



The Right to Decide: Towards a greater understanding of mental capacity and deprivation of liberty

Focus Report: learning lessons from complaints

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Introduction

Making decisions in the best interest of people who lack mental capacity, is a complex and often sensitive issue for the family members involved. Often the decision to restrict a person's freedom - even if it is for their own good - is an emotionally charged one.

The Local Government and Social Care Ombudsman investigates complaints about all types of adult social care. Through our investigations, we are seeing evidence of councils and care providers failing to understand important aspects of this complex subject.

The result is some people are being forced into situations against their will, without proper checks carried out and safeguards put in place. Councils and care providers need to ensure they get these difficult decisions right, in line with the correct procedures, and in a timely way.

This report looks at the common issues we see from our investigations when a council or care provider is involved with a person who lacks mental capacity. These include failures to carry out assessments to ascertain whether someone has capacity to make decisions; poor decision making when deciding on someone's best interests; and not appropriately involving families and friends in the process.

We also see problems with the Deprivation of Liberty Safeguards (DoLS) system. There are cases where proper assessments have not been made – sometimes for years. It is not right that some of the most vulnerable care users are being informally deprived of their freedom without the right checks in place. We know councils have struggled to keep up with the rise in DoLS applications since the 2014 Supreme Court ruling effectively lowered the threshold for cases requiring an authorisation.

This report looks at the impact on people when things go wrong. Examples include a woman who was forcibly removed from the family home in the night without prior notice; a man who was moved to a care home some 15 miles away from his family without formal capacity assessments being done; and a woman who was let down by a number of organisations not taking control to ensure she received good care.

In the year 2016/17 we investigated 1,212 adult social care complaints in detail. We estimate that up to 20% of these concerned mental capacity or DoLS. Following investigation, we upheld 69% of these cases, indicating that there were faults that needed some form of remedy. This is much higher than the average rate of 53% across all our investigations.

We want to improve adult social care services by sharing the lessons from our investigations. So we identify some best practice points to assist councils and care providers to follow the right steps when working with people who lack mental capacity. It should also help carers and friends acting on their behalf.

To aid local scrutiny of services, we also provide a set of questions for councillors to ask their authorities.

Mental Capacity Act

Background

Professionals provide social care support to people who may be having difficulties with making decisions. For some people their capacity to make certain decisions is affected temporarily or permanently. This may be caused, for example, by a stroke or brain injury, a mental health problem, dementia, a learning disability, substance or alcohol misuse.

In the past, people with mental health problems often had decisions made for them which resulted in numerous injustices such as forcible treatment, and loss of control of their finances.

The Mental Capacity Act 2005 aims to empower people who may not be able to make some decisions themselves and also to protect them. The Act has a Code of Practice which sets out the steps that must be followed by professionals and paid carers when considering whether someone lacks mental capacity (unless there is good reason for not doing so). It also allows people to plan ahead in case they are unable to make decisions in the future.

Assessing mental capacity

The Code says it is important to start from an assumption of capacity. Making an unwise decision does not necessarily indicate a lack of capacity. This is a fundamental principle within the Mental Capacity Act that should always be borne in mind by professionals.

Triggers for an assessment can be, for example, the way a person behaves, concerns raised by someone else, or the death of the person who had been providing care. But when a person's capacity is in doubt, a capacity assessment should be carried out in relation to the specific decision to be made and not because of a person's illness, disability, age or behaviour.

The two questions to be asked when professionals are assessing a person's capacity are:

- > Is there an impairment of, or disturbance in, the functioning of the person's mind or brain?
- > If so, is the impairment or disturbance sufficient to cause the person to be unable to make that particular decision?

The assessment process has to be clear. It should set out what decision needs to be made and provide evidence for the assessor's view. It will require the views of all of

the organisations involved in providing support and should include family and carers. Where there is no family or anyone else with legal authority to make decisions for that person, an Independent Mental Capacity Advocate may be assigned when an important decision needs to be made, e.g. a change in accommodation.

The Code says someone lacks capacity if they cannot do one or more of the following four things:

- > Understand information given to them about a particular decision
- > Retain the information long enough to be able to make the decision
- > Weigh up the information available to make the decision
- > Communicate their decision

The assessment must consider them.

A person with a learning disability may lack the capacity to make a major decision but this does not mean they cannot decide what to eat, wear and do each day. And a person with mental health problems may be unable to make decisions when they are unwell but able to make them when they are well. Someone with dementia is likely to lose the ability to make decisions as the dementia worsens.

Deprivation of Liberty Safeguards

Deprivation of Liberty Safeguards (DoLS) is an aspect of the Mental Capacity Act, and is there to protect those who lack mental capacity while in a care home or hospital from harm.

DoL safeguards apply to anyone:

- > aged 18 and over
- > who suffers from a mental disorder or disability of the mind – such as dementia or a profound learning disability
- > who lacks the capacity to give informed consent to the arrangements made for their care and / or treatment and
- > for whom deprivation of liberty (within the meaning of Article 5 of the European Convention on Human Rights) is considered, after an independent assessment, to be necessary in their best interests to protect them from harm.

The safeguards protect the interests of an extremely vulnerable group of service users, and aim to:

- > ensure people can be given the care they need in the least restrictive regimes
- > prevent arbitrary decisions that deprive vulnerable people of their liberty
- > provide safeguards for vulnerable people
- > provide them with rights of challenge against unlawful detention
- > avoid unnecessary bureaucracy.

DoLS came into force in 2009. It followed a 2004 European Court of Human Rights ruling that exposed a gap in mental health law for compliant, but incapacitated, patients. At the time of the ruling, it was estimated as many as 50,000 care home residents and 22,000 hospital in-patients were being deprived, informally, of their liberty.



Common Issues and Complaints

Not completing mental capacity assessments

The Mental Capacity Act Code of Practice has clear steps to follow if somebody's mental capacity is in doubt. This includes carrying out a mental capacity assessment which focuses on the decision making process itself.

When someone's liberty is at stake, it is imperative that these assessments are carried out, they follow the Code of Practice guidelines, and the reasoning is evidenced. Assessments must be related to specific decisions, and not simply related to someone's general ill health or disability.

Jane and Elsie's story

Jane's mother, Elsie, was in her 80s and spent some periods at a nursing home after struggling to cope at home. She was admitted to hospital and stayed for a month when she suffered an illness related to her diabetes.

Upon returning to the nursing home, Jane felt the council, nursing home and the NHS failed to take control to ensure Elsie was receiving adequate care. Jane said no one took charge to assess her mother's mental capacity. Elsie regularly refused personal care, the medication required to control her diabetes and displayed aggression towards nurses and carers. She slept in her recliner chair.

Some six weeks later, Elsie's GP referred her to hospital. She had developed severe pressure sores, sepsis, dehydration, uncontrolled diabetes, chronic hip and knee pain and stayed in hospital for three and a half months.

Jane complained to the nursing home, was unhappy with its response, and came to us. The investigation by our Joint Working Team found the nursing home at fault for not considering Elsie's capacity properly.

The nursing home had taken a generalised approach to assessing Elsie's mental capacity and relied on the views of others. It had a responsibility to carry out its own decision-specific assessments, which should have been triggered by Elsie's refusal of care and been done on a daily basis.

We did acknowledge the nursing home had referred Elsie to the GP, who involved mental health services, and it raised a safeguarding alert. We found the council did not handle the safeguarding alert affectively.

The nursing home agreed to provide Elsie with £500 for her pain and distress and £250 to Jane for distress caused to her. It also agreed to complete an action plan to address its failings and provide us and Jane with copies.

Pete's story

Pete was in his forties when he suffered a stroke. When he left hospital, he was placed in a care home because he needed 24-hour support, but from the outset he told his social workers he wanted to live independently, with support.

Unfortunately his social workers made assumptions about his capacity to make decisions about where he wanted to live and about what property would be suitable for him, without carrying out the proper assessments. So Pete was left living in the care home for a long time. Throughout the time in the care home, Pete made repeated calls to be moved so he could live in the community.

It wasn't until Pete changed social workers some years later, and his own psychologist challenged the previous social worker's assumptions, that a proper capacity assessment was made. This assessment found Pete did have the capacity to decide where he wanted to live. And it was many months before he was found a suitable property.

Pete complained to us and we found social workers failed to consider properly Pete's ability to make decisions until they made a proper capacity assessment and fundamentally failed to support him through the care planning process.

Social workers delayed considering all the options available. By focusing solely on the belief Pete's best option was extra care housing when none was available in his preferred area, they delayed finding appropriate accommodation for him. The investigation also found social workers missed numerous opportunities to assess Pete's capacity at times when key decisions were made about his care and accommodation.

To remedy the complaint we asked the council to apologise to Pete and pay him £2,000 to recognise the frustration and distress caused by the delays in carrying out mental capacity assessments and not considering fully all the options available to him. It also reviewed its practices to ensure that mental capacity assessments are carried out at the appropriate times and documented properly.

Common Issues and Complaints

Delays in carrying out mental capacity assessments

It is important that mental capacity assessments are carried out thoroughly, and the more serious or complex the decision, the more formal it should be. However, we have seen cases where unnecessary delay in the process has added to an already stressful situation for the people affected. Sometimes a delay in assessment could cause someone to receive the right treatment later than they should have.

Anna and Julian's story

Anna's uncle, Julian, had collapsed and was taken to hospital. A few weeks later, after a needs assessment, he was discharged to return home on a trial basis, with some support.

Soon after returning home, carers raised concerns about Julian's ability to manage. A social worker tried to visit Julian but he did not answer. With concerns about his welfare, the police had to force entry into Julian's home and found him in a poor state. The council moved him to a care home. It could only find a placement in a different borough.

The council's plan was to keep Julian in emergency respite care for only three weeks. But the case was found to be more complex than originally thought because Julian was found to need long term support. The case was transferred to different teams and also to different officers within teams when one allocated social worker had to go on leave.

A mental capacity assessment found that Julian did not have capacity to decide his accommodation and care needs. It was finally decided that Julian's needs would be best met in a care home near his friends and family. But Julian had spent 10 months away.

Our investigation found the council took too long to refer Julian to a qualified social worker, which held up completion of the mental capacity assessment, and it didn't complete his support plan in good time. There was also a dispute between Julian's GP and the local NHS Trust about who should carry out a psychiatric assessment, which added further delay but was not down to the actions of the council.

The council's delay added an extra two months onto the process. This left the uncertainty of not knowing whether, but for the delay, Julian might have moved back sooner to the area he knew near his family. The council agreed to pay Julian £200 for distress and lost opportunity. It also agreed to apologise to Julian and his family.

Common Issues and Complaints

Poor 'best interests' decision making

If a person lacks capacity to make a particular decision then whoever is making that decision, or taking any action on that person's behalf, must do this in the person's 'best interests'.

When deciding whether a decision is in someone's best interests the decision makers must consider the person's welfare in the broadest sense. This would include their past and present wishes and feelings together with relevant medical and social circumstances. If there is a conflict about what is in a person's best interests and all attempts to resolve the dispute have failed, the Court of Protection might need to provide final arbitration.

Jaya and Mohan's story

Jaya complained to us that her husband Mohan, who had dementia, was forced by social workers to move away into a care home, against his wishes and those of his family.

Mohan had been diagnosed with dementia around two years earlier. He lived in the family home and attended a day centre once a week. As his health worsened, the police were called on several occasions when he began 'wandering'.

The council moved him to a care home some 15 miles away. Jaya had to take two buses there and back when she went to visit him.

Our investigation found the council decided Mohan had 'no capacity to make decisions' in meetings held to assess his care needs. But there was no indication that a mental capacity or a best interests assessment were carried out, as required by the law, despite Mohan being removed from his family home to a care home.

The fault was compounded by the failure to carry out DoLS assessments when Jaya repeatedly asked that Mohan return home. The family were told the police would be called if Jaya tried to remove Mohan, and they were also never advised of their rights to appeal the council's decisions through the Court of Protection.

The council agreed to our recommendations to apologise to the family and pay them £750 for their distress, and time and trouble in pursuing their complaint. We also asked it to provide refresher training for social care staff on the Mental Capacity Act, best interests and DoLS assessments, plus the role of the Court of Protection. We said this may involve the council reviewing the status of other residents who may be deprived of their liberty without proper authorisation.

John and Hilary's story

John complained about the way the council removed his mother, Hilary, from the family home without her consent and against the will of the family.

Hilary had mobility and communication difficulties due to advanced Parkinson's disease. A Community Matron raised concerns about the care provided to Hilary so a home visit took place with council staff. Hilary was found to be in urine soaked bedding and clothing, had not eaten so far that day and had drunk limited fluids. After another visit the next day, the council decided she did not have capacity to make any decisions about her care needs.

On the same evening, the Matron attended the home with police and ambulance staff to remove Hilary. John told her they could not do this without written confirmation that Hilary did not have capacity to make her own decisions. John asked his mother if she wanted to go to hospital and she said no. The Matron then rang the council to check the information about Hilary's capacity. The council officer said Hilary 'did not have capacity and she must be removed to a place of safety'.

In hospital, after various tests, it was discovered that there were no medical reasons for Hilary to be in hospital.

A Mental Capacity Assessment carried about a month later found that Hilary did not have capacity to decide her future care plans.

Our investigation found the council failed to consider 'less restrictive' options of establishing whether medical treatment was needed for Hilary, such as calling out her GP. It had also failed to establish that Hilary lacked capacity to make a decision about her care needs that day. It was known that her capacity fluctuated and not being able to communicate on the day the officers visited did not mean she lacked capacity.

We also found that if the council had established Hilary lacked capacity to decide if she should stay at home, it still needed to follow the Mental Capacity Act and Code of Practice to make a best interests decision. This should have involved considering Hilary's known wishes, consulting with those important to her and considering their views.

We concluded that a vulnerable adult was forcibly removed from home in the evening with no prior warning, without consent and in the presence of police. This caused severe and avoidable distress and anxiety to Hilary and severe distress and outrage to her family.

The council agreed to write to Hilary and her family to apologise for the injustice caused. It also agreed to pay £1,000 to Hilary for her distress. It also agreed to pay £600 for the family's distress and also their time and trouble taken in complaining.

Common Issues and Complaints

Disagreements with the process and involving families

Making best interests decisions for someone else can be an emotive subject. Sometimes family and friends affected may disagree with the decisions made, or with each other on what would be in the best interest for their loved one.

Family members and close friends may be able to provide valuable background information but their wishes must not be substituted for a proper evidence-based assessment.

In the following case, we highlight where a family didn't agree with the process but the council had demonstrated good practice in following the correct law and guidance.

Helen and Richard's story

Helen complained to us that the council failed to consider Richard, her father's best interests when it decided to move him to a different care home. She said it did not consider properly the dynamics in Richard's relationship with his wife.

When Richard was first placed in a care home all his family used to visit. This included Helen and her brother and sister and also Richard's wife. Richard settled in to the care home but said he missed his wife. Case notes also record conflict between the family members.

Richard's wife was then admitted to a care home. This home had been the first choice for Richard but had no free beds at the time. The council asked the family for their views on moving Richard to the home in which his wife now resided. Richard's son supported the move but Helen and her sister didn't, on the grounds it would affect his health.

The council also asked Richard. He was recorded as getting distressed at the thought of moving, but he also expressed a wish for his wife to be with him. It was not possible for Richard's wife to move because he was in a nursing home and she did not need nursing care.

The council tried to get an Independent Mental Capacity Advocate involved. But this was refused as Richard had family members to advocate on his behalf. It then allocated a social worker to carry out a mental capacity assessment.

The social worker visited on three different occasions and Richard expressed a wish to be with his wife. Care home staff also confirmed this. Helen said he was expressing a wish to return home and he believed his wife was still at home. The officer found that it was not clear whether Richard understood the implications of moving to a different care home. It was decided Richard did not have capacity to decide whether he should move.

A best interests meeting was organised with family members invited. Information from other sources was also taken into account including from Richard's GP. The meeting decided it was in Richard's best interests to move to the same care home as his wife.

With the family's assistance, including Helen and her sister, Richard was moved to the same care home as his wife. Initially he was distressed but later visits by the council found he was settled and happy to be reunited with his wife.

Although Helen disagreed it was in Richard's best interests, our investigation found the council followed the code of practice set out in the Mental Capacity Act 2015 before coming to a decision to move Richard.

Common Issues and Complaints

Delay in obtaining DoLS authorisations

Councils and care providers need to make sure that DoLS orders are in place at the right time. In many of the cases in which we find fault, there has been a significant delay in applying for an authorisation. It is unlawful for someone to be deprived of their liberty without an authorisation.

Mary and Graham's story

Graham had severe dementia and used to be supported by his wife, Mary, at home. After a period of respite in a care home, Graham did not return home. Mary said he would have to come home as they could not afford the cost of his care.

The care home manager contacted the council because he was worried that Mary would try to take Graham home. She had tried on one occasion, but Graham refused to leave with her.

The council assessed Graham and agreed a DoLS order. However, this was some six months after the respite care began.

Our investigation found that the care provider, which was acting on behalf of the council, should have applied for a DoLS order as soon as Graham became resident. This was because he always met the requirements for the order: he needed constant supervision; was unable to leave the care home of his own free will; and lacked the capacity to agree to these arrangements.

It was clear that the care provider only thought about applying to the council for the DoLS order when Mary tried to remove Graham. The council failed to follow the Code of Practice because it did not tell Mary about the application or involve her in the decision. Family, friends and carers who know the person well should be consulted as part of the assessment process – they may have suggestions as to how someone can be supported without having to deprive them of their liberty.

Mary suffered the frustration and outrage of not being involved in decisions about her husband's care. The council agreed to apologise to Mary and remind staff about the importance of involving family members in making best interests decisions.

Johanna's story

Johanna moved into a care home. She was already suffering with early dementia and consequent memory problems. Her dementia continued to worsen until she lost capacity to make her own decisions about her future care.

However, it was not until a Care Quality Commission inspection some six years later, the care provider was alerted that some residents were being deprived of their liberty. It then applied to the council for a DoLS order for Johanna.

The council said because of the increase in DoLS applications following the Cheshire judgment, it used a risk assessment tool developed by the Association of Directors of Adult Social Services to assess Johanna's priority, and concluded she was at low risk. It was around 10 months later that her case was allocated for DoLS assessment.

Johanna's daughter complained to us and our investigation criticised the care provider for failing to make the DoLS application earlier. From the case records it was not possible to tell when Johanna's condition had deteriorated to the point where the provider should have applied for the authorisation. However, it clearly had deprived Johanna of her liberty without the proper safeguards in place. In addition, neither the provider nor the council had informed Johanna's daughter, the next of kin, that a DoLS request had been made.

We also found fault with the council for failing to assess Johanna within the prescribed timescales, but noted it had taken a risk-based approach to assess the urgency of her assessment.

The council agreed to pay a small financial payment to Johanna's daughter, who had complained, to work with the care provider to address faults, and to share the lessons learned with its DoLS team.

Common Issues and Complaints

Carrying out full assessment before applying for DoLS order

Six assessments have to take place before a DoLS authorisation can be given, although the most important of these is the “best interests” assessment.

1. An age assessment, to make sure you are aged 18 or over.
2. A mental health assessment to confirm that you have been diagnosed with a ‘mental disorder’ within the meaning of the Mental Health Act.
3. A mental capacity assessment to see whether you have capacity to decide where your accommodation should be. If you have, you should not be deprived of your liberty and the authorisation procedure should not go ahead.
4. A best interests assessment to see whether you are being, or are going to be, deprived of your liberty and whether it is in your best interests. This should take account of your values and any views you have expressed in the past, and the views of your friends, family, informal carers and any professionals involved in your care.
5. An eligibility assessment to confirm you are not detained under the Mental Health Act 1983 or subject to a requirement that would conflict with the Deprivation of Liberty Safeguards. This includes being required to live somewhere else under Mental Health Act guardianship.
6. A ‘no refusals’ assessment to make sure that the deprivation of liberty does not conflict with any advance decision you have made about your care, or the decision of an attorney under a lasting power of attorney or a deputy appointed by the Court of Protection.

In making best interests decisions, there can be disagreement between family members over the outcome. In the following case, the representatives of the complainant believed he had been unlawfully denied his liberty, but our investigation found the council had followed good practice and carried out a full and comprehensive assessment of capacity before applying for its DoLS order.

Felix's story

Felix was a 72 year old man with alcohol-related dementia. He had been held in a care home on a supervision order after being assessed as lacking capacity to plead in a criminal case for burglary.

At the end of the supervision order, the care home applied for a DoLS authorisation. Felix wanted to leave the home and return to his home town, where he had not lived for 20 years. A section 12 doctor (a psychiatrist who specialises in the diagnosis of mental disorders) agreed with the DoLS authorisation for three months.

Towards the end of the authorised period, a social worker undertook a best interests assessment of Felix. The social worker conducted two detailed assessment interviews with Felix, some days apart. He also sought evidence from care home staff and management, from the section 12 doctor, from a senior social worker who had known Felix for many years, and from Felix's advocate.

He took into account results from a recent Memory Nurse's test which showed "dramatic decline" in Felix's cognition. Everyone he consulted agreed that the DoLS authorisation was required, to safeguard Felix. The social worker said Felix would be at serious risk of neglect, malnutrition, dehydration and inability to manage his alcohol intake if he left the care home. He believed Felix would be "exposed to unacceptable risks and his life would be endangered" and that he did not have capacity to make decisions about his future accommodation and care.

The DoLS authorisation was granted, but Felix's advocate asked for the matter to be referred to the Court of Protection because Felix was very keen to leave the home, and insisted he could manage independent living. Before the case went to Court, Felix was also diagnosed with Alzheimer's and prescribed drugs to treat it. A psychiatrist who assessed Felix for the Court proceedings concluded that Felix did then have capacity to make his own decisions about his future accommodation.

Solicitors complained on Felix's behalf that the council should have conducted a more forensic assessment of Felix's capacity when it first applied for a DoLS authorisation. They said the best interests assessment conducted by the social worker had been inadequate, a psychiatrist should have undertaken the assessment, and Felix had been unlawfully deprived of his liberty from that point on.

Our investigation found the best interests assessment had been undertaken in accordance with the guidance and there was no evidence to suggest the social worker had failed to take into account any relevant information. The capacity assessment had been time- and decision-specific; and had considered how Felix could understand, retain and weigh up the information which he needed to make a decision. We did not find fault with the way the council acted.

Good Practice: Getting it right first time

From our investigations we have developed the following good practice points:

- > Carry out a proper mental capacity test where it appears that an individual is consistently making decisions not in their best interest. Follow Mental Capacity Act Code of Practice and ensure reasoning is well evidenced
- > Ensure best interest assessments are properly carried out. For example:
 - > Rely on up-to-date information
 - > Involve the relevant person's representative (RPR) to ascertain past and present wishes and feelings
 - > Involve views of family members and those affected
- > Consider the 'least restrictive' option when care planning for a person who lacks capacity
- > Involve an Independent Mental Capacity Advocate where there are family disputes
- > Ensure there is no unnecessary delay in carrying out mental capacity assessments DoLS authorisations
- > Obtain a DoLS authorisation where relatives or friends are being banned from visiting the person affected in a care home
- > Do not use locked doors or restrictive measures to stop an individual leaving a home or hospital without a DoLS authorisation being in place

Questions for scrutiny

Councils and all other bodies providing local public services should be accountable to the people who use them.

The Local Government and Social Care Ombudsman was established by Parliament to support this. We recommend a number of key questions that councillors, who have a democratic mandate to scrutinise the way councils carry out their functions, can consider asking.

How does your authority:

- > follow the Mental Capacity Act Code of Practice when working with people who may lack capacity to make decisions?
- > ensure that 'best interests' assessments involve the family members or other people affected?
- > deal with and prioritise Deprivation of Liberty Safeguards (DoLS) applications to ensure there are no people who may informally be having their freedom restricted?
- > monitor the use of 'locked door' settings and ensure DoLS applications are in place for all cases?
- > learn from the outcomes of complaints to improve services, and share this with the public?
- > use the Ombudsman's reports and decisions to develop its own policy and practice?

The role of the Ombudsman

Local Government and Social Care Ombudsman investigates unresolved complaints about councils and other bodies providing local public services; and all adult registered adult social care providers. This includes any adult social care regardless of whether it is arranged or funded privately or through the council.

We share the learning from our complaints to help improve local public, and adult social care, services.

We are a free service. We investigate complaints in a fair and independent way - we do not take sides.

If we find something wrong, we make recommendations for the council or care provider to take action to put it right. What we ask the council to do will depend on the particular complaint, how serious the fault was and how the person was affected.

We have no legal power to force councils to follow our recommendations, but they almost always do.

Some of the things we might ask a service provider to do are:

- > apologise
- > pay a financial remedy
- > improve its procedures so similar problems do not happen again

Investigating complaints about health and social care

We are the Ombudsman for any type of adult social care complaint and the Parliamentary and Health Service Ombudsman has jurisdiction for complaints about health services.

People may have a complaint about services provided by both health and social care organisations. Instead of having to complain to both ombudsmen, we have a Joint Working Team that can investigate these issues together.

This gives the public:

- > a single investigator who can look at the whole case from all angles
- > a quicker and more focused investigation

It also means the different organisations being investigated only have to deal with a single point of contact

Annex: context of the DoLS landscape

The “Bournewood gap”

The origins of the present Deprivation of Liberty Safeguards lay in what came to be known as the Bournewood case. In 1997, Mr HL - a severely autistic, non-verbal, man – was admitted to Bournewood psychiatric hospital after he self-harmed at his day centre. Medical staff couldn't decide whether his symptoms were behavioural or indicative of a mental illness, so he was admitted for 'observation'. He was not discharged until four months later, when his carers said he looked like a concentration camp victim.

His carers began legal action while Mr HL was still in hospital. The Court of Appeal agreed that the failure of statutory provisions for compliant, incapacitated patients was an “indefensible gap in our mental health law”. However, the legal case was not finally concluded until 2004, when the European Court of Human Rights ruled that Mr HL had been deprived of his right to liberty, because he had been held “in his best interests” - not under the protection of a section of the Mental Health Act, against which there were appeal rights, but under a common law doctrine of “necessity”.

The phrase “Bournewood gap” was coined to describe the position of service-users like Mr HL, who were not allowed to leave their care setting,

who could not give consent to treatment but who did not object to hospital admission, and so did not prompt the use of a detention section of the Mental Health Act.

The “Cheshire West” judgment

In 2014, a Supreme Court judgment held that the “acid test” of whether someone was deprived of their liberty was if they lacked the capacity to consent to their care or treatment arrangements, were under continuous supervision and control, and were not free to leave. All three elements had to be in place to constitute a deprivation of liberty.

That ruling overturned previous judgments which had defined deprivation of liberty more restrictively. The Court now said that a person's lack of objection to their placement, the purpose of it or the extent to which it enabled them to live a relatively normal life for someone with their level of disability, were all irrelevant to whether they were deprived of their liberty.

The rise in DoLS applications

The outcome of the 2014 ruling was a significant rise in the number of cases, particularly in care homes, where residents were now deemed to be deprived of their liberty – perhaps because (in the interests of their own safety)

they were not allowed out of the home on their own, or doors were locked to prevent them wandering.

Councils have since struggled to keep up with the additional burden placed on them following the ruling. In the meantime, the Association of Directors of Adult Social Services has advised councils to use a streamlined approach of desktop assessments to complete deprivation of liberty cases triaged as ‘low priority’ in a bid to clear the backlog of referrals.

The Future of DoLS

The Law Commission published a draft Bill on 13 March 2017 setting out its recommendations for the replacement of the Deprivation of Liberty Safeguards and other significant amendments to the Mental Capacity Act 2005.

The proposal for Liberty Protection Safeguards (LPS) is considered to be less onerous than DoLS while still offering human rights protections.

Some of the key points of the LPS are that they would apply to any setting; cover 16 and 17 year olds; introduce a simplified best interest assessment; extend the responsibility for giving authorisations to the NHS and have a two-tier authorisations process.

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