity to consent to being represented and supported by an IMCA, the care home manager would have to notify the responsible body if they believe that it would be in the cared-for person's best interests to have one.

38. Concerns about these proposals have been voiced from various quarters including representatives of local government,<sup>34</sup> care providers,<sup>35</sup> NGOs,<sup>36</sup> and legal professionals.<sup>37</sup> Objections to the proposal centre on whether care home managers have the necessary skills and knowledge to arrange or undertake the assessments and whether they are sufficiently independent to do so.

39. It is questionable whether care home managers are trained and resourced to take on these additional responsibilities. It is also unclear who would be responsible for undertaking the necessity and proportionality assessment (other than someone with

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32 Law Commission, [Mental Capacity and Deprivation of Liberty](#), HC 1079

33 [Mental Capacity \(Amendment\) Bill \[HL\]](#), Schedule 1 (18) (2). The criteria for AMCP status will be set in regulation (Schedule 1, Part 4).

34 Directors of Adult Social Services, [The Mental Capacity \(Amendment\) Bill – ADASS Statement](#), 4 September 2018

35 Care England, [Conflict of Interest](#), 5 September 2018

36 Inclusion London, [Briefing on the Mental Capacity Amendment Bill](#), A cross-sector representation of issues and concerns relating to the Mental Capacity (Amendment) Bill HL, and Age UK, Briefing: [Mental Capacity \(Amendment\) Bill \(HL\), Committee Stage](#), September 2018

37 The Law Society, [Parliamentary briefing: Mental Capacity \(Amendment\) Bill - House of Lords committee stage](#), 3 September 2018

“appropriate experience and knowledge”). Undertaking an assessment of necessity and proportionality would require at least some understanding of the meanings of these terms including for the purposes of satisfying Article 5 ECHR.

40. There is a need to clarify the scope of the role of care home managers. The impact assessment provided by the Government suggests that care home managers would be provided with only half a day’s familiarisation on the new scheme.<sup>38</sup> Even if care home managers would be arranging, rather than undertaking, the assessments, in our view, it is doubtful that they could develop the requisite knowledge and skills in this time frame.

41. It is welcome that the Care Quality Commission (CQC) would have a role in checking authorisations as part of their inspections process.<sup>39</sup> As a further safeguard we suggest that in care homes rated by the inspectorate as “inadequate” or “requiring improvement”, assessments should not be undertaken or arranged by the care home manager but by someone within the responsible body itself. In such cases the independent review would then be carried out by someone from within the same responsible body so it would be important that the Code of Practice sets out clear guidelines to ensure that the review is truly independent. We consider this wider issue further at paragraph 54.

42. Serious questions have also been asked about whether care home managers are sufficiently independent to take on this new role. There is arguably an inherent conflict of interest if the person arranging the assessment also has a financial interest in securing placements in the care home. Professor Martin Green OBE, Chief Executive of Care England, which represents independent providers of adult social care said in a statement:

“As providers we are very concerned about the inherent conflict of interest associated with placing Liberty Protection Safeguards assessment responsibilities on registered care home managers.”<sup>40</sup>

43. In response to such criticisms, the Government has stated that “care home managers are not approving authorisations themselves; that role remains with Local Authorities, which will provide independent scrutiny and oversight”.<sup>41</sup> However, unless the care home manager indicates that an AMCP referral is required, the only information available to the responsible body upon which to conduct its pre-authorisation review is the information supplied by the care home manager.

**44. *In light of this, it is a significant concern that the statement that care home managers would be required to provide to the responsible body (Schedule 1 (14)) does not appear to include a record of the assessment of necessity and proportionality, only the capacity and medical assessments. We recommend that the Bill is amended to require that care home managers must provide a record of the necessity and proportionality assessment. We suggest the following amendment:***

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38 Impact Assessment, [Mental Capacity \(Amendment\) Bill, 29 June 2018](#)

39 Impact Assessment, [Mental Capacity \(Amendment\) Bill, 29 June 2018](#), para 8.10

40 Care England, [Conflict of Interest](#), 5 September 2018

41 Letter from Lord O’Shaughnessy to Lords regarding [points raised during the second reading of the Mental Capacity \(Amendment\) Bill](#), dated 24 July 2018

## Schedule 1, paragraph 14

### Amendment 3

Page 11, line 32, after “paragraph 15” insert “and 16”.

45. The Government has asserted that its proposals provide the degree of independence required by the case law arising from Article 5 ECHR.<sup>42</sup> We accept that the proposals relating to care home managers are likely to be compliant with this requirement. However, we remain concerned that, in practice, care home managers would face conflicts of interest that will seriously hinder their ability to make objective assessments.

46. Our concerns are heightened by the fact that the care home manager would be tasked with determining whether the cared-for person should have access to either an AMCP or an IMCA. Both these roles provide important safeguards of the individuals’ rights under Article 5 ECHR and decisions about who requires such safeguards should be made independently.

47. It was a key feature of the Law Commission’s proposal that assessments should be carried out as an integral part of routine care planning, before arrangements for care or treatment are put in place (under DoLS they happen afterwards). The ‘illustrative person journeys’ published by the DHSC to show the differences between the two schemes suggests that this aspiration is retained under LPS, with care home managers being expected to arrange or conduct their assessments before an individual moves into the care home.<sup>43</sup> We question how this would work in practice. Particularly in cases where no suitable assessment already exists on which they can rely, how would the care home manager be able to ascertain the wishes and feelings of a person they may not even have met?

### Conclusion

**48. Whilst some of the provisions in the Bill may comply with Article 5 ECHR, we have serious reservations about whether the Bill does enough to protect those who are at risk of unlawful detention. We are also concerned that the Government’s impact assessment significantly underestimates the resources required for implementation. For example, we question the assumption made in the Government’s impact assessment that “there will be no net change in costs to providers of authorisations and administration.”<sup>44</sup>**

**49. If the Government goes ahead with its proposal for care home managers to facilitate the assessment process, it is essential that safeguards for those subject to the authorisation process are enhanced including: a duty to consult the cared-for person directly; a broader criterion for referral to an AMCP; and a requirement for a stronger right to an independent advocate. Amendments to the Bill to affect these changes are set out below.**

42 [Explanatory Notes to the Mental Capacity \(Amendment\) Bill](#), para 47

43 Department for Health and Social Care, [Mental Capacity \(Amendment\) Bill, Illustrative person journeys under DoLS v Liberty Protection Safeguards](#), ANNEX B (as referenced in letter from Lord O’Shaughnessy dated 24 June 2018)

44 Impact Assessment, [Mental Capacity \(Amendment\) Bill, 29 June 2018](#)

## Duty to consult

50. Schedule 1 (17) sets out who the responsible body or care home manager must consult with in order to ascertain the person's wishes and feelings in relation to the arrangements. Conspicuously absent from the list of consultees are the cared-for persons themselves. This seems to be at odds with the Minister's statement in his letters to Peers of 24 July 2018 that "[d]uring the assessment process, the person's wishes and feelings must be identified through consultation with the individual and others who care for them. This consultation duty is more explicit than that currently required under the DoLS requirements [ ... ]"<sup>45</sup>

51. *To ensure that this is the case and in light of the requirement under ECHR case law that consideration should be given to the wishes and feelings of the cared-for person,<sup>46</sup> we consider it essential that the cared-for person be included among the list of consultees. We suggest the following amendment:*

Schedule 1, paragraph 17

### Amendment 4

Page 12, line 24, at end insert -

“(a) the cared-for person”

## Referral to an Approved Mental Capacity Professional

52. The Bill introduces the new role of Approved Mental Capacity Professional (AMCP) - a health or social care professional who is specifically trained to carry out assessments in the cases most in need of independent oversight.<sup>47</sup> The AMCP would act “on behalf” of the local authority but would be an independent decision-maker who cannot be directed to make a particular decision.

53. *As currently drafted, the legislation only permits a referral to an AMCP when the care home manager or responsible body has a reasonable belief that the person does not wish to reside or receive care or treatment in the place provided for by the arrangements.<sup>48</sup> We are concerned that this criterion is too narrow, particularly in the context of care homes. At a minimum, it should be broadened to include cases in which relatives or those with a genuine relationship with the cared-for person object.<sup>49</sup> Other situations in which referral to an AMCP might be appropriate include those in which the cared-for person is prohibited contact with named persons, when the person is deprived of their liberty for psychiatric treatment, or in exceptional cases, such as those with very high levels of restraint. We suggest the following amendment:*

45 Letter from Lord O'Shaughnessy to Lords regarding [points raised during the second reading of the Mental Capacity \(Amendment\) Bill](#), dated 24 July 2018

46 A.-M.V. v Finland (App no 53251/13) [2017] ECHR 273.

47 [Mental Capacity \(Amendment\) Bill \[HL\]](#), Schedule 1, Part 4

48 [Mental Capacity \(Amendment\) Bill \[HL\]](#), Schedule 1 (18) (2)

49 Dr Lucy Series ([MCB0001](#))

## Schedule 1, paragraph 18

### Amendment 5

Page 13, line 15, at end insert -

- “(c) relatives of the cared-for person, or those with a genuine relationship with the cared-for person, object to the care and treatment arrangements, or
  - (d) the cared-for person is prohibited from making contact with named persons, or
  - (e) the cared-for person is subject to high levels of restraint, or
  - (f) the care home manager or responsible body considers the case to be exceptional.
- (2) For the purpose of sub-section (1)(c), a person with a “genuine relationship” with the cared-for person may be a relative, friend, carer, or anyone who can be reasonably expected to be concerned for the welfare of the cared-for person.”

## Independence of reviews

54. Human rights law requires that authorisations of deprivations of liberty are reviewed independently. Accordingly, the Bill provides that a person who is not involved in the day-to-day care of, or in providing any treatment to, the person must also carry out a pre-authorisation review to determine whether it is reasonable for the responsible body to conclude that the authorisation conditions are met. In cases where the person is objecting to the proposed arrangements, an Approved Mental Capacity Professional must carry out the pre-authorisation review.<sup>50</sup>

**55. In our view, these proposals are technically compliant with the Article 5 requirement for independence, although it is always open to States to have higher standards. We reiterate the concerns expressed in our previous report that the review process is not free from conflict of interest. Whilst it would be disproportionate to establish a separate review body, we seek assurances from the Government that the Code of Practice will set out clear guidelines to eradicate conflicts of interest.**

## Advance consent

56. The Law Commission’s proposals introduced the possibility of providing advance consent to care and treatment arrangements that would otherwise amount to a deprivation of liberty. In our previous report we considered that advance consent for care arrangements should be valid as long as safeguards are in place to verify the validity of this consent. We recommended formalising the arrangements for the giving of advance consent and establishing a monitoring mechanism to ensure that the arrangements put in place respect any stipulations the person concerned has made about his or her future care, and that proper records are kept. The records should be in writing, explaining the circumstances in which consent is given and, if the person to whom consent relates has not given the consent personally, the authority for giving that consent.

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50 [Mental Capacity \(Amendment\) Bill \[HL\]](#), Schedule 1, para 18

57. In the ‘recommendation by recommendation’ response to the Law Commission’s proposals’ published in July 2018, the Government set out its reasoning for not taking forward advance consent to care and treatment arrangements that would otherwise amount to a deprivation of liberty:

“Our engagement with stakeholders indicated a lack of support for including in the Bill provision for advance consent to being deprived of liberty, as they were unable to confidently envision a future scenario where they felt could ‘trust’ the advance decision for the specific future circumstances. Without robust monitoring processes, advance consent in some long stay settings could also be interpreted as people ‘giving up’ their protections and human rights”.<sup>51</sup>

58. *It continues to be our belief that advance consent, with appropriate safeguards, could offer people greater choice and control over their future care and treatment arrangements. We suggest the following amendment:*

#### **Amendment 6**

Insert the following new clause:

Advance decisions to consent to care and treatment arrangements

(1) The Mental Capacity Act is amended as follows.

(2) After section 26 insert -

26A Advance consent to care and treatment arrangements

(1) “Advance consent” means a decision made by a person after he or she has reached 18 and when he or she has capacity to do so, that the person consents to specific care and treatment arrangements if—

- (a) at a later time and in such circumstances as the person may specify, a specified care or treatment arrangement is proposed to be carried out or continued by a person providing care or treatment, and
- (b) at that time the person lacks capacity to consent to the care or treatment arrangements.

(2) A decision to give advance consent to specific care and treatment arrangements is only valid if:

- (a) it is in writing
- (b) it is signed by the person or by a representative in the person’s presence and by the person’s direction,
- (c) the signature is made or acknowledged by the person in the presence of a witness, and

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51 Letter from Lord O’Shaughnessy to Lords regarding [points raised during the second reading of the Mental Capacity \(Amendment\) Bill](#), dated 24 July 2018

- (d) the witness signs it, or acknowledges his signature, in the person's presence.
- (3) For the purposes of subsection (1), a decision may be regarded as specifying a care or treatment arrangement even though expressed in layman's terms.
- (4) The person may withdraw or alter an advance decision at any time when he has capacity to do so. In such circumstances, an alteration or withdrawal (including a partial withdrawal) must also be in writing in compliance with sub-section (2).
- (5) A decision to give advance consent is not valid if there are reasonable grounds to believe that circumstances exist which the person did not anticipate at the time of giving the advance consent and, if the person had anticipated them, would have affected the decision to give consent.

## 4 Advocacy and rights of appeal

### Access to an independent advocate

59. Part 5 of Schedule 1 provides that the cared-for person should be represented and supported either by an ‘appropriate person’ or an Independent Mental Capacity Advocate (“IMCA”). An IMCA is an advocate instructed under the MCA who is responsible for supporting and representing a person who lacks capacity to make certain decisions. If the person has capacity to consent to being represented by an IMCA and requests it, then one should be appointed. Where the person lacks the capacity to consent, the care home manager or responsible body must request an IMCA where they are satisfied that being represented and supported by one would be in the person’s best interests. An IMCA must be appointed unless there is an ‘appropriate person’ who would be suitable to represent and support the person. In certain circumstances the appropriate person must themselves be provided with an IMCA.<sup>52</sup>

60. These arrangements are significantly weaker than those proposed by the Law Commission which would have given an automatic right to an independent advocate for those subject to LPS authorisation on an opt-out basis.<sup>53</sup> In our report we supported the enhancement of rights to an independent advocate which we viewed as an important factor in ensuring that individuals can exercise their rights to challenge authorisations. This is essential for compliance with Article 5(4) ECHR, which requires that everyone deprived of their liberty be entitled to take proceedings by which the lawfulness of their detention shall be decided speedily by a court. It is also important for compliance with Article 12 CRPD in supporting the person to exercise decision-making capacity.

61. *We note that the practicality and resource implications of providing advocates to all will be affected by whether the definition of ‘deprivation of liberty’ is revisited to reduce the numbers of people caught by it. Notwithstanding our concerns about the shortage of advocates and the need for appropriate funding for them, we continue to believe that access to advocacy should be available as of right. This should not be subject to a best interests test. We suggest the following amendment:*

#### Schedule 1, paragraph 36

##### Amendment 7

Page 18, line 41, delete paragraph 36(1) - (3) and insert “The responsible body must take all reasonable steps to appoint an IMCA to represent and support all cared-for persons”.

### Rights of appeal

62. Under Article 5(4) ECHR, those deprived of their liberty have a right to bring a court review of the lawfulness of their detention. In our previous report we noted that under DoLS the rate of appeal to the Court of Protection is extremely low; only 1% of DoLS authorisations are appealed. By comparison appeals are brought in 47% of decisions to detain someone under the MHA. This suggested to us that there are barriers to exercising appeal rights and we recommended that the individual’s right to participate in court ought

52 [Mental Capacity \(Amendment\) Bill \[HL\], Schedule 1, Part 5](#)

53 [Law Commission, \*Mental Capacity and Deprivation of Liberty\*, HC 1079, para 12.40](#)

to be set out in statute and that responsibility for securing the individual's access to court should be prescribed clearly on the face of the Bill. Whilst the individual's appropriate person and advocate should have a duty to appeal on their behalf where necessary, the responsible body should be under a clear statutory duty to refer cases where others fail to do so, for example, when the individual objects or the arrangements are particularly intrusive.<sup>54</sup>

**63. *The Bill as it stands is silent on this issue and in its impact assessment the Government predicts that as a result of the introduction of the AMCP role the number of appeals to the Court of Protection will halve to a mere 0.5% of applications. In light of this we strongly reiterate our previous recommendations. We suggest the following amendment:***

#### **Schedule 1, paragraph 21**

##### **Amendment 8**

Page 14, line 7, at end insert new clause-

Duty to assist the cared-for person to access court

- (1) The cared-for person has a right to challenge their authorisation before a court.
- (2) The appropriate person, the IMCA (where appointed) and the responsible body are all under a duty to assist the cared-for person to access a court in order to challenge their authorisation in circumstances where:
  - (a) the cared-for person, the family of the cared-for person, or another person in a genuine relationship with the cared-for person, has expressed objection to the care and treatment arrangements; or
  - (b) the care or treatment arrangements are particularly intrusive.
- (3) Where an authorisation is challenged in court, the appropriate person, the IMCA and the responsible body are all under a duty to facilitate, as far as possible, the cared-for person's participation in court proceedings.

**64. *We also consider it essential that the cared-for person and their 'appropriate person' are provided with information about the authorisation and their rights to challenge the authorisation in court. This is a safeguard required under Article 5 (4) ECHR.<sup>55</sup> Such a requirement currently exists under DoLS but is not included in the LPS scheme. The Government has suggested that the right to make a Subject Access Request (SAR) under the General Data Protection Regulation (GDPR) offers an alternative means by which the cared-for person or their family can obtain information about an authorisation;<sup>56</sup> we do not accept this is an adequate substitute. This omission ought to be remedied. We suggest the following amendment:***

54 Written evidence from Dr Lucy Series ([DOL0068](#)), p 5, submitted to the Committee's inquiry into The Right to Freedom and Safety: Reform of the Deprivation of Liberty Safeguards. Note that if an IMCA fails to bring a challenge to court in circumstances where such a challenge is required to secure an individual's Art 5(4) rights, the local authority is required to bring the case to court.

55 Van Der Leer v The Netherlands (App no 11509/85) (1990) 12 EHRR 567, para 28; X v United Kingdom (App no 7215/75) [1981] ECHR 6; LM v Slovenia (App no 32863/05) Chamber Judgment [2014] ECHR 608.

56 HL Deb, 15 October 2018, [col 337](#)

**Schedule 1, paragraph 21****Amendment 9**

Page 14, line 7, at end insert -

*Right to information*

21A(1) Throughout the authorisation process, the cared-for person must be fully informed of their rights.

(2) The responsible body must take all reasonable steps to ensure that the cared-for person is informed of and understands, as far as possible, the nature of the process and their rights within the process, including:

- (a) the steps involved in the authorisation process;
- (b) the nature, duration, and effect of the authorisation;
- (c) their right to object to the authorisation and the right to a review by an Approved Mental Capacity Professional;
- (d) their right to challenge an authorisation decision in court under section 21ZA;
- (e) their right to be supported and represented by an appropriate person;
- (f) their right to have an IMCA appointed;
- (g) their right to have the authorisation reviewed regularly.

## Conclusions and recommendations

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### Defining deprivation of liberty

1. A definition on the face of the Bill is important to give cared-for persons, their families, and professionals greater certainty about the parameters of the scheme. It would also ensure that scrutiny and resources are deployed where necessary. It is undeniable that any definition in statute may be revised or refined by future case law but, in our view, it is not possible to design and implement an effective system of safeguards without having a clear sense of to whom it should apply. (Paragraph 17)
2. The Bill does not set out a specific ‘route’ for authorisations for persons living in their own home, however it is understood that it is envisaged that the local authority or clinical commissioning group would carry out the required assessments. We seek further clarity from the Government about how and by whom assessments will be made in domestic settings. It is not clear to what extent the requirements for authorisations would be extended to self-funders who, or whose families, make their own domestic care arrangements. (Paragraph 19)
3. *We recognise that these issues are complex and require considerable expertise to ensure that any statutory definition is pragmatic, medically appropriate, non-discriminatory, and compliant with Article 5. Whilst we are mindful of the inherent difficulties, nevertheless, we believe that the lack of a statutory definition may result in persistent problems with the new scheme. We therefore recommend that a workable definition is included in the Bill and consider that the two approaches discussed above are worthy of Parliamentary debate.* (Paragraph 32)

### Authorisation of arrangements

4. *It is a significant concern that the statement that care home managers would be required to provide to the responsible body (Schedule 1 (14)) does not appear to include a record of the assessment of necessity and proportionality, only the capacity and medical assessments. We recommend that the Bill is amended to require that care home managers must provide a record of the necessity and proportionality assessment.* (Paragraph 44)
5. Whilst some of the provisions in the Bill may comply with Article 5 ECHR, we have serious reservations about whether the Bill does enough to protect those who are at risk of unlawful detention. We are also concerned that the Government’s impact assessment significantly underestimates the resources required for implementation. For example, we question the assumption made in the Government’s impact assessment that “there will be no net change in costs to providers of authorisations and administration.” (Paragraph 48)
6. If the Government goes ahead with its proposal for care home managers to facilitate the assessment process, it is essential that safeguards for those subject to the authorisation process are enhanced including: a duty to consult the cared-for person directly; a broader criterion for referral to an AMCP; and a requirement for a stronger right to an independent advocate. (Paragraph 49)

7. *To ensure that individuals are consulted and in light of the requirement under ECHR case law that consideration should be given to the wishes and feelings of the cared-for person, we consider it essential that the cared-for person be included among the list of consultees. (Paragraph 51)*
8. *As currently drafted, the legislation only permits a referral to an AMCP when the care home manager or responsible body has a reasonable belief that the person does not wish to reside or receive care or treatment in the place provided for by the arrangements. We are concerned that this criterion is too narrow, particularly in the context of care homes. At a minimum, it should be broadened to include cases in which relatives or those with a genuine relationship with the cared-for person object. Other situations in which referral to an AMCP might be appropriate include those in which the cared-for person is prohibited contact with named persons, when the person is deprived of their liberty for psychiatric treatment, or in exceptional cases, such as those with very high levels of restraint. (Paragraph 53)*
9. *In our view, these proposals are technically compliant with the Article 5 requirement for independence, although it is always open to States to have higher standards. We reiterate the concerns expressed in our previous report that the review process is not free from conflict of interest. Whilst it would be disproportionate to establish a separate review body, we seek assurances from the Government that the Code of Practice will set out clear guidelines to eradicate conflicts of interest. (Paragraph 55)*
10. *It continues to be our belief that advance consent, with appropriate safeguards, could offer people greater choice and control over their future care and treatment arrangements. (Paragraph 57)*

### Advocacy and rights of appeal

11. *We note that the practicality and resource implications of providing advocates to all will be affected by whether the definition of ‘deprivation of liberty’ is revisited to reduce the numbers of people caught by it. Notwithstanding our concerns about the shortage of advocates and the need for appropriate funding for them, we continue to believe that access to advocacy should be available as of right. This should not be subject to a best interests test. (Paragraph 60)*
12. *The Bill as it stands is silent on appeal rights and in its impact assessment the Government predicts that as a result of the introduction of the AMCP role the number of appeals to the Court of Protection will halve to a mere 0.5% of applications. In light of this we strongly reiterate our previous recommendations. (Paragraph 62)*
13. *We also consider it essential that the cared-for person and their ‘appropriate person’ are provided with information about the authorisation and their rights to challenge the authorisation in court. This is a safeguard required under Article 5 (4) ECHR. Such a requirement currently exists under DoLS but is not included in the LPS scheme. The Government has suggested that the right to make a Subject Access Request (SAR) under the General Data Protection Regulation (GDPR) offers an alternative means by which the cared-for person or their family can obtain information about an authorisation; we do not accept this is an adequate substitute. This omission ought to be remedied. (Paragraph 63)*

# Declaration of Interests<sup>1</sup>

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## **Baroness Hamwee**

- No relevant interests to declare

## **Baroness Lawrence of Clarendon**

- No relevant interests to declare

## **Baroness Nicholson of Winterbourne**

- No relevant interests to declare

## **Baroness Prosser**

- No relevant interests to declare

## **Lord Trimble**

- No relevant interests to declare

## **Lord Woolf**

- Relative with autism

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<sup>1</sup> A full list of Members' interests can be found in the Register of Lords' Interests: <https://www.parliament.uk/mps-lords-and-offices/standards-and-financial-interests/house-of-lords-commissioner-for-standards-/register-of-lords-interests/>

# Formal minutes

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**Wednesday 24 October 2018**

Members present:

Baroness Hamwee, in the Chair

Ms Karen Buck MP	Baroness Lawrence of Clarendon
Joanna Cherry MP	Baroness Nicholson of Winterbourne
	Baroness Prosser
	Lord Trimble
	Lord Woolf

Draft Report (*Legislative Scrutiny: Mental Capacity (Amendment) Bill*), proposed by the Chair, brought up and read.

*Ordered*, That the Chair's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 64 read and agreed to.

Summary read to.

*Resolved*, That the Report be the Twelfth Report of the Committee.

*Ordered*, That Ms Karen Buck make the Report to the House of Commons and that the Report be made to the House of Lords.

[Adjourned till Wednesday 31 October 2018 at 3.00pm.]

## Published written evidence

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The Committee has published the briefing paper prepared for Parliamentarians by Dr Lucy Series as [MCA0001](#).

## List of Reports from the Committee during the current Parliament

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All publications from the Committee are available on the [publications page](#) of the Committee's website. The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

### Session 2017–19

First Report	Legislative Scrutiny: The EU (Withdrawal) Bill: A Right by Right Analysis	HC 774 HL 70
Second Report	Proposal for a Draft Human Fertilisation and Embryology Act 2008 (Remedial) Order 2018	HC 645 HL 86
Third Report	Legislative Scrutiny: The Sanctions and Anti-Money Laundering Bill	HC 568 HL 87
Fourth Report	Freedom of Speech in Universities	HC 589 HL 111
Fifth Report	Proposal for a draft British Nationality Act 1981 (Remedial) Order 2018	HC 926 HL 146
Sixth Report	Windrush generation detention	HC 1034 HL 160
Seventh Report	The Right to Freedom and Safety: Reform of the Deprivation of Liberty Safeguards	HC 890 HL 161
Eighth Report	Freedom of Speech in Universities: Responses	HC 1279 HL 162
Ninth Report	Legislative Scrutiny: Counter-Terrorism and Border Security Bill	HC 1208 HL 167
Tenth Report	Enforcing Human Rights	HC 669 HL 171
Eleventh Report	Second Legislative Scrutiny Report: Counter-Terrorism and Border Security Bill	HC 1616 HL 195
First Special Report	Human Rights and Business 2017: Promoting responsibility and ensuring accountability: Government Response to the Committee's Sixth Report of Session 2016–17	HC 686
Second Special Report	Mental Health and Deaths in Prison: Interim Report: Government Response to the Committee's Seventh Report of Session 2016–17	HC 753
Third Special Report	Legislative Scrutiny: Counter-Terrorism and Border Security Bill: Government Response to the Committee's Ninth Report of Session 2017–19	HC 1578
Fourth Special Report	Windrush generation detention: Government Response to the Committee's Sixth Report of Session 2017–19	HC 1633