



**Law  
Commission**  
Reforming the law

---

---

## **Mental Capacity and Deprivation of Liberty Interim Statement**

---

---

**25 May 2016**

---

---

# MENTAL CAPACITY AND DEPRIVATION OF LIBERTY

## INTERIM STATEMENT

- 1.1 The Law Commission's review of the deprivation of liberty safeguards ("DoLS") began in 2014.<sup>1</sup> The project forms part of the Law Commission's 12th programme of law reform, and its scope was formalised by a reference from the Department of Health to the Law Commission under section 3(1)(e) of the Law Commissions Act 1965.
- 1.2 The Law Commission's consultation paper on deprivation of liberty was published on 7 July 2015.<sup>2</sup> It set out a comprehensive replacement scheme for the DoLS, wider in scope, which we called "protective care" (summarised below). The public consultation ran from publication until 2 November 2015.
- 1.3 This interim statement is intended to update stakeholders on the key issues that have emerged at consultation and some of our initial conclusions. It is not a consultation document (though we are seeking suggestions as to a name for the scheme that we now propose: see paragraph 1.48 below). The publication of the statement responds to a formal request from the Minister of State for Community and Social Care, Alistair Burt MP.
- 1.4 We have concluded that legislative change is the only satisfactory solution to the problems we outline below. During the next phase, the Law Commission will produce draft legislation and a final report. The process of developing draft legislation is likely to result in some changes of substance to the approach outlined here. This statement should not be construed as necessarily representing our final position.
- 1.5 The final report and draft legislation will be published before the end of 2016. It will then be for the Government to decide how the recommendations will be taken forward.

## BACKGROUND TO THE REVIEW

- 1.6 The DoLS are contained in schedules A1 and 1A to the Mental Capacity Act 2005. They were introduced into the Act following the case of *HL v United Kingdom*, which concerned a psychiatric inpatient who been deprived of his liberty without the necessary procedural safeguards.<sup>3</sup> The DoLS establish an administrative process for authorising deprivations of liberty in a hospital or care home. In broad terms, the DoLS provide for professional assessments – conducted independently of the hospital or care home in question – of whether

<sup>1</sup> The Law Commission is a non-political independent body, set up by Parliament in 1965 to keep all the law of England and Wales under review, and to recommend reform where it is needed.

<sup>2</sup> Law Commission, *Mental Capacity and Deprivation of Liberty: A Consultation Paper* (2015), Consultation Paper No 222.

<sup>3</sup> *HL v United Kingdom* (2005) 40 EHRR 32 (App No 45508/99).

the person lacks capacity to decide whether to be accommodated in the hospital or care home for the purpose of care or treatment, and whether it is in his or her best interests to be deprived of liberty. The authorisation can be challenged through an administrative review procedure or in the Court of Protection.

- 1.7 The DoLS have been subject to considerable criticism ever since their introduction. In March 2014, two events inflicted significant damage. First, the House of Lords post-legislative scrutiny committee on the Mental Capacity Act published a report which, amongst other matters, concluded that the DoLS were not “fit for purpose” and proposed their replacement.<sup>4</sup> A few days later, a Supreme Court judgment (usually referred to as “*Cheshire West*”) gave a significantly wider definition of deprivation of liberty than that which had been previously understood to apply in the health and social care context.<sup>5</sup> The judgment laid down an “acid test” for deprivation of liberty: whether a person is subject to continuous supervision and control and is not free to leave.
- 1.8 The practical implications of this judgment for local authorities and the state have been significant. For example, there has been a tenfold increase in DoLS applications in England and a 16 fold increase in Wales since the judgment, and it is estimated that only half of these have been processed owing to the resulting pressures on local authorities and local health boards.<sup>6</sup>
- 1.9 As a result of these events, the Government asked the Law Commission to undertake a review of the DoLS. The purpose of the review is to consider how the law should protect people who lack capacity to consent to their care and treatment and who need to be deprived of liberty to receive that care or treatment. Article 5 of the European Convention on Human Rights (“ECHR”) guarantees the right to personal liberty and provides that no-one should be deprived of their liberty in an arbitrary fashion. The review also considers a person’s rights under article 8 of the ECHR to respect for private and family life. Improving care for those deprived of their liberty as well as supporting the involvement of families and carers in the process has been central to the review.

## **PROTECTIVE CARE**

- 1.10 As noted above, the consultation paper set out a new scheme called protective care. Broadly speaking, protective care had three aspects: the supportive care scheme, the restrictive care and treatment scheme, and the hospitals and palliative care scheme.
- 1.11 The supportive care scheme applied to people lacking capacity to decide their living arrangements, and who were moving into, or already living in, a care home, supported living or shared lives accommodation. The purpose of supportive care

<sup>4</sup> House of Lords Select Committee on the Mental Capacity Act: Report of Session 2013-14: Mental Capacity Act 2005: Post-legislative Scrutiny (2014) HL 139, para 32.

<sup>5</sup> *P v Cheshire West and Chester Council and P v Surrey County Council* [2014] UKSC 19, [2014] AC 896.

<sup>6</sup> Health and Social Care Information Centre, *Mental Capacity Act 2005, Deprivation of Liberty Safeguards (England), Annual report 2014-15* (2015) and Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales, *Deprivation of Liberty safeguards: Annual Monitoring Report for Health and Social Care 2014-15* (2016).

was to recognise the individual's article 8 ECHR rights to private and family life, and provide protection for people whose rights were at risk, but who did not require forms of care and treatment which either restricted or deprived them of their liberty. The protective measures included confirmation that a proper assessment had taken place and care planning procedures had been instigated. There would also be rights to advocacy (or an appropriate person).

- 1.12 The restrictive care and treatment scheme provided the direct replacement for the DoLS. It applied to people lacking capacity to decide their living arrangements, and who were moving into, or already living in, care home, supported living or shared lives accommodation and where a deprivation of liberty or some other form of restrictive care or treatment was being proposed. Referrals for this scheme would be made to an Approved Mental Capacity Professional, who would be required to undertake an assessment, or arrange for an assessment to be completed by another professional (such as the person's allocated social worker or nurse), and then decide whether to authorise a deprivation of liberty.
- 1.13 Any person assessed as eligible for this scheme would be provided with a number of safeguards. For example, the person's ongoing care and treatment would be overseen by an Approved Mental Capacity Professional who would need to confirm that regular review meetings were taking place (involving the family), any conditions were being implemented, and an advocate (or appropriate person) and representative had been appointed and were providing ongoing support. The person (as well as others, such as family members and advocates) would have rights to seek reviews of the care and treatment and apply to the First-tier Tribunal to challenge the restrictive care and treatment.
- 1.14 The restrictive care and treatment scheme allowed for the authorisation of a deprivation of liberty in domestic and family settings, as well as in care home, supported living or shared lives accommodation. The deprivation of liberty would need to be authorised expressly by the person's care plan prepared, for example, pursuant to the Care Act 2014 of the Social Services and Well-being (Wales) Act 2014 and the Approved Mental Capacity Professional would be required to confirm that objective medical evidence and other article 5 ECHR requirements had been secured.
- 1.15 A separate scheme was proposed to authorise deprivation of liberty in hospital and palliative care settings. The person could be deprived of liberty for up to 28 days based on the report of a clinician (and further certified by an independent doctor). During this period, a named clinician must be appointed, and the person would have rights to advocacy (or an appropriate person). The person (as well as others, such as family members and advocates) would have rights to seek reviews of the treatment plan and apply to the First-tier Tribunal. Deprivations of liberty beyond 28 days would require the authorisation of an Approved Mental Capacity Professional.
- 1.16 To address the interface between protective care and the Mental Health Act 1983, we provisionally proposed a new mechanism would be introduced under that Act to enable the admission to psychiatric hospital of people who lack capacity, need to be deprived of liberty in their best interests and are not

objecting to their care and treatment.

- 1.17 We also proposed that the Coroners and Justice Act 2009 should be amended to provide that coroner's inquests are only necessary where the coroner is satisfied that the person was deprived of their liberty at the time of their death and that there is a duty under article 2 of the ECHR to investigate the circumstances of that individual's death.

## **PUBLIC CONSULTATION**

- 1.18 During our four month public consultation we attended 83 events across England and Wales. These events covered a wide audience, including service users, patients, family members and other unpaid carers, health and social care professionals, academics, lawyers, service providers, regulatory bodies, and voluntary, charitable and campaigning organisations. At each of the consultation events we attended, we received a wide range of views on various different aspects of our proposals.

- 1.19 This was one of the most extensive public consultation exercises undertaken by the Law Commission and we benefitted greatly from the active involvement of a wide range of participants at consultation events. As a general observation, we were struck by the widespread support for our project and the need to reform this area of law as a matter of priority.

- 1.20 We received 583 written responses to the consultation paper, from a range of different individuals and organisations. These included:

- (1) 263 from local authorities (including corporate responses on behalf of the local authority and personal responses from individuals working within local authorities);
- (2) 206 responses from health organisations (including NHS bodies, personal responses from health care staff and independent health services);
- (3) 152 from private individuals (including patient, service users and family members and other unpaid carers);
- (4) 67 from independent advocacy organisations and individual advocates;
- (5) 60 responses from legal bodies (including law firms, professional associations, and personal responses from barristers and solicitors);
- (6) 49 from best interests assessors;
- (7) 43 from academia (including universities, academic research organisations and personal responses from academics);
- (8) 42 from mental health groups such as charities, specialist psychiatric service providers, and individual professionals (for example, psychiatrists, Approved Mental Health Professionals and clinical psychologists);
- (9) 42 from end of life and palliative care organisations, including hospices

and charities;

- (10) 26 from social housing organisations;
- (11) 19 from health and social care providers; and
- (12) 13 from members of the judiciary (including Court of Protection judges, members of the mental health tribunal and judges of the Family Division of the High Court).

1.21 We are grateful to all those who took the time to respond to our consultation paper. Our detailed analysis of the responses will be published at the same time as the final report and draft legislation. The analysis presented below is only a brief summary of certain key areas, and does not attempt to present the range of opinions that we received.

### **Key messages from consultation**

- 1.22 The main strengths of protective care were perceived to be its emphasis on prevention and improving mainstream health and social care practice, and the location of managing restrictions and deprivation of liberty within the wider health and social care system. Consultees noted that the use of assessments and reviews produced under existing legislation, such as the Care Act 2014 and section 4 of the Mental Capacity Act, would be an important way of avoiding duplication and promoting improved outcomes. Social workers, for example, felt that the principles of protective care resonated with social work values and good practice.
- 1.23 Many felt that the proposals would streamline the process of obtaining authorisations and enable a person-centred approach. There was general support for the removal of the requirement of six separate assessments in every case (and in particular the automatic medical assessment). There was also widespread agreement that existing care plans should provide the authority for deprivation of liberty, rather than a separate system of bureaucracy. Some welcomed the greater emphasis on professional discretion over legalism, and the ability to utilise the skills of mainstream professionals who are already working with the relevant person.
- 1.24 Many welcomed the introduction of a graduated scheme which offered safeguards to people with impaired decision-making capacity at one end of the spectrum, through to the deprivation of liberty of adults who lacked decision-making capacity at the other. There was strong support for the inclusion of article 8 ECHR rights, and the move towards a more individual-focused approach rather than focusing exclusively on the notion of deprivation of liberty.
- 1.25 Some consultees felt that the idea of different tiers or levels of safeguards would be cumbersome and overly complex, generating significant additional financial costs and bureaucracy. Further, there was concern that it would undermine the common language and understanding of the DoLS across all settings. It was argued by some that, in principle, the same safeguards should be made available to all people who lacked decision-making capacity, regardless of the type of accommodation in which they were accommodated.

- 1.26 Others considered that the complexity of the proposed scheme was a logical reflection of the various contexts in which deprivation of liberty occurs (palliative care and intensive care settings were often mentioned in this context). It was argued that for most individuals, family members and professionals – who will generally interact with the proposed scheme within one particular setting – the proposed scheme would be considerably less complex and bureaucratic than the DoLS.
- 1.27 Many felt that the distinction between supportive and restrictive care was without meaning given the apparent lowering of the threshold for deprivation of liberty following the *Cheshire West* judgment. In other words, it was argued by some that almost all people who lack capacity and who were living in a care home or some other form of care environment will satisfy the acid test that we referred to in paragraph 1.7 above. A number of consultees were concerned that supportive care merely duplicated existing legal requirements and good practice, and was therefore unnecessary.
- 1.28 Most consultees supported our proposal to introduce a right to apply to the First-tier Tribunal. Those who were in favour of this proposal focused their support around three central themes: the efficiency gains of a tribunal system, its accessibility for users and its flexibility and simplicity. However, there was some support for maintaining the role of the Court of Protection, particularly from the Court’s judiciary and legal practitioners.
- 1.29 The notion of a bespoke system for hospitals was supported by a majority of consultees. Many agreed that it recognised the different context of deprivation of liberty in a hospital where patients are often discharged before the DoLS assessment has been completed – compared to the context of long-stay care homes. It was also argued that currently in hospitals there was limited awareness of the DoLS process amongst NHS staff, since this is seen as a local authority matter, and that our proposal would ensure that health workers would become active partners. Others felt that the hospital scheme would undermine multi-agency working and force services into “silos” when dealing with deprivations of liberty. A number of consultees were concerned that NHS staff would be allowed to deprive patients of liberty without any oversight from a social worker or other non-medical assessor, and therefore wanted the involvement of the Approved Mental Capacity Professional in every case. Some felt that the 28 day period was too long for a deprivation of liberty in hospital, while others argued it was too short and would generate unnecessary re-assessments.
- 1.30 A majority of consultees agreed with our proposed new admission mechanism under the Mental Health Act. Several consultees felt that our proposal would clarify the law and introduce much-needed certainty into decision-making. Many practitioners described difficulties that currently arise at the interface with the Mental Health Act. We were told about stand-offs between mental health clinicians and DoLS assessors over which regime should be used to detain the patient. Those who disagreed with the proposal frequently mentioned the stigmatisation conferred by “sectioning” under the Mental Health Act. Others were concerned that compliant incapacitated patients might be denied important safeguards, such as entitlement to free after-care services under section 117 of the Mental Health Act. A number of consultees stated their preference for the

“fusion” of the Mental Health Act and Mental Capacity Act into a single legal framework, similar to the Mental Health Bill in Northern Ireland.

- 1.31 We also received many responses to our provisional proposals regarding coroner’s inquests. The current law – which requires an inquest where a person dies while under a DoLS, even if the cause of their death was entirely natural – was seen to be causing unnecessary work for coroners and upset to families. We received reports, for example, of police arriving at the deceased’s deathbed; one consultee reported their impression of a “crime scene”; another referred to issues over whether the deceased’s body should be taken to the official mortuary rather than by the family’s preferred funeral director.
- 1.32 Many consultees pointed to the impact of the current economic climate on the public sector, especially in respect of NHS and care services. A significant number of local authorities reported that they are failing to cope with existing demands, not just those imposed following *Cheshire West* but also those arising from the introduction of the Care Act, an aging population, and the national living wage. Many reported being forced to reduce budgets significantly. Some consultees felt that our proposals had underestimated this economic reality, and that protective care unrealistically expanded the remit of statutory services by, for example, drawing in article 8 ECHR matters as well as article 5 of the ECHR, and expanding rights to advocacy and professional roles.
- 1.33 Finally, a significant number of consultees argued that any system which is based on *Cheshire West* will be unsustainable. It was argued that the acid test defies common sense, the most frequently quoted examples being end-of-life care and intensive care units. Most concerns related to the practical implications of *Cheshire West*. Local authorities reported significant increases in the numbers of referrals locally (often above the tenfold national figure), widespread non-compliance with time-scales for assessments and many “low-level” or “community” cases being left unassessed. Many queried why the Law Commission was not seeking to legislate away the acid test.

## **INTERIM CONCLUSIONS**

- 1.34 Consultation has confirmed that there is a compelling case for replacing the DoLS. Most consultees perceived the DoLS to be overly technical and legalistic and, more significantly, to have failed to deliver improved outcomes for people who lack capacity and their families and other unpaid carers. The DoLS were not designed to deal with the increased numbers of people considered to be deprived of liberty following *Cheshire West*. The financial pressures weighed heavily on the minds of consultees. The widespread reports of backlogs, breached statutory timescales and increased workloads mean that any notion that the existing system can be patched up to cope even in the short term, in our view, is not sustainable.
- 1.35 Most consultees welcomed the general thrust of our provisional proposals and indicated support for the core elements of protective care. But a number of concerns were raised about the financial implications. Many felt that protective care, whatever its merits, would be too costly to implement, particularly in the current economic climate, and that any new scheme needed to focus much more



on securing cost efficiencies and value for money.

- 1.36 There is some force in these arguments. Nevertheless, we do not accept that safeguards should be reduced to the bare minimum or that we should not consider any reforms that may generate additional costs. We remain committed to the introduction of a new scheme that delivers article 5 ECHR safeguards in a meaningful way for the relevant person and their family. Moreover, there are some reforms that remain fundamental to our new scheme and will need to be properly financed, such as rights to advocacy.
- 1.37 Nevertheless, it is our view that the new scheme must demonstrably reduce the administrative burden and associated costs of complying with the DoLS by providing the maximum benefit for the minimum cost. With this in mind, we have therefore concluded that the new scheme should focus solely on ensuring that those deprived of their liberty have appropriate and proportionate safeguards, and should not seek to go as widely as the protective care scheme.
- 1.38 We propose to recommend a more straightforward, streamlined and flexible scheme for authorising a deprivation of liberty. The responsibility for establishing the case for a deprivation of liberty will be shifted onto the commissioning body (such as the NHS or local authority) that is arranging the relevant care or treatment, and away from the care provider. This should provide greater clarity, since the body directly responsible for the proposed deprivation of liberty would need to provide evidence to support its case. The required evidence would include a capacity assessment and objective medical evidence of the need for a deprivation of liberty on account of the person's mental health condition. The commissioning body would also be required to undertake certain steps such as arranging for the provision of advocacy (or assistance from an appropriate person) and consulting with family members and others.
- 1.39 All those deprived of liberty would be eligible for safeguards to secure the protection of their rights under article 5 of the ECHR. For example, all those deprived of their liberty (as well as others, such as family members and advocates) would have rights to seek reviews of their deprivation of liberty and bring legal proceedings to challenge the deprivation of liberty. There will also be comprehensive rights to advocacy.
- 1.40 We also want to avoid unnecessary duplication in the new scheme by enabling the commissioning body to make use, where one exists, of the person's existing care plan under the Care Act or the Social Services and Well-being (Wales) Act. Similarly, we want to ensure that existing review processes under that legislation can be used for the purpose of reviewing deprivations of liberty. For similar reasons, we do not intend that the commissioning body should always be required to carry out fresh assessments to be carried out. It should be open to the commissioning body to rely on existing assessments (where appropriate).
- 1.41 By way of amendments to the rest of the Mental Capacity Act, we will also seek to maintain, as much as possible, the article 8 ECHR protections that were contained in the supportive care elements of the scheme, but in such a way as to minimise the demand upon services. These amendments will be aimed primarily at ensuring that there is proper consideration, in advance of the decision being made, of the necessity of removing individuals from their own home and placing

them in institutional care in the name of their best interests. The failures of public bodies in this regard have been evident in high-profile cases such as *London Borough of Hillingdon v Neary* and *Essex County Council v RF*.<sup>7</sup> The amendments would also aim at giving greater priority to the person's wishes and feelings when a best interests decision is being made, and qualifying the immunity from legal action in respect of best interests decisions under section 5 of the Mental Capacity Act so as to provide additional procedural safeguards in respect of certain key decisions by public authorities.

- 1.42 In addition we are considering whether a defined group of people should receive additional independent oversight of the deprivation of their liberty, which would be undertaken by an Approved Mental Capacity Professional. Owing to the vast number of people now considered to be deprived of their liberty following *Cheshire West*, it would not be proportionate or affordable to provide such oversight to all those caught by article 5 of the ECHR. Whilst we are still working to develop the precise criteria that would operate to identify this group, we envisage that this group would consist of those who are subject to greater infringement of their rights, including, in particular, their rights to private and family life under article 8 of the ECHR.
- 1.43 In these cases, the commissioning body would be expected to refer any such proposal to an Approved Mental Capacity Professional, accompanied by the relevant assessments (such as the capacity assessment) and the medical evidence required by article 5 of the ECHR. The role of the Approved Mental Capacity Professional would be to agree or not agree to the proposed deprivation of liberty. Their role would not extend to ongoing reviews and the monitoring of cases.
- 1.44 In the light of our revised approach, we do not consider that there is the same necessity to establish a bespoke general hospital scheme. We consider that our new system is sufficiently clear and straightforward to apply in any setting where a deprivation of liberty for the purposes of article 5 of the ECHR may occur, including hospitals, care homes, supported living and shared lives accommodation, and domestic and private settings.
- 1.45 The interface between the DoLS and the Mental Health Act generated significant debate. Consultation has confirmed our view that the new scheme should not attempt to maintain parallel legal regimes for detaining people for mental health assessment and treatment in psychiatric and other hospitals. Our scheme will therefore not be used to authorise deprivation of liberty in such cases. But we are persuaded that there should be no additional mechanism inserted into the Mental Health Act to cater for compliant incapacitated patients. The underlying policy aim of the provisional proposal can, instead, be achieved by providing that, if such patients are to be admitted to hospital (general or psychiatric) for purposes of assessment and treatment for mental disorder, their admission should be on the basis of the existing powers of the Mental Health Act.
- 1.46 We have also concluded that the Coroners and Justice Act 2009 should be amended to remove our proposed scheme from the definition of state detention.

<sup>7</sup> *London Borough of Hillingdon v Neary* [2011] EWHC 1377 (COP), [2011] 4 All ER 584 and *Essex County Council v RF* [2015] EWCOP 1.

In conjunction with the Department of Health's proposals for a medical examiner system, this will mean that deaths of people subject to our new scheme are reported to medical examiners, who will be under a duty to make enquiries and refer the death to a coroner if the medical examiner forms the opinion that the death was attributable, amongst other matters, to a failure of care.<sup>8</sup> The coroner will have the power to conduct an inquest in an appropriate case but will not be obliged to do so.

- 1.47 At consultation we provisionally proposed that the First-tier Tribunal should review cases under our new scheme, thereby replacing the role of the Court of Protection. This proposal was supported by a significant number of consultees. We were told that the advantages of a tribunal system included its accessibility, informality and speedy decision-making. But others pointed to the existing levels of knowledge and expertise in the Court of Protection and the difficulties of demarcation or overlap with the remainder of the Mental Capacity Act if a tribunal jurisdiction was introduced. We have not yet reached a final decision and will be considering our position further over the coming months.
- 1.48 Finally, perhaps the issue that provoked most debate at consultation was the nomenclature associated with the DoLS. Most consultees felt that the term "deprivation of liberty safeguards" was at best unhelpful and, at worst, meant that people were being denied access to legal rights. Some consultees were similarly critical of our proposed new terminology, including the label "protective care". A number of consultees suggested the name "liberty safeguards", whilst the next favourite was "capacity safeguards". However, there was no consensus on the terminology that should be adopted. Therefore we invite further views (by 23 June 2016) on the name that should be given to the new scheme. Please send your suggestions to [Olivia.Bird@lawcommission.gsi.gov.uk](mailto:Olivia.Bird@lawcommission.gsi.gov.uk).

25 May 2016

<sup>8</sup> Department of Health, *Introduction of medical examiners and reforms to death certification in England and Wales: policy and draft regulations* (2016).