House of Commons
House of Lords

Joint Committee on Human Rights

The Right to Freedom and Safety: Reform of the Deprivation of Liberty Safeguards

Seventh Report of Session 2017–19

HC 890
HL PAPER 161

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Joint Committee on Human Rights

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Contacts

All correspondence should be addressed to the Clerk of the Joint Committee on Human Rights, Committee Office, House of Commons, London SW1A 0AA. The telephone number for general enquiries is 020 7219 2467; the Committee's email address is jchr@parliament.uk

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Article 5 of the European Convention on Human Rights (ECHR) prohibits arbitrary deprivation of liberty. Consequently, it is vital to have mechanisms to ensure that the arrangements made for vulnerable people who lack mental capacity are in their best interests. It is also important that resources are, as far as possible, directed to care rather than to legal and bureaucratic processes. This report seeks to advise the Government on how to address a serious problem that has emerged in these legal and bureaucratic processes.

The current Deprivation of Liberty Safeguards (DoLS) scheme safeguards against arbitrary detention of people who are deemed to lack capacity to consent to their care or treatment, such as older people living with dementia, people with autism and people with learning disabilities. However, the scheme is broken. The Supreme Court's decision that a person is subject to "confinement" when "under continuous supervision and control" and "not free to leave" (the 'acid test'),[1] irrespective of their contentment, has resulted in a tenfold increase in the number of DoLS applications.

This has placed extreme pressure on Local Authority resources. Seventy percent of the almost 220,000 applications for DoLS authorisations in the past year were not authorised within the statutory time frame.[2] Consequently, many incapacitated people continue to be deprived of their liberty unlawfully and those responsible for their care, or for obtaining authorisations, are having to work out how best to break the law.

At the Government's request, the Law Commission has produced proposals for a new system of safeguards. The Commission proposes replacing DoLS with Liberty Protection Safeguards (LPS). LPS would authorise the specific arrangements that give rise to the deprivation of liberty. They are, therefore, more targeted than DoLS, which authorise the deprivation of liberty in general. LPS would apply to wider categories of people than DoLS, as they would extend to domestic settings, persons aged 16 and over, and persons of "unsound mind". DoLS currently only apply to care homes and hospitals and over 18s with a mental disorder.

We support the principle that Article 5 safeguards should be applied to all those deprived of their liberty regardless of their care arrangements, but the potential expansion of the scheme into domestic settings runs the risk of creating an invasive scheme that is difficult to operate effectively. This highlights the importance of establishing more clearly the definition of "deprivation of liberty" so that such safeguards are applied to those who truly need them.

The Law Commission did not grapple with this difficult issue. We recognise that deprivation of liberty is an evolving Convention concept rooted in Article 5; the difficulty is how this is interpreted and applied in the context of mental incapacity. In our view, Parliament should provide a statutory definition of what constitutes a deprivation of liberty in the case of those who lack mental capacity in order to clarify

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

2 NHS Digital, Mental Capacity Act (2005) Deprivation of Liberty Safeguards (England) 2016/17, Statistics, 1 November 2017

the application of the Supreme Court's acid test and to bring clarity for families and frontline professionals. Without such clarity there is a risk that the Law Commission's proposals will become unworkable in the domestic sphere.

The Law Commission's proposals for independent review of authorisations for deprivations of liberty are in our view compliant with the European Convention on Human Rights. It would be disproportionate to establish a separate review body. Nonetheless, we recommend that the Code of Practice must set out clear guidelines to deal with potential conflicts of interest.

The Law Commission's proposals introduce 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. We consider that advance consent for care arrangements should be valid, as long as safeguards are in place to verify the validity of this consent.

The provision of advocacy helps to ensure that individuals can exercise their rights to challenge authorisations, as the advocate may initiate court proceedings. Unlike DoLS, which provided advocates on an 'opt in' basis, LPS provides advocates as of right. We support this enhancement of rights to advocacy. However, we recognize the shortage of advocates available and urge the Government to consider appropriate funding arrangements for adequate levels of advocates. We also suggest that an individual's right to participate in court ought to be codified 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 behalf of the individual, 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.

The Law Commission proposes that the question of whether the Court of Protection (CoP) should retain jurisdiction to hear challenges or whether this should be transferred to the First Tier Tribunal (FTT) should be reviewed by the Lord Chancellor, the Lord Chief Justice and the Senior President of Tribunals. We consider that a tribunal system has serious merits for consideration.

At present, the Legal Aid Agency can refuse non-means tested certificates for challenges to DoLS where there is no existing authorisation. The current system has produced arbitrary limitations on the right of access to a court. Legal aid must be available for all eligible persons challenging their deprivation of liberty, regardless of whether an authorisation is in place, particularly given the vast number of people unlawfully deprived due to systemic delays and failures.

DoLS apply to those with a mental disorder. LPS will apply to persons of "unsound mind" to reflect the wording of Article 5. We recommend that further thought be given to replacing "unsound mind" with a medically and legally appropriate term and that a clear definition is set out in the Code of Practice.

The interface between the Mental Capacity Act (MCA) and the Mental Health Act (MHA) causes particular difficulties. Deciding which regime should apply is complex, and causes the courts and practitioners difficulties. The Law Commission proposes

to maintain the two legal regimes: the MHA would apply to arrangements for *mental disorders;* the LPS would apply to arrangements for *physical disorders*. Inevitably, problems will continue to arise at the interface between these two regimes. We are particularly concerned by two issues. Firstly, this proposal requires 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, we are concerned that there would be essentially different laws and different rights for people lacking capacity depending upon whether their disorder is mental or physical. We consider that the rights of persons lacking capacity should be the same irrespective of whether they have mental or physical disorders.

The Law Commission's proposals could form the basis of a better scheme for authorising deprivations of liberty, directing scrutiny to those who need it most. However, while it should be cheaper than the application of the current DoLS to all those falling within the *Cheshire West* definition, it is not cost free. We urge the Government to consider how this new scheme might be appropriately funded.

1 Introduction

Overview

1. Article 5 of the European Convention on Human Rights (ECHR) prohibits arbitrary deprivation of liberty. This applies to everyone equally, including those who lack mental capacity. It is important to have mechanisms to ensure that the arrangements made for vulnerable people who lack mental capacity are in their best interests. It is also important that resources are, as far as possible, directed to care rather than to legal and bureaucratic processes. In 2014, the House of Lords Select Committee on the Mental Capacity Act criticised the current system for authorising deprivations of liberty as being bureaucratic and burdensome. That same year, the Supreme Court's judgment in *Cheshire West* extended the requirement for authorisation of deprivations of liberty to a wider group of people thereby increasing the problem.

2. Consequently, at the Government's request, the Law Commission has produced proposals for a new system of safeguards—the Liberty Protection Safeguards (LPS). This report looks at those proposals and makes recommendations regarding their implementation. We consider that the Government and Parliament now need to act swiftly to ensure that there is a system which protects those at risk from unlawful deprivations of liberty whilst ensuring resources are concentrated on care rather than process.

3. In considering this issue, we bear in mind the evidence we have heard from carers, academics and lawyers alike, that the most important objective is to "deliver the right care that properly meets the interests of the individuals concerned."[3] Dr Lucy Series reminded us that "at the root of all this is a very human question about the power that, often indirectly, the Mental Capacity Act hands to the health and social care professionals to make life-changing decisions about disabled people."[4] Individuals and their rights lie at the heart of this inquiry.

What is the problem?

4. The Deprivation of Liberty Safeguards (DoLS) scheme, set out in the Mental Capacity Act 2005 (MCA), safeguards against arbitrary detention for people who are deemed to lack capacity to consent to their care or treatment.

5. DoLS are commonly applied to older people living with dementia, people with autism and people with learning disabilities. They may also apply in some medical settings, for example in cases of brain injury. DoLS aim to ensure that people are only deprived of their liberty when it is in their best interests and where there is no other less restrictive way to provide necessary care and treatment.

6. DoLS set out the process for authorising a deprivation of liberty of someone in a care home or hospital setting who lacks mental capacity. The care home or hospital must make a request to the relevant supervisory body (the Local Authority or Welsh Health Board)

3 Q1 [Alexander Ruck Keene]
4 Q1 [Dr Lucy Series]

which in turn must arrange a series of six assessments, including ones to assess mental capacity and to ascertain whether the proposed deprivation is in the individual's best interests. An authorisation will be granted if the requirements are all met.[5]

7. The person deprived of liberty must have a representative appointed with legal powers to represent them, usually a family member or friend. Other safeguards provided under the DoLS include the right to challenge authorisations in the Court of Protection and access to Independent Mental Capacity Advocates (IMCAs).

8. However, there is consensus that this scheme is broken and, as a result, thousands of people are being unlawfully detained. There were 217,000 applications for DoLS authorisations in the past year (2017),[6] about three times more than the number of people detained under the Mental Health Act.[7] The vast majority of these applications are not authorised within the time frame of 21 days set out in the Deprivation of Liberty Safeguards Code of Practice.[8] Currently, 70% of applications do not meet this time limit, with 10% taking more than one year.[9] Deprivation of liberty without lawful authority violates Article 5 of the European Convention on Human Rights (ECHR), which protects the right to liberty and security of the person. This means that those responsible for care and treatment are having to work out how best to break the law.[10]

Why has this problem arisen?

9. In 2014, a House of Lords Select Committee on the Mental Capacity Act found that the DoLS system was unfit for purpose. In particular, they found that "the provisions are poorly drafted, overly complex and bear no relationship to the language and ethos of the Mental Capacity Act […] Worse still, far from being used to protect individuals and their rights, they are sometimes used to oppress individuals, and to force upon them decisions made by others without reference to the wishes and feelings of the person concerned."[11]

10. In the same year, in the case of *Cheshire West*, the Supreme Court had to decide when a person is deprived of their liberty in the context of social care. The MCA states that deprivation of liberty has the same meaning as Article 5(1) ECHR,[12] which has been defined by the European Court of Human Rights as (1) confinement for a not negligible

5 The steps for authorising DoLS are as follows: 1. Capacity assessment; 2. Mental Disorder assessment; 3. Best interests assessment; 4. No refusals assessment (arrangements must not conflict with a valid decision of a donee of a lasting power of attorney or a court appointed deputy); 5. Eligibility assessment (e.g. an individual will be ineligible for DoLS if they are objecting to psychiatric treatment for a mental disorder); 6. Age assessment; 7. Authorised by a signatory. See Schedule 1A, MCA 2005

6 Q10 [Stephen Chandler]

7 Q3 [Dr Lucy Series]

8 Deprivation of Liberty Safeguards, Mental Capacity Act 2005, Code of Practice

9 Annual statistics released in November 2017 show that there were 217,235 applications for DoLS received during 2016/17; an increase of 11 per cent on 2015/16. The backlog of cases increased by 7 per cent to 108,545 and the number of applications not completed that had been waiting more than one year as at 31 March 2017 was 29,585; an increase of 68 per cent on the previous year. Source: NHS Digital, Mental Capacity Act (2005) Deprivation of Liberty Safeguards (England) 2016/17, Statistics, 1 November 2017

10 Alex Ruck Keene (DOL0120), para 3

11 House of Lords, Report of the Select Committee on the Mental Capacity Act 2005: Post-Legislative Scrutiny, Session 2013–14, HL Paper 139, p 7

12 Mental Capacity Act 2005, Section 64(5)

period of time; (2) lack of valid consent; (3) where the State is responsible.[13] There was, however, no statutory guidance as to what Parliament considered would in practice constitute a deprivation of liberty.

11. The Supreme Court considered Strasbourg case law, although they noted there was no precise precedent in the context of social care. 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",[14] to be determined "primarily on an objective basis".[15] 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."[16] This judgment set the 'acid test' for determining when a person is deprived of their liberty.

12. The judgment resulted in a tenfold increase in the number of DoLS applications being made in recent years. As explained by Stephen Chandler from the Association of Directors of Adult Social Services, following *Cheshire West*, "the law now said that a number of groups of individuals needed to be considered in the context of the Mental Capacity Act. That included many people who were in long-term stable care arrangements and for whom the process of going through the Mental Capacity Act would make little or no difference to the way their care and support was arranged day to day."[17] Nicholas Paines QC of the Law Commission opined that "an already unfit for purpose system was suddenly loaded with a manifold increase in cases."[18]

13. Local authorities have struggled to cope with the resource implications of the judgment and a very large backlog of cases has built up. We heard evidence from Stephen Chandler that "prior to the Cheshire West decision, we were meeting the majority of referrals, but the exponential increase in referrals following the Cheshire West case has meant that local authorities are not able to meet the increased demand."[19] As a result, many people are currently deprived of their liberty without any lawful authorisation: the most recent statistics indicate 100,000 may be affected.[20]

What is the way forward?

14. There is broad agreement that the system should be reformed–the question is how and when. In 2014, the Law Commission was asked by the Government to review the Mental Capacity Act. In 2017, the Law Commission put forward proposals to reform DoLS and produced a draft Bill.[21] Their proposals are "designed to cope with the increased number of people considered to be deprived of their liberty following Cheshire West, to be less bureaucratic and complex than DoLS and to provide improved safeguards at lower cost."[22] The intention of our inquiry was to consider the Law Commission's proposals and

13 Storck v Germany (Application No. 61603/00) at para 74; Stanev v Bulgaria (Application No. 36760/06) at para 117
14 Cheshire West and Chester Council v P [2014] UKSC 19, [2014] MHLO 16, paras 49, 63 and 87
15 Cheshire West and Chester Council v P [2014] UKSC 19, [2014] MHLO 16, paras 76–87
16 Cheshire West and Chester Council v P [2014] UKSC 19, [2014] MHLO 16, para 46
17 Q10 [Stephen Chandler]
18 Q11 [Nicholas Paines QC]
19 Q10 [Stephen Chandler]
20 Mental Capacity Act 2005, Deprivation of Liberty Safeguards, (England), 2016–17, Official Statistics
21 Law Commission, Mental Capacity and Deprivation of liberty, HC 1079, March 2017
22 Law Commission, Mental Capacity and Deprivation of liberty, HC 1079, March 2017, p 49

make recommendations as to the Government's next steps. In particular, we wanted to scrutinise the draft Bill proposed by the Law Commission and consider its compliance with human rights law.

15. In doing so, we are acutely aware of the resource implications of the current system and the proposals. The Law Commission estimates that full implementation of the current system would cost £2billion per year while full implementation of their proposals would require £200million, although this is contested.[23]

16. Whilst the Government has broadly accepted the Law Commission's proposals, their official response stated that they will deal with this "when Parliamentary time allows".[24] We consider that reform is needed urgently. Although we recognise the proposals are not a panacea, the evidence we have received, for the most part, indicates that they will help to improve the situation. The Law Commission's proposals should be implemented as quickly as possible, subject to further consideration on a few key issues discussed below.

23 Mental Capacity and Detention - Law Commission, Impact assessment, 13 March 2017

24 Government Response to the Law Commission's review of Deprivation of Liberty Safeguards and Mental Capacity, 14 March 2018

2 Legal Framework

Article 5 European Convention on Human Rights

17. Article 5 of the European Convention provides that no one shall be arbitrarily deprived of his or her liberty. There is an exhaustive list of circumstances in which a person can be lawfully deprived of his or her liberty.[25] Article 5(1)(e) provides an exception for the lawful detention of persons of "unsound mind", subject to certain minimum conditions.

18. In *Guzzardi v. Italy*, the European Court of Human Rights ('European Court') considered what circumstances would amount to a deprivation of liberty attracting the protection of Article 5. The Court held that the distinction between deprivation of and restriction upon liberty is merely one of degree or intensity, and not one of nature or substance–one must start with the concrete or actual situation of the individual concerned and take account of a range of criteria, such as the type, duration, effects and manner of implementation of the measure in question.[26] The European Court has provided that a person is deprived of liberty for the purpose of Article 5 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).[27]

19. In order to comply with human rights law, any deprivation of liberty under Article 5(1)(e) requires the following minimum conditions and safeguards:

a) Objective medical evidence of a true mental disorder of a kind or degree warranting compulsory confinement, which persists throughout the period of detention;[28]

b) Consideration of less restrictive alternatives;[29]

c) Independence between those providing the care and treatment and those authorising the deprivation of liberty;[30]

d) The right to a speedy determination by a court of the lawfulness of the detention and immediate release where the deprivation of liberty is found to be unlawful or no longer necessary.[31]

25 European Convention on Human Rights, Art 5 (1)(a) to (f))
26 Guzzardi v. Italy, (1980) 3 EHRR 333 at para 93
27 Storck v Germany (Application No. 61603/00) at para 74; Stanev v Bulgaria (Application No. 36760/06) at para 117
28 Stanev v. Bulgaria, para. 145; D.D. v. Lithuania [2012] ECHR 254, para. 156; Kallweit v. Germany, App. No. 17792/07, para. 45; Shtukaturov v. Russia, Application No. 44009/05 [2008] ECHR 223, para. 114; Varbanov v. Bulgaria, Application No. 31365/96 [2000] ECHR 457, para. 45; and Winterwerp v. the Netherlands (1979–80) 2 EHRR 387 (Application No. 6301/73), para 39
29 Stanev v Bulgaria (2012) 55 EHRR 22 (Application No. 36760/06), para 43
30 IN v Ukraine (Application No. 28472/08), para 81
31 European Convention on Human Rights, Article 5(4)

e) Regular reassessment of whether detention criteria are met.[32]

20. Deprivations of liberty affect rights beyond Article 5. As noted by Dr. Lucy Series, decisions under the MCA affect "rights to have contact with your family, to choose where you live, to choose how you live your everyday life."[33] These decisions therefore engage Article 8, which protects the right to private and family life, including personal autonomy. Article 6 is also engaged, as individuals subject to DoLS have the right to access justice and challenge the deprivation of their liberty before a court of law.

Convention on the Rights of Persons with Disabilities

21. The UN Convention on the Rights of Persons with Disabilities (CRPD), aims to protect the rights of people who have long-term physical, mental, intellectual, or sensory impairments. The UK has ratified this Convention (making it binding in international law), but it has not been incorporated into domestic law.

22. Article 14 of the Convention stipulates that the "existence of a disability shall in no case justify a deprivation of liberty". Article 12(2) of the Convention 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, i.e. 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.

23. 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".[34]

24. The CRPD Committee has recently assessed the UK's compliance with the UNCRPD and has recommended that the UK "abolish all forms of substituted decision-making concerning all spheres and areas of life by reviewing and adopting new legislation in accordance with the Convention to initiate new policies in both mental capacity and mental health laws," and "repeal legislation and practices that authorise non-consensual involuntary, compulsory treatment and detention of persons with disabilities on the basis of actual or perceived impairment."[35] Both the CPRD Committee and the (former) Council of Europe Commissioner for Human Rights adopt the position that the involuntary

32 Winterwerp v. the Netherlands, (1979–80) 2 EHRR 387 (Application No. 6301/73). For a fuller discussion of these requirements, see Law Commission, Mental Capacity and Deprivation of liberty, HC 1079, March 2017, p 243; and European Court of Human Rights, Guide on Article 5: Right to Liberty and Security, April 2018.

33 Q2 [Dr Lucy Series]

34 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

35 United Nations, Convention on the Rights of Persons with Disabilities, Concluding observations on the United Kingdom (3 October 2017, CRPD/C/GBR/CO/1), paras 31 and 35

detention of persons with disabilities based on risk, dangerousness, or need for care or treatment is contrary to the right to liberty and amounts to an arbitrary deprivation of liberty.[36]

25. However, the CRPD Committee's interpretation of the Convention is contested and stands at odds with the approach of the European Court and the UN Human Rights Committee, which adopt the position that while a disability itself does not justify a deprivation of liberty, such a deprivation may be justified if necessary and proportionate for the purpose of protecting the individual or others from harm, as a last resort, for the shortest period of time possible, with adequate safeguards.[37] The European Court has recently considered the UK's DoLS scheme in an admissibility decision and found that the procedures in place were compliant with Article 5 of the Convention.[38]

26. We note that in *AM-V v Finland*,[39] the European Court considered and rejected the CRPD Committee's interpretation of Article 12 of the CPRD, namely that the will and preferences of an individual should always be determinative of any decision taken in their name.[40] The view of the CRPD Committee is clearly contested and is not incorporated into UK law. We prefer the approach of the European Court when assessing whether the proposed scheme is human rights compliant.

Mental Capacity Act 2005

27. Under the MCA, a person who lacks capacity and is in a hospital or care home for the purpose of being given care or treatment may be subjected to restrictions which amount to a deprivation of liberty. Such measures may be permitted by authorisation under the statutory scheme. Deprivation of liberty without such authority would otherwise be unlawful. Under Schedule 1A of the MCA, the person deprived of liberty is entitled to various safeguards to protect their rights.

36 United Nations, Committee on the Rights of Persons with Disabilities, Guidelines on Article 14, 2015, para 13; Council of Europe, Thematic Work, August 2017. See Alex Ruck Keane, Discussion Paper: Deprivation of Liberty, Cheshire West and the CRPD, p 6

37 Office of the United Nations High Commissioner for Human Rights, Committee on the Rights of Persons with Disabilities, General Comment 35 on Article 9, 2014, para 19

38 RB v UK, Application No. 6406/15, 12 Sept 2017

39 Application no. 53251/13, decision of 23 March 2017

40 AM-V v Finland [2017] ECHR 273

3 Law Commission Proposals

28. In 2017, the Law Commission put forward proposals to replace DoLS with Liberty Protection Safeguards (LPS).[41] LPS perform a similar function to DoLS. However, they provide legal authorisation for *specific arrangements* that deprive a person of their liberty where the person concerned lacks capacity to consent to their care and treatment arrangements. They are, therefore, more specific and detailed than DoLS, which authorise the deprivation of liberty in general and not the specific care and treatment arrangements.

29. LPS would also apply whenever a person is deprived of their liberty, i.e. when they are (1) under continuous supervision and control and not free to leave, (2) there is no valid consent, and (3) the State knows or ought to know of the situation. They would apply to a wider number of people than DoLS, as the scheme will be extended from care homes and hospitals to include any place of care except for mental health hospitals. The scheme would also be extended to any person aged 16 and over who is of "unsound mind" and lacks capacity to consent to care or treatment. The LPS scheme is therefore wider than the DoLS scheme, which only applies to over 18s with a mental disorder.

30. Under LPS, a person would have the same rights as under DoLS, (advocacy, review, and appeal). However, the right to advocacy would be enhanced under LPS as the person deprived of their liberty would be referred to an advocate automatically, whereas under DoLS a person has to 'opt in' to get an advocate.

31. The LPS seeks to focus more resources on the most complex cases which require extra safeguards, such as those cases where individuals object to their care and treatment or the authorisation is necessary to prevent harm to others. In these circumstances, cases are referred by an Independent Reviewer to an Approved Mental Capacity Professional who will reconsider whether the criteria for DoLS have been met. Conversely, the Law Commission proposes that cases can be authorised in a more straightforward manner where there is no doubt that the arrangements are in the best interests of the individual and the individual concerned does not object.[42]

41 See Annexes 1 and 2 for a high-level overview of DoLS and LPS respectively. For full details of the proposals, see Law Commission, Mental Capacity and Deprivation of liberty, HC 1079, March 2017.

42 Q11 [Tim Spencer-Lane]

4 Overview of findings

32. There is consensus that the current system is broken and hundreds of thousands of people are being unlawfully detained. According to those who gave evidence to the Committee, there is broad support for the Law Commission's proposals.

33. In response to our inquiry, some stakeholders set out a range of positive benefits they believe will be delivered by the LPS:

a) LPS is intended to be portable and fully integrated with care planning and should precede rather than follow the care arrangements. This will help to ensure that human rights issues are considered before rather than after care arrangements are made.

b) LPS would replace the current 'Best Interests' test with a 'Necessary and Proportionate' test, which better reflects the requirements of Article 5 ECHR, placing greater emphasis on whether there is a less restrictive alternative to deprivation of liberty.[43]

c) As part of the introduction of the LPS, the Mental Capacity Act will be amended so that the person's wishes and feelings are the starting point of any assessment.[44]

d) LPS provides for civil proceedings to be brought against private care providers who do not obtain appropriate authorisation.[45]

e) LPS extends safeguards to 16 and 17 year olds, avoiding the onerous process of applying to the Court of Protection.[46]

f) LPS seek to give much greater scrutiny to the small minority of cases where the person who is being deprived of their liberty objects to this happening, or where the deprivation of liberty is being done in the interests of public safety rather than purely in the best interests of the person.[47] This recognises that in the vast majority of cases there is little or no dispute about whether the care arrangements which amount to a deprivation of liberty are in the person's best interests.

34. However, stakeholders have raised a number of concerns that require further attention. We address some of these in Chapter 6. Before doing so, we turn in Chapter 5 to the underlying issue–the current definition of deprivation of liberty as set out in *Cheshire West*. We consider that this requires Parliamentary attention.

43 Equality and Human Rights Commission (DOL0116), para 26; Professor Rob Heywood (DOL0043)
44 Professor Rob Heywood (DOL0043)
45 Professor Rob Heywood (DOL0043)
46 Equality and Human Rights Commission (DOL0116)
47 St Thomas Training (DOL0008)

5 Defining deprivation of liberty

35. The Law Commission did not, understandably, grapple with the difficult question of defining 'deprivation of liberty' when considering the reform of the DoLS scheme. The Law Commission's proposals are based on the 'acid test' for 'confinement' as set out in *Cheshire West*, which is the current law. On the one hand, Lady Hale sets out strong policy reasons for adopting a wide definition of deprivation of liberty, based on the vulnerability of the cohort of people who lack mental capacity and the need to ensure decisions are made in their best interests.[48] On the other, this judgment has led to an unsustainable situation and has captured many people within the definition who may object to being categorised as deprived of their liberty. As Alex Ruck Keene, specialist mental capacity barrister, noted in evidence, at present, an individual in an adult foster placement with a devoted carer is in the same legal situation as an individual detained in a high-end psychiatric institution objecting to treatment.[49] Our inquiry therefore considered whether Parliament should debate this issue with a view to setting out a definition in statute.

36. Sir Nicholas Mostyn and Sir William Charles, retired family court judges, submitted that the proposed LPS are based upon the acid test as a starting point and that this is legally wrong and should be revisited by the Supreme Court.[50] Sir Nicholas noted that "no case from Strasbourg has come close to saying that the case of someone of "unsound mind" (as Article 5 puts it) falls within the terms of that article if they are being looked after in their own home."[51] Further, he argued that "[i]t is surely vanishingly unlikely that Strasbourg would disagree with the narrower test: it is after all completely consistent with its jurisprudence, which mandates a fact sensitive approach and which looks at the range of factors such as the intensity of the restrictions in question."[52]

37. Baroness Elaine Murphy agreed that a new definition is required, suggesting that:

> "[t]he criteria for 'deprivation of liberty' needs urgent reconsideration before any new legislation is approved. I do not believe it is reasonable to include admission and / or residence of incapacitated persons in homes and hospitals where there is no objection by patient, family carers or professional carers, nor to include private individuals living by choice in their own family homes supervised by family members or professional carers. Deprivation of liberty should apply only to those who express dissent or opposition by word or deed to where they are cared for and/or to how they are treated."[53]

38. Mark Neary, who has a son with autism, believes that the current definition is too wide as it captures his son, who is living contently 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 week that Steven is being deprived of his liberty in his own home on two

48 Cheshire West and Chester Council v P [2014] UKSC 19, [2014] MHLO 16, para 57
49 Q3 [Alexander Ruck Keene]
50 Sir Nicholas Mostyn (DOL0012) and Sir William Charles (DOL0052)
51 Sir Nicholas Mostyn (DOL0012)
52 Sir Nicholas Mostyn (DOL0012), para 5
53 Baroness Elaine Murphy (DOL0025)

> 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. When I compare it to eight years ago, that was an obvious deprivation of liberty. He was kept away from his own home. Seclusion was part of the deprivation at times. Physical restraint and medication were part of the deprivation at the time. None of that exists now in his own home, but we have come down such a crazy road in the last eight years that we cannot tell the difference between deprivation of liberty in an institutionalised unit and in someone's own home."[54]

39. Graham Enderby, a long-term carer, agreed: "[w]e have gone so overboard after this judgment, it is ridiculous […] People living in their homes have often consented to be in their own homes […] They already have a care package that suits them. Just because their memory or capacity goes, they are automatically deprived of their liberty now."[55]

40. We recognise that deprivation of liberty is a living, evolving Convention concept rooted in Article 5, which has been defined by the European Court. The difficulty is how this is interpreted and applied in the context of mental incapacity.

41. The Supreme Court's interpretation of Article 5 casts the net wide, capturing people who are content and those who have expressed *de facto* consent (albeit not 'valid consent' for the purpose of the law). This has led to some families feeling distressed that their loved ones are considered deprived of their liberty as a result of their care plans, as well as leading to substantial resourcing issues. This approach also sits at odds with the UNCRPD, which emphasises respecting the autonomy and wishes of those with disabilities.

42. Notably, since *Cheshire West*, an exception to the 'acid test' has been made where a deprivation of liberty is required for the purpose of life-saving treatment.[56] In *Ferreira*, the court adopted a causative approach to the 'acid test', asking the question: is the individual under continuous supervision and control and *therefore* not free to leave? In other words, is it the continuous supervision and control that is preventing the individual from being free to leave, or is it the underlying condition (for example, because the individual is unconscious)? The court found that in circumstances where the individual's underlying condition was the cause of the individual not being free to leave, then this was not 'confinement' for the purpose of Article 5.[57] There has, therefore, been some backtracking from the 'acid test' in cases concerning life-saving treatment, which may cause confusion for frontline practitioners as to the boundaries of 'confinement'.

43. An alternative approach to re-visiting the interpretation of 'confinement' would be to reconsider the meaning of valid consent (the second and subjective limb of the test for deprivation of liberty). For consent to be 'valid', the individual concerned must have

54 Q8 [Mark Neary]
55 Q8 [Graham Enderby]
56 Ferreira v HM Senior Coroner for Inner South London and others [2017] EWCA Civ 31
57 Ferreira v HM Senior Coroner for Inner South London and others [2017] EWCA Civ 31

capacity to consent. Therefore, where an individual is assessed as lacking mental capacity, they cannot give valid consent to their confinement. Graham Enderby explained that, under the current system, assessors "do not look at the individual, how they communicate or how they express any form of consent or contentment."[58]

44. It is arguable that 'valid consent' could be construed more widely than the current position, which would recognise that there are ways in which an individual, whilst lacking mental capacity, may nevertheless be capable of expressing consent to specific care or treatment arrangements.[59] The evidence of Caroline Docking, whose daughter has severe disabilities, illustrates the complexity of consent:

> "[…] [My daughter's] life is full of things that she can do. She smiles and laughs all the time. She loves music and soap operas and concerts and shopping. She loves swimming and being out and about in her car or just for walks.
>
> "[She] has her own home and a totally amazing group of staff who are completely in tune with her needs. They are able to know when she is happy or not so happy. They ask her opinion on every aspect of her life–even though she can't reliably respond. They look for the very subtle signals that [she] gives to show when she is in need of something and has something to 'say'. They take great pride in enabling her to have as full and self-directed a life as she can possibly have. They absolutely do not 'control her' although that is how their support is interpreted through DOLS. […]."[60]

45. ***In our view, Parliament should set out a statutory definition of deprivation of liberty which clarifies the application of the Supreme Court's acid test and brings clarity for frontline professionals. In doing so, Parliament will be mindful of the fact that any definition must comply with Article 5. The courts will be under a duty to interpret the statutory provision compatibly with Convention rights.[61] We note the decision in Ferreira and consider that it is possible to legislate for a Convention-compliant definition that would produce greater clarity and would extend safeguards only to those who truly need them, whilst respecting the right to personal autonomy of those who are clearly content with their situation, even if they are not capable of verbalising such consent.***

58 Q8 [Graham Enderby]
59 Alex Ruck Keene (DOL0120)
60 Caroline Docking (DOL0050)
61 Human Rights Act 1998, Section 3

6 Recommendations relating to the Law Commission's proposals

Domestic settings

46. The Law Commission proposes to extend safeguards from care homes and hospitals to all settings except mental health hospitals. This would include domestic settings which currently fall outside the DoLS scheme. At present, authorisation must be sought directly from the Court of Protection, although often it is not, as applications are onerous and often thought by all concerned to be inappropriate. In evidence, we heard that this extension would cover potentially a further 30,000 people,[62] although we expect this may be a conservative estimate given the vast numbers of people receiving care in their own homes.

47. We have received mixed views on this proposal. A number of parents and carers felt that an extension of LPS into personal homes would be too intrusive and violate the individual's right to personal autonomy where they have no objection to their 'confinement'.[63]

Box 1: Evidence from Caroline Docking

> […] Because of two facts the local authority and the law considers [my daughter] to be deprived of her liberty. Those two facts are:
>
> she does not have capacity to make decisions
>
> she has a 2 to 1 care package (considered to be constant supervision and control)
>
> Both of these facts are true, but as E's mum, I can see very clearly that they do not deprive her of anything. Let's look at these issues one at a time.
>
> Firstly, [she] has a profound disability. She does not have capacity to make decisions and she never will have. This means that because the State considers her liberty to be deprived that will apply for her whole life. Can you imagine how upsetting it is as E's mum for me to see that the State is defining her life as being led from within a 'gilded cage'. It's a horrible image, and couldn't be further from the truth.
>
> Secondly, having a 2:1 care package means that [she] has the freedom to live her life and that her physical and medical needs are met, but the way that community DOLS have been interpreted means that this automatically makes her subject to DOLS. […].
>
> Having 2 carer's means that [she]is free to do whatever she likes, whenever she likes. […] It is the ultimate irony that the support that gives E freedom is the thing that triggers the process for a community DOLS.
>
> Effectively […] we have deprived [her] of her liberty by taking her shopping, to the spa, to the theatre and cinema, to numerous concerts including Take That. Also, this means that in her own home and in her own car, she is deprived of her liberty.

62 Q3 [Dr Lucy Series]

63 Caroline Docking (DOL0050), Q5 [Mark Neary], and Age UK (DOL0059), Garden Chambers (DOL0084)

> Community DOLS are now triggered at a much lower level that would be the case in an institution. Looking at the specified features of a DOLS in hospital or care home, young people like E would not be subject to this as she is not sedated, there is no physical restraint, there are no objections from the family about the care, the placement is stable, there are no locked doors of other restrictions. Also, importantly, E is free to leave at any time she likes–unfortunately she doesn't have the ability to do that independently due to her physical disabilities.
>
> I fully understand that E's disabilities make her potentially very vulnerable. However, in practice she has a loving close family, a fabulous care team, an exceptional care provider, a supportive landlord, an involved GP and numerous helpful hospital consultants and specialist nurses. […]
>
> The law protects E very well without needing to apply DOLS. Whenever there is a difficult or unusual decision to make, this is well supported by the Best Interests process, fully involving all of the relevant people.
>
> DOLS adds nothing to E's life. It is just a bureaucratic process which somehow implies that her life is not free. Nothing could be further from the truth.

Source: Caroline Docking (DOL0050)

48. We understand and share these concerns. However, whilst the current definition of 'confinement' remains good law, it appears logical to extend the safeguards to cover domestic settings in appropriate circumstances. Persons who are not free to leave and are under continuous control and supervision, and who are not able to give 'valid consent', are deprived of their liberty for the purpose of Article 5, even if this is within their own homes and they are perfectly content with their circumstances. The law requires that such individuals are extended the same protections as those in other settings. Extending LPS to all settings except for mental health hospitals would avoid onerous court proceedings for authorisations and provide a holistic approach for individuals moving between settings.[64] On the other hand, we note the Care Quality Commission's concern about finding " the right balance between no oversight and complete intervention across the range of proposed settings it applies to."[65] In our view, this makes the need for Parliament to consider the definition of deprivation of liberty more pressing.

49. ***We support the Law Commission's proposal to extend safeguards into domestic settings in order to ensure Article 5 safeguards are applied to all persons deprived of their liberty irrespective of where they reside, but Parliament needs to consider the delicate balance between safeguarding and disproportionate intrusion. We note that while the impact of extending safeguards into domestic settings would be limited if the definition of deprivation of liberty were to be narrowed, it would still be an expansion of the scheme. In making this recommendation, we are mindful of the resource implications for Local Authorities as domestic cases previously dealt with by the Court of Protection would now fall to them. We urge the Government to consider how appropriate funding arrangements can be made to implement this new scheme.***

64 Ms Trish O'Hara (DOL0001); Equality and Human Rights Commission (DOL0116)
65 Care Quality Commission (DOL0104)

Independence of reviews

50. The Law Commission proposes that an independent review of the assessments should be carried out in all cases, in order to confirm that it is reasonable for the local authority or local health board to conclude that the conditions for an authorisation are met, or to refer the case to an Approved Mental Capacity Professional (AMCP) in more complex cases requiring further scrutiny.[66] The independent reviewer cannot be someone involved in the day-to-day care of, or provision of treatment to, the individual concerned. However, the reviewer could be a person from the same body responsible for authorising the deprivation of liberty.

51. In evidence, concerns have been raised regarding the extent to which the reviews will be truly independent. Some have noted that this system effectively asks local authorities and NHS bodies to scrutinize their own decision-making and rubber stamp their own practices.[67] In evidence, Graham Enderby, expressed his worries regarding the review process: "the people commissioning the care, or even running the care home that someone is put in, authorise the deprivation of liberty, provide the people who authorise the deprivation of liberty and then conduct the reviews. It is the same authority. They are also relied on to appoint people to represent the individual, whether they be advocates or family members. Everything is within their control."[68]

52. ***Human rights law requires that authorisations of deprivations of liberty are reviewed independently. The European Court of Human Rights has held that where the same clinicians are responsible for depriving a person of their liberty and for their treatment, there must be guarantees of independence.[69] In our view, the Law Commission proposals are compliant with this requirement. However, the review process is not entirely free from conflict of interest. Whilst it would be disproportionate to establish a separate review body, we recommend that the Code of Practice must set out clear guidelines to eradicate conflicts of interest.***

Advance consent

53. The Law Commission's proposals introduce the possibility of providing advance consent to care and treatment arrangements that would otherwise amount to a deprivation of liberty.[70] This is not currently possible under the DoLS scheme. In providing advance consent, the element of 'valid consent' would be satisfied such that Article 5 would not be engaged and authorisation would not be needed.

54. However, some have raised concerns that advance consent could be viewed as a catch-all, open-ended concept and that there may be scope for abuse.[71] We understand these concerns but consider that with safeguards this option enhances the rights of those who wish to make decisions as to their future care and treatment where they have sufficient foresight to do so, preventing unnecessary interference with private life. There is already a precedent for advance consent in the event of future incapacity; under the MCA,

66 Law Commission, Mental Capacity and Deprivation of liberty, HC 1079, March 2017, p 97–104
67 Mrs Rachel Hubbard (DOL0015), Conwy County Borough Council (DOL0018), Tony Anyaegbu (DOL0023), and Integritas Support Ltd (DOL0044)
68 Q1 [Graham Enderby]
69 IN v Ukraine, Application No. 28472/08
70 Law Commission, Mental Capacity and Deprivation of liberty, HC 1079, March 2017, p 171
71 Roger Laidlaw (DOL0045); Professor Rob Heywood (DOL0043)

an individual can make an advance decision to refuse medical treatment.[72] We see no reason as to why this should not apply to advance consent for specific care and treatment arrangements.

55. ***We consider that advance consent for care arrangements should be valid as long as safeguards are in place to verify the validity of this consent. The current proposals do not require any formalities as to the giving of advance consent–it can be given orally or in writing. We would recommend 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.***

Advocacy and rights of appeal

56. The provision of advocacy is an important factor in ensuring that individuals can exercise their rights to challenge authorisations, as the advocate may initiate court proceedings. This is essential for compliance with Article 5(4), 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. Unlike DoLS, which provides advocates on an 'opt in' basis, LPS provides advocates as of right. We heard from Mark Neary in evidence that, despite being entitled to an advocate, he and his son were not referred to an advocate until after the fourth DoLS authorisation, some seven months after his son's detention, which significantly delayed their access to court.[73]

57. ***We support the enhancement of rights to an independent advocate in the Law Commission's proposals. However, there is a shortage of such advocates. The Government should ensure consideration is given to appropriate funding arrangements so that advocates can be appointed as early as possible.***

58. Concerns have been raised in evidence that LPS perpetuate complex and overlapping duties of the appropriate person, Independent Mental Capacity Advocate, Approved Mental Capacity Professional, and responsible body to exercise the individual's rights of appeal.[74] There is also concern that these arrangements involve conflicts of interest as the responsible body may not wish to refer its decision to judicial scrutiny at a high cost.[75] We received evidence from Dr. Lucy Series that, based on research undertaken by Cardiff University, the best estimate is that fewer than 1% of DoLS authorisations are appealed to the Court of Protection.[76] When compared to the rate of appeal against detention under the MHA (47%),[77] this suggests that there is a barrier to exercising these appeal rights.

59. Dr Lucy Series suggested that access to justice is hindered by the complex and costly process of getting to court, which is "designed by lawyers for lawyers".[78] Her research

72 Mental Capacity Act 2005, Section 24
73 Q5 [Mark Neary]
74 Dr Lucy Series (DOL0068)
75 Dr Lucy Series (DOL0068), p 5
76 Q4 [Dr Lucy Series]
77 Q4 [Dr Lucy Series]
78 Q4 [Dr Lucy Series]

found that "these cases cost on average £25,000. They could cost hundreds of thousands in certain cases. We found that the average duration of a case was seven months. Half the cases lasted longer than that. In the sample that we looked at, 8% of people died before they got final determination from the court, because this is a population that is much older and very often ill."[79]

60. Mark Neary told us that the right to access court was fundamental in securing his son's freedom following four consecutive unlawful DoLS authorisations. He explained that his son was due to go to a respite unit for three days, but having been moved to a local assessment and treatment unit was detained there for a year. Mr. Neary concluded that, "[u]ltimately, the deprivation of liberty safeguards enabled Steven's freedom, because we were able to access the courts through the very fact the DoL was in place. Even though the judge in this case decided that all four DoLS had been unlawful, the very fact they had been in place enabled him to access the court and then gain his liberty and freedom."[80]

61. ***We suggest that the individual's right to participate in court ought to be codified and that responsibility for securing the individual's access to court should be prescribed clearly on the face of the Bill.***[81] ***Whilst the individual's appropriate person and advocate should have a duty to appeal on their behalf,***[82] ***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.***[83]

Forum

62. The Law Commission leaves open the question of whether the Court of Protection (CoP) should retain jurisdiction to hear challenges or whether this should be transferred to the First Tier Tribunal (FTT). They recommend that the Lord Chancellor, the Lord Chief Justice and the Senior President of Tribunals should review this.[84]

63. Some stakeholders are concerned that moving the jurisdiction to the FTT would mean a loss of specialist expertise currently held by the CoP.[85] However, the weight of the evidence to our inquiry fell in favour of a tribunal system as this would be more efficient, accessible, and cost effective and would enhance the rights of the individual concerned to be directly involved in proceedings.[86]

64. In evidence, we heard that many of the cases before the Court of Protection are *prima facie* concerned with detention but are in fact concerned with wider issues such as care and treatment, residence, and contact with family and friends. A separate tribunal solely for detention cases may not, therefore, be appropriate.[87] Dr Lucy Series suggests that "one

79 Q4 [Dr Lucy Series]
80 Q1 [Mark Neary]
81 Mental Health and Court of Protection Team, Doughty Street Chambers (DOL0088), paras 9 and 11
82 See RD and Others (Representatives and Advocates: Duties and Powers Practice Note) [2016] EWCOP 49, in which the CoP set out guidance for representatives and advocates on how to decide when it is appropriate to apply to court to challenge a DoLS authorisations, e.g. when the authorisation appears contrary to P's best interests, or when there is a less restrictive option. These could be set out in statute or the code of practice.
83 Dr Lucy Series (DOL0068), p 5. 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.
84 Law Commission, Mental Capacity and Deprivation of liberty, HC 1079, March 2017, p 139
85 Mental Health and Court of Protection Team, Doughty Street Chambers (DOL0088), para 6
86 Mental Health Tribunal Members Association (MHTMA) (DOL0033), para 3.3; Dr Lucy Series (DOL0068)
87 Q5 [Dr Lucy Series and Alexander Ruck Keene]

solution would be effectively to try to tribunalise the Court of Protection–to keep many members of the judiciary, who are very expert in this area, but to look at the processes of the tribunal, many of which are more accessible, more efficient, more informal and give the person themselves greater opportunities to participate."[88]

65. ***It is clear that there is a need for expertise alongside accessibility, informality and speed. We recommend that any future consideration by the Lord Chancellor, the Lord Chief Justice and the Senior President of Tribunals should give serious consideration to the merits of a tribunal. Any future tribunal will need sufficient powers to consider not just the issue of detention but the wider issues at stake.***

Legal Aid

66. It is imperative that the LPS system provides legal aid for challenges to authorisations. At present, the Legal Aid Agency can refuse non-means tested certificates for challenges to DoLS where there is no existing authorisation.[89] In other words, perversely, the person deprived of their liberty can lose access to challenge this in court because of their unlawful detention. It has also been drawn to our attention that if individuals are joined as a party to any judicial authorisation procedure, they will not be eligible for non-means-tested legal aid, and may therefore be compelled to pay for the privilege of protection.[90]

67. ***The current system has produced arbitrary limitations on individuals' right of access to a court. Legal aid must be available for all eligible persons challenging their deprivation of liberty, regardless of whether an authorisation is in place, particularly given the significant number of people unlawfully deprived due to systemic delays and failures.***

Unsound mind

68. DoLS apply to those with a mental disorder. LPS would apply to persons of "unsound mind" to reflect the wording of Article 5, which would capture wider conditions such as locked-in syndrome. We are concerned, along with a number of stakeholders, that that the term "unsound mind" is stigmatising and unclear given it does not reflect the terminology of modern psychiatry, and may lead to unnecessary litigation.[91]

69. ***We recommend that further thought be given to replacing "unsound mind" with a medically and legally appropriate term and that a clear definition is set out in the Code of Practice.***

Interface

70. The interface between the Mental Capacity Act and the Mental Health Act causes particular difficulties. The MCA is entirely distinct from the MHA. As explained in the MHA Review Interim Report, "the MCA relates to a person's ability (capacity) to function and to make a particular decision. This is different to the status of someone diagnosed

88 Q5 [Dr Lucy Series]
89 Mental Health and Court of Protection Team, Doughty Street Chambers (DOL0088), para 12
90 Mental Capacity Law and Policy, Discussion Paper: Deprivation of Liberty, Cheshire West, and the CRPD, Alex Ruck Keene, Dec 2017, para 4, accessed May 2018.
91 Luton and Bedfordshire CCG's (DOL0103); Bevan Brittan LLP (DOL0092); and Garden Court Chambers (DOL0084)

with a mental disorder as defined in the MHA and who is subject to its powers. The MCA covers all decision-making, whereas the MHA 1983 is largely limited to decisions about care in hospital and medical treatment for mental disorder."[92] The two regimes interact when authorising the deprivation of a person's liberty in hospital arising from their care and treatment for mental disorder.

71. Under the current system, an individual is ineligible for DoLS and must be detained under the MHA if that individual falls within the scope of the MHA[93] and is objecting to psychiatric treatment.[94] If the individual falls within the scope of the MHA but is not objecting to psychiatric treatment, then the assessor has a choice as to detaining under the MHA or under DoLS. If the individual falls at the interface between the two schemes, the assessors must consider what is the least restrictive way of achieving the proposed treatment.[95] This is a complex consideration, causing both professionals and the courts great difficulty. We have received evidence that the interface has led to "widespread illegality by the misapplication of legislation, largely because of staff taking a flippant attitude to patients' rights and preferring the DoLS scheme [to the MHA] because this places fewer demands on them."[96]

72. The Law Commission proposes to maintain the two legal regimes: the MHA would apply to arrangements for mental disorders; the LPS would apply to arrangements for physical disorders.[97] Inevitably, problems will continue to arise at the interface between these two regimes.

73. One preferred solution would be to consider fusion of the MCA and MHA, with one legislative scheme governing non-consensual care or treatment of people suffering physical and/or mental disorders.[98] However, the MHA is currently under review and fusion is not an immediate solution.[99] We do not think reform to DoLS can be delayed until the MHA review is over. Therefore, an interim way forward must be considered.

74. ***We agree that the Law Commission's proposals for dealing with the interface between the Mental Health Act and the Mental Capacity Act are likely to alleviate some of the confusion with the current system, as objection to treatment would no longer be a relevant factor. However, we are concerned by two issues. Firstly, this proposal requires assessors to determine the primary purpose of the assessment or treatment of a mental or physical disorder–this is difficult where persons have multiple physical and mental disorders. Secondly, we are concerned that there are essentially different laws and different rights for people lacking capacity depending upon whether their disorder is mental or physical. We consider that the rights of persons lacking capacity should be the same irrespective of whether they have mental or physical disorders. We encourage***

92 The Independent Review of the Mental Health Act, Interim Report, May 2018, p 23

93 A person (P) is within the scope of the MHA (A) If P could be detained under the powers in s.2 or 3 of the MHA (i.e. compulsory admission for assessment or treatment of a mental disorder) and (B) If P would be accommodated in hospital for the purpose of being given medical treatment for mental disorder. (Conversely, if 'but for' P's physical needs, P would not be detained, then P would not be within the scope of the MHA and would therefore be eligible under DoLS). See Mental Capacity Act 2005, Schedule 1A. Ineligible Persons, Case E.

94 Determined by taking into account all the circumstances (wishes, feelings, behaviour etc).

95 AM v South London and Maudsley NHS Foundation Trust [2013] UKUT 0365 (AAC)

96 Roger Laidlaw (DOL0045)

97 Law Commission, Mental Capacity and Deprivation of liberty, HC 1079, March 2017, p 147–155

98 See for example the Mental Capacity (NI) Act 2016 which fused mental health and capacity legislation following the Bamford Review of 2007. Note also the recent consultation in Scotland regarding proposals to reform the Adults with Incapacity (Scotland) Act 2000.

99 The Independent Review of the Mental Health Act, Interim Report, May 2018

those undertaking the Mental Health Act review to bear this in mind and to seek to ensure that rights are applied equally to persons irrespective of the condition causing their incapacity.

7 Conclusion

75. **The Law Commission's proposals could form the basis of a better scheme for authorising deprivations of liberty, directing scrutiny to those who need it most. That scheme should be implemented urgently. But while the new scheme should be cheaper than the application of the current DoLS to all those falling within the Cheshire West definition, it is not cost free. Not only will there will be ongoing costs for local authorities, the courts and the health service, there will be transition costs. We urge the Government to consider how this scheme might be appropriately funded.**

Conclusions and recommendations

Defining deprivation of liberty

1. *In our view, Parliament should set out a statutory definition of deprivation of liberty which clarifies the application of the Supreme Court's acid test and brings clarity for frontline professionals. In doing so, Parliament will be mindful of the fact that any definition must comply with Article 5. The courts will be under a duty to interpret the statutory provision compatibly with Convention rights. We note the decision in Ferreira and consider that it is possible to legislate for a Convention-compliant definition that would produce greater clarity and would extend safeguards only to those who truly need them, whilst respecting the right to personal autonomy of those who are clearly content with their situation, even if they are not capable of verbalising such consent.* (Paragraph 45)

Recommendations relating to the Law Commission's proposals

2. *We support the Law Commission's proposal to extend safeguards into domestic settings in order to ensure Article 5 safeguards are applied to all persons deprived of their liberty irrespective of where they reside, but Parliament needs to consider the delicate balance between safeguarding and disproportionate intrusion. We note that while the impact of extending safeguards into domestic settings would be limited if the definition of deprivation of liberty were to be narrowed, it would still be an expansion of the scheme. In making this recommendation, we are mindful of the resource implications for Local Authorities as domestic cases previously dealt with by the Court of Protection would now fall to them. We urge the Government to consider how appropriate funding arrangements can be made to implement this new scheme.* (Paragraph 49)

3. *Human rights law requires that authorisations of deprivations of liberty are reviewed independently. The European Court of Human Rights has held that where the same clinicians are responsible for depriving a person of their liberty and for their treatment, there must be guarantees of independence. In our view, the Law Commission proposals are compliant with this requirement. However, the review process is not entirely free from conflict of interest. Whilst it would be disproportionate to establish a separate review body, we recommend that the Code of Practice must set out clear guidelines to eradicate conflicts of interest.* (Paragraph 52)

4. *We consider that advance consent for care arrangements should be valid as long as safeguards are in place to verify the validity of this consent. The current proposals do not require any formalities as to the giving of advance consent–it can be given orally or in writing. We would recommend 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.* (Paragraph 55)

5. *We support the enhancement of rights to an independent advocate in the Law Commission's proposals. However, there is a shortage of such advocates. The Government should ensure consideration is given to appropriate funding arrangements so that advocates can be appointed as early as possible.* (Paragraph 57)

6. *We suggest that the individual's right to participate in court ought to be codified 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, 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.* (Paragraph 61)

7. *It is clear that there is a need for expertise alongside accessibility, informality and speed. We recommend that any future consideration by the Lord Chancellor, the Lord Chief Justice and the Senior President of Tribunals should give serious consideration to the merits of a tribunal. Any future tribunal will need sufficient powers to consider not just the issue of detention but the wider issues at stake.* (Paragraph 65)

8. *The current system has produced arbitrary limitations on individuals' right of access to a court. Legal aid must be available for all eligible persons challenging their deprivation of liberty, regardless of whether an authorisation is in place, particularly given the significant number of people unlawfully deprived due to systemic delays and failures.* (Paragraph 67)

9. *We recommend that further thought be given to replacing "unsound mind" with a medically and legally appropriate term and that a clear definition is set out in the Code of Practice.* (Paragraph 69)

10. *We agree that the Law Commission's proposals for dealing with the interface between the Mental Health Act and the Mental Capacity Act are likely to alleviate some of the confusion with the current system, as objection to treatment would no longer be a relevant factor. However, we are concerned by two issues. Firstly, this proposal requires assessors to determine the primary purpose of the assessment or treatment of a mental or physical disorder–this is difficult where persons have multiple physical and mental disorders. Secondly, we are concerned that there are essentially different laws and different rights for people lacking capacity depending upon whether their disorder is mental or physical. We consider that the rights of persons lacking capacity should be the same irrespective of whether they have mental or physical disorders. We encourage those undertaking the Mental Health Act review to bear this in mind and to seek to ensure that rights are applied equally to persons irrespective of the condition causing their incapacity.* (Paragraph 74)

Conclusion

11. The Law Commission's proposals could form the basis of a better scheme for authorising deprivations of liberty, directing scrutiny to those who need it most. That scheme should be implemented urgently. But while the new scheme should be cheaper than the application of the current DoLS to all those falling within the Cheshire West definition, it is not cost free. Not only will there will be ongoing

costs for local authorities, the courts and the health service, there will be transition costs. We urge the Government to consider how this scheme might be appropriately funded. (Paragraph 75)

Annex 1: Deprivation of Liberty Safeguards (DoLS) overview

What?

A Deprivation of Liberty Safeguard provides legal authorisation for depriving a person of their liberty. The safeguards provide protection for people who lack capacity to consent to care or treatment and who have restrictions in place to keep them safe.

When?

A person is deprived of their liberty when they are under "continuous supervision and control and not free to leave."

Where?

Any registered care home or hospital in England and Wales.

How?

Two types of DoLS authorisations:

(1) Urgent: the care home or hospital can authorise the deprivation of liberty themselves for up to 7 days (can be extended to 14 days with Local Authority permission)

(2) Standard: independent assessors (e.g. specially trained social workers, nurses, occupational therapists), authorised by the supervisory body (Local Authority or Welsh Health Board), can authorise the deprivation of liberty for up to one year.

Who?

Any adult aged 18 and over who has a mental disorder and lacks capacity to consent to care or treatment.

Rights?

A person placed under a DoLS has a number of rights including: the right to an advocate and representative for support; the right to review of the authorisation; and the right to challenge the authorisation in court.

Annex 2: Liberty Protection Safeguards (LPS) overview

What?

Liberty Protection Safeguards perform a similar function as DoLS. They provide legal authorisation for specific arrangements that deprive a person of their liberty. They apply where the person lacks capacity to consent to the care and treatment arrangements that give rise to the deprivation of liberty. (More specific than the DoLS).

When?

A person is deprived of their liberty when they are under "continuous supervision and control and not free to leave." (Same as under the DoLS).

Where?

The scheme will be extended from care homes and hospitals to include any place of care except for mental health hospitals. (Wider than the DoLS).

Who?

The scheme will be extended to any person aged 16 and over who is of unsound mind (wider than mental disorder) and lacks capacity to be resident for care or treatment. (Wider than the DoLS scheme).

How?

(1) Life-sustaining treatment: urgent cases are restricted to "life-sustaining treatment or to prevent a serious deterioration in the person's condition." No time limit applies. (Narrower than DoLS).

(2) Standard LPS authorisation: independent assessors (e.g. specially trained social workers, nurses, occupational therapists), authorised by the supervisory body (Local Authority, NHS Trusts), can authorise the deprivation of liberty for up to one year. If the individual does not wish to receive care/treatment at a particular place or there is risk of harm to others, a referral will be made to an Approved Mental Capacity Professional for additional scrutiny.

Rights?

A person has the same rights as under DoLS (advocacy, representation, review, and appeal), but under LPS a person gets an advocate automatically.

Declaration of Lords' Interests[100]

Baroness Hamwee

- No relevant interests to declare

Baroness Lawrence of Clarendon

- No interests declared

Baroness Nicholson of Winterbourne

- No relevant interests to declare

Baroness Prosser

- No relevant interests to declare

Lord Trimble

- No interests declared

Lord Woolf

- Relative with autism

100 A full list of Members' interests can be found in the Register of Lords' Interests: http://www.parliament.uk/mpslords-and-offices/standards-and-interests/register-of-lords-interests/

Formal minutes

Wednesday 27 June 2018

Members present:

Ms Harriet Harman MP, in the Chair

Fiona Bruce MP	Baroness Hamwee
Ms Karen Buck MP	Baroness Nicholson
Jeremy Lefroy MP	

Draft Report (*The Right to Freedom and Safety: Reform of the Deprivation of Liberty Safeguards*), 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 75 read and agreed to.

Summary read and agreed to.

Annexes read and agreed to.

Resolved, That the Report be Seventh Report of the Committee.

Ordered, That the Chair make the Report to the House of Commons and that the Report be made to the House of Lords.

[Adjourned till Wednesday 4 July 2018 at 3.00pm

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Wednesday 21 March 2018

Graham Enderby, Mark Neary, Dr Lucy Series, Research Fellow and Lecturer in Law, Cardiff University, Alexander Ruck Keene, Barrister, 39 Essex Chambers Q1–8

Wednesday 28 March 2018

Nicholas Paines QC, Commissioner, Law Commission, **Tim Spencer-Lane**, Lawyer, Law Commission, **Betsey Lau-Robinson**, Head of Safeguarding Adults, the Mental Capacity Act & Prevent, University College London Hospital, **Stephen Chandler**, Director, Adult Social Services, Somerset Council Q9–17

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

DOL numbers are generated by the evidence processing system and so may not be complete.

1 ADASS and LGA (DOL0079)
2 Advocacy Centre North (DOL0037)
3 Age UK (DOL0059)
4 Alan Capps (DOL0062)
5 Alex Ruck Keene (DOL0120)
6 Alzheimer's Society (DOL0073)
7 Baroness Elaine Murphy (DOL0025)
8 Bevan Brittan LLP (DOL0092)
9 Birmingham City Council (DOL0039)
10 Board of Deputies of British Jews (DOL0094)
11 Bracknell Forest Council (DOL0070)
12 British Association of Social Workers (DOL0026)
13 British Geriatrics Society (DOL0054)
14 British Institute of Human Rights (DOL0112)
15 Browne Jacobson solicitors (DOL0077)
16 Cambridgeshire County Council (DOL0093)
17 Camden and Islington NHS Foundation Trust (DOL0074)
18 Camden DOLS Team (DOL0096)
19 Care Quality Commission (DOL0104)
20 Caroline Docking (DOL0050)
21 changing perspectives (DOL0098)
22 Christine Wells (DOL0101)
23 Community DoLS Team Notts county council (DOL0080)
24 Community Integrated Care (DOL0095)
25 Conwy County Borough Council (DOL0018)
26 Creative Support (DOL0058)
27 Department of Health and Social Care (DOL0114)
28 Derbyshire County Council's DoLS Team (DOL0082)
29 Devon County Council (DOL0035)
30 Dimensions (DOL0041)
31 Dr Andrew Brennan (DOL0106)
32 Dr David Jolley (DOL0011)
33 Dr James Warner (DOL0024)

34 Dr Lucy Series (DOL0068)
35 Dr Oluwatoyin Sorinmade (DOL0014)
36 East Sussex County Council (DOL0030)
37 Edge Training and Consultancy Ltd (DOL0078)
38 Equality and Human Rights Commission (DOL0116)
39 Garden Court Chambers (DOL0084)
40 Greater Huddersfield and North Kirklees clinical commissioning groups (DOL0065)
41 Gwent DoLs consortium (DOL0029)
42 Herefordshire Council (DOL0049)
43 Hertfordshire County Council (DOL0067)
44 Hospice UK (DOL0086)
45 Housing Learning & Improvement Network (DOL0071)
46 Hywel Dda University Health Board (DOL0048)
47 Integritas Support Ltd (DOL0044)
48 Kent County Council (DOL0110)
49 Keri-Michele Lodge (DOL0031)
50 Lancashire County Council (DOL0100)
51 Leicester City Council (DOL0032)
52 Lesley Irvine, Diana Duhig and Malcolm Irvine (DOL0021)
53 London Borough of Barnet (DOL0051)
54 London Borough of Hillingdon (DOL0099)
55 London Borough of Newham (DOL0108)
56 Luton and Bedfordshire CCG's (DOL0103)
57 Mental Health and Court of Protection Team, Doughty Street Chambers (DOL0088)
58 Mental Health Tribunal Members Association (MHTMA) (DOL0033)
59 Miss Lucy Bright (DOL0013)
60 Mr Alan Challoner (DOL0019)
61 Mr Chris Lucas (DOL0083)
62 Mr Dan Simms (DOL0006)
63 Mr Ivan Mugabi (DOL0004)
64 Mr James Godber (DOL0040)
65 Mr Jim Poyser (DOL0017)
66 Mr Nigel Keir (DOL0066)
67 Mr Paul Craven (DOL0005)
68 Mr Peter Parker (DOL0009)
69 Mr Roger Hargreaves (DOL0016)
70 Mr Toby Williamson (DOL0087)
71 Mrs Annette Wilby (DOL0047)

72 Mrs Carol Wilkinson (DOL0010)

73 Mrs Caroline Hanman (DOL0118)

74 Mrs Rachel Hubbard (DOL0015)

75 Ms Eleanor Tallon (DOL0064)

76 Ms Rachel Griffiths (DOL0090)

77 Ms Trish O'Hara (DOL0001)

78 National Autistic Taskforce (DOL0027)

79 Newcastle City Council (DOL0060)

80 NHS Norther Easter and Western Devon Clinical Commissioning Group (DOL0056)

81 Norfolk County Council (DOL0072)

82 North East Lincolnshire MCA Strategic Network (DOL0042)

83 Nottinghamshire County Council Adult Social Care and Public Health Senior Leadership Team (DOL0061)

84 Older People's Commissioner for Wales (DOL0028)

85 POhWER (DOL0102)

86 Prof Baroness Ilora Finlay (DOL0107)

87 Professor Phil Fennell (DOL0069)

88 Professor Rob Heywood (DOL0043)

89 Public Health Wales (DOL0063)

90 Rethink Mental Illness (DOL0055)

91 Richard Jones (DOL0075)

92 Roger Laidlaw (DOL0045)

93 Royal Hospital for Neuro-disability (DOL0121)

94 Salford City Council, Salford Clinical Commissioning Group and Salford Royal NHS Foundation Trust (DOL0076)

95 Sense (DOL0022)

96 Sheffield City Council (DOL0057)

97 Shropshire Council Adult SOCIAL CARE (DOL0105)

98 Simon Cramp (DOL0117)

99 Sir Nicholas Mostyn (DOL0012)

100 Sir William Charles (DOL0052)

101 St Thomas Training (DOL0008)

102 Sussex Partnership NHS Foundation Trust (DOL0046)

103 The Royal College of Psychiatrists (DOL0091)

104 Tony Anyaegbu (DOL0023)

105 Turning Point (DOL0081)

106 University College London Hospitals NHS Foundation Trust (DOL0085)

List of Reports from the Committee during the current Parliament

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 Paper 70
Second Report	Proposal for a Draft Human Fertilisation and Embryology Act 2008 (Remedial) Order 2018	HC 645 HL Paper 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
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