



In this special report, we set out a series of perspectives on the Mental Capacity (Amendment) Bill in advance of the first day of Committee stage on 5 September.

We summarised the bill in our [July report](#). Lord O’Shaughnessy, Parliamentary Under Secretary for Health (Lords) has provided a [letter](#) to peers setting out matters following its second reading in Parliament, and numerous peers have tabled [amendments](#), focusing, in particular, on issues around care homes, necessity and proportionality (and its relationship to best interests) and advocacy.

In the balance of this report, we set out perspectives from Neil and Tor, along with those sent to us in response to our request in our ‘end of term’ email in July. We do not pretend that these cover all possible perspectives, and are aware that many organisations either have or will be preparing briefings (by way of example, the ADASS/LGA position can, for instance, be seen [here](#)). We hope, though, that the perspectives gathered here will further help inform debate upon this vitally important Bill.

Note, Alex’s contribution to this Report has been limited to editing the material received into house style; his role on the independent Review of the Mental Health Act 1983 means that he is precluded from taking part in the current debates (although not precluded from taking a keen interest therein!).

Editors

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The picture at the top, “*Colourful*,” is by Geoffrey Files, a young man with autism. We are very grateful to him and his family for permission to use his artwork.

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All views expressed here are expressed in a personal capacity and (where relevant) not to be taken as representing the views of the body employing the relevant individual.

Neil Allen (Barrister, 39 Essex Chambers)

Watering down the right to liberty

The Mental Capacity (Amendment) Bill 2018 will replace DoLS and the Court of Protection equivalent. It cherry picks bits of the Law Commission’s (‘Commission’) 2017 proposal but fundamentally departs from it in many respects. That proposal derived from 83 nationwide events and 583 written responses from interested persons and organisations. But the provisions of the government’s 2018 Bill are very different. This paper provides a legal analysis of some of those provisions to inform their development during the forthcoming parliamentary debates. It considers the 2017 proposal, the evidence before the [Joint Committee on Human Rights](#) (‘JCHR’), the [2018 Bill and its explanatory notes](#), and a [letter of clarification](#) dated 24 July 2018 from Lord O’Shaughnessy (‘the letter’), the Parliamentary under Secretary of State for Health.

Terminology

The letter explains that LPS is very much a second stage, the first being a “clinical decision” taken that the relevant care/treatment is in the person’s best interests. It is important going forward to avoid such terminology as best interests is *not* a clinical

decision. The language of the law (and the Code) makes a difference to its use. The Bill retains the language of “deprivation of liberty” and “authorisations”. Many dislike the former term. But, to be fair, the difficulty in not referring to it is that the law needs to be sufficiently explicit in what it is dealing with where Article 5 is concerned. The proposed colloquial name is “liberty protection safeguards” rather than “deprivation of liberty safeguards” which is an improvement. But including “protection” risks care providers being unduly risk-averse, so perhaps “liberty safeguards” might better capture the true essence of what the Bill aims to achieve.

The current “detained resident” will become the “cared-for person” whose current “place of detention” will become a “particular place”. Amongst the “authorisation conditions” (rather than “qualifying requirements”), the current “any disorder or disability of the mind” will be replaced by “unsound mind”. And the “relevant person’s representative” will become their “appropriate person”.

Scope of LPS

Similar to DoLS, LPS “does not apply to the direct delivery of the care and treatment” as this is covered by MCA ss5-6. Rather, it applies to arrangements enabling that care or treatment to be provided. Some might consider this line to be rather thin. LPS is very much a one-size-fits-all approach. It applies to deprivations of liberty occurring anywhere, including hospitals, care homes, supported living

and shared lives schemes, domestic and private settings. However, contrary to the Law Commission's proposal and the JCHR evidence, LPS only applies to those aged 18 and over, to the exclusion of 16- and 17-year olds. It may well be that the government decides to await the Supreme Court's *Birmingham* decision (being heard in October) before deciding whether to lower the age limit.

DoLS focuses on what happens in a place of detention, whereas the Bill adopts the Commission's focus on "the arrangements" giving rise to the deprivation of liberty. Those arrangements could relate, for example, to residing in "a particular place" (whereas the Commission referred to "one or more particular places"), receiving care or treatment at "a particular place", or the means and manner of transporting the person "between places".

The Bill does not therefore say so explicitly but, according to its explanatory notes, the legislation "clarifies that the arrangements may apply in more than one setting", such as a care home to a planned hospital admission. And the notes say that it is intended that the authorisation record can travel with the cared-for person between different settings. But it should be noted that arrangements giving rise to a deprivation of liberty in setting A can be very different to those in setting B. Indeed, the intensity of restrictions in the residential side of a care home can be very different to the nursing side of the same care home.

The LPS trigger

"Deprivation of liberty" is retained as the trigger for safeguards with no statutory definition. The threshold will continue to be governed by case law and, ultimately, the Strasbourg Court (yes, even after Brexit!). The evidence given to the JCHR showed a lack of consensus as to whether Parliament should define the term. But the lack of statutory definition should come as no surprise given that any hope of legal certainty in borderline cases is little more than a search for the

philosopher's stone. Moreover, a statutory definition would be pointless because any legislation would have to be construed by the courts so as to comply with Article 5. Parliament would have to provide a trigger that was pitched below the Article 5 threshold so as to avoid otherwise unlawful deprivations of liberty. The judiciary are likely to continue to err on the side of caution, keeping the bar low, and more case law seems likely, particularly in relation to domestic and private settings.

Responsibility for securing the safeguards

The Bill provides a slightly different process, depending on whether the liberty deprivation will be in a care home or not. The reason for the difference given in the letter is to "incentivise the ownership of mental capacity and deprivation of liberty within all care providers and workforce". And "the opportunity to ensure that the workforce plays a full role in the care and treatment of people, and any associated deprivation of liberty, is too important to miss". Considering the issues at the point of care planning "tackles a major shortfall of the current system".

The aim is laudable. After all, there is concern that Article 5 (not to mention the MCA generally) is not that well embedded in day-to-day care planning. But this radical change from the Commission's proposal is likely to provoke much debate. Moreover, it is not clear why care homes have been singled out. If the aim is to better embed the law within all care providers, why have a separate procedure for just care homes?

(i) Care homes

A care home manager will be required to provide a statement to the responsible body that:

- (a) The person is 18 or over;
- (b) The arrangements give rise to a deprivation of liberty (with reasons);

- (c) The arrangements are not excluded by the MHA provisions;
- (d) The cared-for person has been determined to lack the relevant capacity, is of unsound mind, and the arrangements are necessary and proportionate;
- (e) Consultation has been carried out;
- (f) Appropriate person and/or advocacy requirements have been carried out;
- (g) Whether the person does/not wish to reside or receive care/treatment (with reasons).

The manager is responsible for doing or organising what is necessary to achieve (a)-(g). S/he arranges the assessments for the criteria for detention. S/he consults necessary consultees and secures LPS representation/advocacy. S/he identifies whether there is an objection. One may legitimately question whether it is appropriate for a proposed detainer to be doing so much in arranging the proposed detainee's detention. And, for that matter, whether care home managers are going to be willing and able to meet these significant expectations. The half-day training estimate for managers is beyond optimistic.

Accompanying the care home manager's statement must be a record of the capacity and unsound mind assessments (but bizarrely not the necessity and proportionality determination which is a glaring omission), evidence of the consultation undertaken, and a pre-prepared draft authorisation record which specifies all arrangements seeking authorisation, the length of authorisation sought, a programme for its review, details as to how the appropriate person/advocacy provisions have been complied with, anything else LPS requires to be specified, and any other information.

Someone (not clear who) not involved in the cared-for person's day-to-day care/treatment will conduct a pre-authorisation review, but the adequacy of what is likely to be a desktop exercise is open to doubt. The review involves reading the care home

manager's statement, the information on which it relies, and determining whether it is reasonable for the local authority to conclude that the authorisation conditions are met. It is perhaps akin to the current role of the DoLS authoriser. It is a form of independent scrutiny but it is far removed from what is happening on the ground. It is very different to securing independence in the *assessment* of the detention criteria.

(ii) Places other than care homes

The procedure here is very similar, except that it is the responsible body – rather than a care home manager – that will be doing or organising what is necessary to evidence (a)-(g) above. So either a hospital manager, a CCG/Local Health Board (if the arrangements are carried out mainly through NHS continuing health care), or a local authority will do this. Similar concerns arise here in terms of the lack of independence in the assessment process.

It is worth noting that where the pre-authorisation review is not undertaken with AMCP involvement (ie the person does not object), there is no statutory obligation for anyone to consult with the cared-for person themselves. Some might consider this to be a serious oversight giving rise to human rights concerns. Contrast the Bill with the COPDOL11 process which stresses the importance of consulting with P. Indeed, it may well be that the Bill's provisions as drafted fail to represent the government's intention. According to the letter:

“A major criticism of the current DoLS system is that the voice of the individual isn't heard. This is why we want to ensure a wide range of people to be consulted with (including the person themselves), meaning the person's voice is at the heart of the process.” (my emphasis)

If that is the intention, it must be in the legislation.

Approved mental capacity professionals

This is a new role but is based upon that of the current best interests assessor, “most of whom we

expect will ‘convert’”, according to the letter. The AMCP is a key safeguard as they will undertake independent assessments and can veto the proposed arrangements. The Bill requires local authorities to make arrangements for AMCPs to be approved and to ensure there are enough of them. The Commission proposed that AMCPs would be acting on behalf of local authorities (similar to AMHPs and the MHA s.114(10)). But the Bill does not say either way. If AMCPs are not required to act on behalf of local authorities, this may provide scope for independent AMCPs to operate without having to be employed by local authorities. Nor is there any requirement (as contained in the Commission’s proposal) for local authorities to appoint someone to manage the conduct and performance of AMCPs. And there is no requirement for those managers to report to the director of adult social services etc. According to the letter, “Internal governance arrangements are a matter for local authorities, but we intend to provide guidance to assist them in the Code of Practice”.

An *independent assessment* of the detention criteria will only take place by an AMCP if “it is reasonable to believe” that the cared-for person does not wish to reside or receive care/treatment at a particular place. In short, the person’s objection triggers AMCP involvement. The AMCP must meet with the person if it appears to the AMCP to be appropriate and practicable to do so (something that care home managers need not do). And AMCPs must consult with anyone named by the cared-for person, those engaged in their care or interested in their welfare, any LPA/EPA, deputy, and any appropriate person and any IMCA.

The evidence to the JCHR said that limiting access to the skills and knowledge of the AMCP to only those who object or pose a risk to others ran the risk of removing the universality of access to human rights. And it was suggested that for many people the involvement of an independent professional with the power to achieve a speedy resolution would be more valuable than a largely theoretical right of appeal to a court.

Safeguards before, not after

What is welcome is the emphasis on securing safeguards before the deprivation of liberty begins. A potential deprivation of someone’s liberty certainly needs to be identified and authorisation sought at the point when a care provider is determining whether it feels able to meet a person’s needs. Not months after P was first deprived of liberty. The JCHR evidence showed a keenness to ensure safeguards *beforehand*, similar to the timing of safeguards for children coming in to local authority care. LPS achieves this. But so too – on paper – does DoLS; yet, in practice, rarely is DoLS secured in advance.

LPS in fact waters down the current requirements and gives rise to potential Article 5 concerns. Currently, a DoLS authorisation can be requested up to 28 days before the detention is due to begin, with all 6 assessments having to be completed within 21 days. Under LPS there must similarly be pre-authorisation by the responsible body but there are no legislative timescales for completing the assessments. Instead the new MCA s.4B (which principally replaces urgent DoLS authorisations) authorises D to take steps which deprive P of liberty if that is necessary for life-sustaining treatment or to prevent a serious deterioration in P’s condition (a “vital act”) in any of these circumstances:

- (a) If a decision is being sought from the court (with no timescale); or
- (b) Whilst the responsible body is carrying out the LPS functions (with no timescale); or
- (c) A care home manager has notified/taken reasonable steps to notify the responsible body of the need for IMCA or appropriate person (with no timescale); or
- (d) There is an emergency, that is – *inter alia* – when it is not reasonably practicable before depriving liberty to do 1, 2 or 3 (with no timescale).

To put it bluntly, D can deprive P of liberty for as long as there is an LPS backlog without limit of time. Contrast this with DoLS where urgent authorisations can last for up to 7 days, during which all assessments must be completed, extendable by a further 7 if there are exceptional circumstances. The lack of statutory timescales give rise to a very real risk of arbitrary detention, contrary to Article 5. For the European Court's decision in *HL v UK* (the 'Bournewood case') was clear there must be a "formalised admission procedure" and warned against there being "no limits in terms of time" attached to a deprivation of liberty. A procedure prescribed by law requires timescales otherwise arbitrary "interim" detention results. In my view, s.4B as drafted is potentially open to abuse. Moreover, where does this leave those Ds with Ps who need to be deprived of liberty but not to prevent a serious deterioration in their condition? Where the deprivation is merely necessary and proportionate?

Advocacy

The Bill's provisions are somewhat confusing in this regard. An IMCA is required if the cared-for person:

- (a) has capacity to consent to being represented and supported by an IMCA and requests one; or
- (b) lacks such capacity but the care home manager or responsible body is satisfied that being represented and supported by an IMCA is in cared-for person's best interests.

But there is no IMCA requirement if the care home manager or responsible body is satisfied that there is an "appropriate person" (eg family member, friend etc). A person is not appropriate unless they are suitable "to represent and support the cared-for person", consent to so acting, and are not engaged in providing care/treatment in a professional capacity. And they will not be suitable if the cared-for has capacity and does not consent to them acting or lacks capacity and it is not in their best interests.

Pausing there, this raises a host of issues including:

- If there is no appropriate person and P lacks 'representation capacity', will it automatically be in their best interests to have an IMCA or is there still a discretion not to instruct one?
- Is it appropriate for care home managers and responsible bodies to be using a best interests approach to IMCA involvement? It could leave representation (or lack thereof) open to abuse.
- What form of representation and support does the appropriate person or IMCA provide? Does it go beyond the role of the current DoLS representative? Is it confined to LPS matters?
- What does "professional capacity" mean? The Commission's proposal also referred to "for remuneration". For example, could a shared lives carer be an appropriate person or do they act in a professional capacity which would render them unsuitable?

Paragraph 37 of the Bill is interesting. The responsible body must take all reasonable steps to appoint an IMCA to support the appropriate person if either (a) that person has capacity to consent to being so supported and requests an IMCA, or (b) that person lacks such capacity but IMCA support for the appropriate person is in the "cared-for person's best interests". This seems to be a role similar to the current s.39D IMCA role under DoLS. But it raises all sorts of issues. First, if the appropriate person lacks 'IMCA support capacity', surely they are not an appropriate person for the cared-for person? Second, the focus on capacity and best interests throughout these advocacy provisions risks significant uncertainty and could be open to abuse as the detainer is considering whether it is in the best interests of the detainee to have an independent advocate to challenge the detainer.

The authorisation conditions

LPS replaces DoLS' 6 conditions (18+, incapacity, mental disorder, no refusals, eligibility, best

interests consisting of DOL, best interests, necessity and proportionality)) with just 3 conditions (incapacity, unsound mind, necessity and proportionality). Before examining them, there is a striking lack of detail in the Bill regarding the assessors. Some detail no doubt will be given in either secondary legislation (as proposed by the Commission) and/or the new Code of Practice. But, unlike the Commission's proposal, the Bill itself does not even require more than one assessor.

The letter agrees that "assessments should be completed by at least two assessors. We will outline how assessments will work operationally in the Code of Practice." Who will they be? What qualifications will be needed? And (as required in the Commission's proposal) will the assessors be independent from each other? According to the letter, "The Code of Practice will set out the appropriate skills and qualifications for those carrying out these assessments. With regards to capacity assessments we want to ensure that all relevant health and care workers can play a role where appropriate." Relegating important detention detail to a Code of Practice is attractive in terms of providing flexibility and enabling changes to be comparatively easily made. But it is risky in Article 5 terms because a Code can be departed from where there are cogent (documented) reasons for doing so. And this could give rise to a risk of arbitrariness.

(i) Mental incapacity

This considers whether the cared-for person "lacks capacity to consent to the arrangements". The "arrangements" are those for enabling care or treatment that give rise to a deprivation of liberty. Focusing on "consent" is interesting as it subtly implies that consenting to, rather than refusing, the arrangements is called for. A more neutral term might be "lacks capacity to decide whether to receive the arrangements". Fluctuating capacity is to be addressed in the Code.

(ii) Unsound mind

There is nothing in the Bill to identify who should

assess this. But this condition comes under a heading referring to "medical assessments" which suggests it will be a medic. In Article 5, a finding of unsound mind requires objective medical expertise, such as a psychiatrist or general practitioner. And in domestic law it could also come from a psychologist.

The term "unsound mind" has its critics. The JCHR evidence from Lancashire County Council, for example, showed general practitioners refusing to use the term when required by the Court of Protection COPDOL11/*Re X* process. The difficulty, of course, is that the term is used by Article 5(1)(e), upon which LPS is based. And the broader the notion of deprivation of liberty, the more "unsound mind" is pressured to capture the circumstances to ensure the care arrangements fall within the Article's ground for their justification.

The Royal College of Psychiatrists' evidence to the JCHR recommended its replacement with "any disorder or disability of mind". It noted that it is difficult to understand how those unconscious due to intoxication, with "locked-in" syndrome, or in a persistent vegetative or minimally conscious state, could be encompassed by the "unsound mind" concept but not by the "any disorder or disability of mind" concept. In any event, the College stated, no-one with these conditions are deprived of liberty by the State; they are deprived by their condition and would be permitted to leave the moment they were physically able to do so.

(iii) Necessary and proportionate

This determination must be made by a person "who appears" to the care home manager or responsible body "to have appropriate experience and knowledge to make the determination". So who will that be? The condition considers whether the "arrangements are necessary and proportionate". And that is it. Necessary for what? Proportionate to what? This, in my view, is a fundamental problem with LPS and risks giving rise to arbitrary detention contrary to Article 5. Contrast this with the Commission's proposal which considered necessity

and proportionality by reference to the likelihood and seriousness of harm occurring (a) to the cared-for person and/or (b) other individuals if the arrangements were not in place.

There will be debate as to the extent to which harm to others should feature. According to the letter, “The Mental Health Act [Wessely] review is considering whether harm to others should be expressly included as part of the necessary and proportionate test”. This fundamental LPS condition certainly cannot be allowed to exist in a factual (and legal) vacuum. It must be anchored to something to satisfy the requirement for legal certainty.

The Authorisation

Unlike the Commission’s proposal, there is nothing in the Bill requiring responsible body reviewers to consider the cared-for person’s behaviour, wishes, feelings, views, beliefs and values. Consideration is only required when the authorisation is subsequently being reviewed. Interestingly, if there is *any* change in *any* of the authorised arrangements, the responsible body must revise the authorisation record. Compare this with the COPDOL11 process, whereby the court authorises an intensity of liberty deprivation; anything less restrictive is permissible but anything more restrictive requires a revision. It would be nonsensical for responsible bodies to be revising the authorisation record when less restrictive arrangements are able to be provided and would lead to unnecessary micromanagement.

The authorisations can last up to 1 year, renewed for up to 1 year, and then renewed for up to 3 years. Could it be possible therefore to have, say, a one-month authorisation, renewed for one month, and then renewed for 3 years? If so, that would be open to abuse and leave the person without assessments for a lengthy period. There is nothing in the Bill as to who gets the authorisation record (in particular, the cared-for person) and the evidence in support.

The current provision for suspending a DoLS authorisation when P is detained under MHA s.2 has gone from LPS. Instead the authorisation record

ceases to have effect. So a new LPS process will presumably be required when the person is discharged from s.2. And there is no requirement to inform the cared-for person of the authorisation ceasing. The Bill merely provides that “any person likely to be carrying out the arrangements is notified”.

There are vague provisions around varying an authorisation. If there has been consultation and “the variation” is “reasonable”, the responsible body may vary. This could allow them to vary and increase the authorised period to the maximum. It presumably also enables them to vary the place where the liberty deprivation is occurring. A variation triggers a review. Somewhat bizarrely, therefore, the responsible body varies and then the responsible body reviews their own variation. It might make better sense if the review could take place before the variation is made, although there must be a degree of flexibility of course to adapt the arrangements to changing circumstances.

The authorisation specifies a programme for “regular reviews” which are done either by the care home manager or the responsible body. Importantly, aside from variations, other review triggers include a reasonable request made by a person with an interest in the arrangements, if the cared-for person becomes subject to the MHA (although para 31(3)(d) needs deleting as it repeats (c)), or the reviewer becomes aware of a significant change in the person’s condition or circumstances. Importantly there must also be a review if there was no AMCP pre-authorisation involvement and the reviewer becomes aware that the cared-for person does not wish to reside/receive care at the place. In that case, the reviewer must refer the case to an AMCP. But there is no requirement for a review if an AMCP pre-authorized and the person still objects. Presumably in this scenario the appropriate person/IMCA would challenge the authorisation via MCA s.21A.

Note therefore that the cared-for person is not given a legal right to request a review themselves. Instead

they must hope that either a person with an interest reasonably requests one, or the reviewer becomes aware of a significant change or their objection. Only at the review stage must the reviewer consider the person's wishes, feelings, views, beliefs and values. As stated above, why these are not ascertained and factored in to the earlier authorisation is a real concern. According to the explanatory notes, the purpose of reviews is "to ensure that authorisation records which travel with the person between different settings are reviewed by successive responsible bodies".

Eligibility

Disappointingly, the Bill retains the status quo. It rejects the Commission's proposal for hospitals, whereby if the purpose of admission was physical healthcare, the NHS body would authorise the DoL under the Commission's scheme. Whereas if the purpose was mental healthcare, the MHA will be used. In legal terms, this had the benefit of simplicity and would more effectively close the *Bournewood* gap. Instead, the confusion as to whether LPS or the MHA ought to be used in mental health wards is set to continue. But there might still be hope, as the Wessely review has been tasked with considering the interface.

Challenging authorisations

Significantly, the letter confirms that non-means tested legal aid will be available for LPS which is very welcome. At present, it is only available for those detained in hospitals and care homes, with legal aid elsewhere being means-tested. In future, *wherever* the person is being deprived of liberty, they will not experience the current injustice arising from the legal aid provisions.

What is not clear is whether there must be a review before a MCA s.21A challenge in the Court of Protection is brought. Presumably, like the current Part 8 process, it will not be a legal obstacle because LPS reviews will not comply with the person's rights under Article 5(4) which require access to a *court*.

What's missing?

A stark omission from the Bill is the need to consult with the cared-for person. Also notable by its absence in the authorisation conditions is any reference to best interests. No-one independent is required to check the decision made on behalf of P to enter into arrangements giving rise to their detention. It is worth recalling that the policy aim behind the decision in *Cheshire West* was to ensure that vulnerable people get *independent* periodic checks on whether the arrangements made for them are in their *best interests*. And, according to *Neary*, the current independent best interests assessment "should be seen as a cornerstone of the protection that the DOL safeguards offer to people facing deprivation of liberty if they are to be effective as safeguards at all". The Bill therefore fails to achieve that aim. Also, according to *G v. E* at para 64, "*the justification of detention in a case under the 2005 Act is not a medical decision but a decision for the court, to be made in the best interests of the person whom it is sought to detain*".

DoLS conditions appear to have gone. Under DoLS, hospital/care home managers must comply with DoLS conditions otherwise they have no defence to liability. And conditions can make a significant difference to P's life and happiness. But all hope is not lost as there may be scope within the Bill to address this, if only when an AMCP is involved. The Bill says that AMCPs can "take *any* other action, so far as it appears appropriate to the Approved Mental Capacity Professional to do so" to determine whether the authorisation criteria are met. What that action could be is not clear. But this broad wording could potentially encompass the equivalent of DoLS conditions and recommendations. And an authorisation could be withheld without compliance with any such action. But there is a lack of detail in the Bill as drafted.

Also absent is the other half of the Commission's proposal to amend the core of the MCA. For example, the need to positively "ascertain" – not just consider – P's wishes and feelings etc and give

“particular weight” to them does not feature in the Bill. According to the letter, the government believes that “a non-legislative approach can drive the behaviour and cultural change needed and we will work with the sector to further spread and support improved practice”. If improvement is not secured, then it will consider legislative change. Not amending the MCA’s core is an opportunity missed in terms of moving towards better CRPD compliance.

Absent too are the Commission’s proposed limitations to the defence to liability. In essence, the Commission’s approach would have required more in the way of evidence where significant Article 8 issues were at stake. According to the letter, health and care workers “should already record these decisions in care and treatment records”. The requirement would “merely generate extra paperwork at the expense of providing direct care”. Article 8 engagement and decision-recording will therefore be left to the Code which is most disappointing. Experience shows that such recording often does not take place adequately, or at all.

Also absent from LPS is the no refusals requirement for welfare LPAs, deputies and advance decisions to refuse treatment. The reason given is that these matters are already covered by the MCA in s.6(6) and 26. Rather than having regulations to strengthen supported decision-making as proposed by the Commission, the government again resorts to addressing this in the Code to bolster the second principle of the Act.

A new statutory Code of Practice is expected in Autumn 2019 and “will set standards and provide other detail”, such as “provision of information to the person”. Whether this should be left to a Code is open to debate. For Article 5(2) requires detention reasons to be provided. Both domestic and European jurisprudence requires the State to provide specific information to a person in simple, non-technical language that they can understand. It must contain the essential legal and factual grounds of

their detention to enable them, if they see fit, to apply to a court to challenge its lawfulness. If the person is incapable of receiving the information, those details must be given to their representative.

Watered Down Protection

It was an entirely foreseeable consequence of the *Cheshire West* decision. Without significant investment, relabelling a vast proportion of the disabled population as ‘deprived’ of their liberty would result in a race to the bottom. A search for the irreducible minimum that domestic law can get away with without breaching the European Convention. For all its faults, there can be no denying that DoLS provides weightier safeguards. Indeed, greater safeguards than the bare bones of Article 5. Whereas in future, more people look set to receive less protection.

Depriving liberty is a serious step in anyone’s life and calls for a corresponding intensity of scrutiny. To do otherwise would devalue the precious currency of liberty. We must always remember what the law is doing on the ground. It is authorising one citizen to detain another. And that carries risks. Risk of social isolation, institutionalisation, loss of independence and employment, restricted contact with the outside world, and the potential undermining of self-esteem and dignity. Such legislative power that derives from being authorised to detain another must be robustly counterbalanced by fair and proper safeguards. Otherwise safeguards designed to prevent abuse may unintentionally become the cause of it.

Victoria Butler-Cole (Barrister, 39 Essex Chambers)

Seven changes to the Mental Capacity (Amendment) Bill that the courts are likely to make unless Parliament gets there first

I have often wondered why obvious problems with legislation were not picked up before it was implemented. A lack of advance thought results in expensive legal challenges being required before

corrections are made, to the detriment of the public purse and the individuals whose rights are violated in the meantime. There is really no excuse in this case, since we have the thorough and thoughtful work of the Law Commission, and a host of caselaw (domestic and European) that tells us what Article 5 demands. We also know, not least from the recent decision of the Supreme Court in *An NHS Trust & Ors v Y & Anor* [2018] UKSC 46 that leaving important aspects of a legal framework to a Code of Practice is not a sensible plan. Here is my prediction of some of the problems with the Bill that will have to be corrected by the courts – for let it not be said that the fat-cat lawyers just waited for the test cases to roll in, rather than trying to get things right at the outset.

1. **CONSULTATION WITH THE CARED-FOR PERSON.** The spectacular failure to include an obligation to consult the very person whose liberty is being restricted, when authorising his or her deprivation of liberty, will be corrected at the first opportunity. The UNCRPD, Article 5 and Article 8 mandate such consultation, even though the s.4 duty to consult in respect of best interests decisions no longer applies as ‘best interests’ is not part of the LPS authorisation process. The simplest route is likely to be by interpreting the phrase ‘*any appropriate person*’ in paragraph 17(2)(e) as including, in all cases, the cared-for person themselves. The courts may also agree that permitting an AMCP to review a proposed authorisation without meeting P in person is not acceptable – the Bill says this is only necessary if ‘*appropriate and practicable*’. It is difficult to think of any circumstances in which not meeting the subject of the proposed authorisation might be appropriate, when the AMCP is tasked with checking capacity as well as the proportionality of the arrangements, and the current provision falls foul of the UNCRPD and existing ECtHR caselaw.
2. **INDEPENDENT ASSESSMENT.** The Bill fails to ensure adequate independence in the

administrative authorisation of a deprivation of liberty. Care home managers, the viability of whose business may depend on the income received in respect of detained residents, are authorised to carry out capacity assessments and to decide whether a deprivation of liberty is necessary and proportionate. Local authorities, whose decision it was to place the person in the particular setting that deprives them of their liberty, will then be asked to confirm that their own decision was indeed correct. The courts will take any opportunity to interpret ambiguities in the Bill in favour of independent assessment, to comply with the requirements of Article 5 and the guidance of the Supreme Court in *Cheshire West*, preferring to do so even if the Code of Practice permits a less rigorous approach.

3. **THREE-YEARLY RENEWAL.** If responsible bodies try to use the long-stop 3 yearly renewal provision in respect of a person with anything other than a degenerative condition such as dementia, the courts are likely to intervene to interpret paragraphs 27(a)(ii), 28(b)(ii) and 29(1)(b) as narrowly as possible. Capacity remains something to be assessed by reference to the provisions of the MCA, which means that it is decision and time-specific. A three-year old capacity assessment cannot be relied on with any confidence in respect of a person with a learning disability, an acquired brain injury, or any other non-degenerative mental impairment.
4. **ENTITLEMENT TO REVIEW BY AN AMCP.** The Bill provides that an AMCP becomes involved only where ‘*it is reasonable to believe that the cared-for person does not wish to*’ reside at the particular place or receive care or treatment there. This will be interpreted generously by the courts, as in the case of *RD* [2017] 1 WLR 1723, so that it will look to what the person would wish, if their views could be ascertained directly – for example where the cared-for person has difficulty with

communication, or where their behaviour indicates dissatisfaction (such as attempts to leave). Given the central importance of this safeguard and the difficulty many cared-for people may have in expressing an objection, the courts may also be persuaded to accept the view of a person interested in P's welfare about the appropriateness of the placement as a basis for triggering the involvement of the AMCP.

5. ACCESS TO THE COURT. The Bill is completely silent in respect of giving information to the cared-for person and others interested in their welfare about the LPS scheme and the methods of challenging an authorisation. This is such a fundamental aspect of protecting Article 5 rights – the very purpose of Article 5 being to ensure that arbitrary detention is avoided by enabling people to access an independent court or tribunal – that it must be included in the statute, not left to a Code of Practice. Duties to facilitate the exercise of Article 5 rights must be expressly spelled out and attributed to identified people or bodies.

6. ACCESS TO AN IMCA. The Bill says that whether or not an IMCA is needed is a best interests decision (which can in some cases be taken by a care home manager despite the obvious conflict of interest) and that having decided that an IMCA is needed, '*all reasonable steps*' must be taken to appoint one by the responsible body. That is not good enough – the ECtHR requires help to be given to people who are deprived of their liberty to exercise their right of access to the court, particularly where they have mental impairments and problems with capacity. Given that the Bill contains precisely no requirements for the cared-for person and their carers or relatives to be informed about the LPS system and the right of access to the Court of Protection (with non-means tested legal aid), the extremely weak provisions about access to IMCAs are unlikely to survive challenge.

7. CAPACITY ASSESSMENTS. The Court of Protection has a record of rejecting capacity assessments conducted by consultant psychiatrists with years of training in mental health and specifically in relation to the MCA. The Bill permits care home managers to assess capacity in this context. There is no way that this will withstand scrutiny by the court, and there are likely to be even more cases in which assessments of incapacity are overturned, as care home managers with little or no relevant training are required to carry out what can be a complex task.

Lorraine Currie (Local Authority MCA/DoLS lead)

Liberty? – Protection? – Safeguards?

I think everyone was shocked at the plot twist between the Law Commission draft Bill and this Bill. Guess what? The Care Home Manager did it! A surprise for most people and not covered at all in the extensive consultation carried out previously.

My concerns are about Rights, the position of public authorities being held accountable for the decisions of others, the conflict of interest between detainer and detainee and the capacity of care home managers to deliver.

There is a view that DoLS did not add any value to a person's life and was/is invasive and intrusive for families, overly burdensome and not cost effective. I don't share this view. Every person I've encountered subject to DoLS, at least someone independent of the place where they are detained has had a really good look at their situation.

The Best Interests assessment is focussed and thorough and the consultation is essential. Does it yield any fruit? For some the only fruit it yields is the independent oversight; for others there is more substantive fruit. This might be small changes suggested to the care home. It might be environmental. It might be looking at the person's hobbies and interests and accommodating these to

minimise their sense of detainment. Or it might be a wholesale decision that this is not the place for them. So I am sad because I do not, hand on heart, at this stage feel the new Bill delivers the same.

As I write, I wonder just how much of each of the key words are actually represented in this Bill.

Liberty: does it deliver anything in terms of Liberty? I have seen so many arbitrary decisions uncovered by the DoLS process, especially for those who fund their own care and are taken to care homes by relatives. Do I think this Bill which provides for the detainer to assess the detainee, the care home manager (who may also own and financially benefit from the care home) to assess whether this admission is necessary and proportionate, will prevent arbitrary detention? No I don't.

I believe that we will have a two-tier system. One for those in Supported Living etc. (who are more likely to be younger people, possibly with learning disabilities or brain injury); these people will have the assessments carried out by a professionally qualified person. There will be another group in care homes (who are most likely to be older people with dementia) and these people will have the assessments carried out by those who may stand to benefit and those for whom there is no requirement to be professionally qualified.

Protection is another key word, but what protection is offered? Assessment in care homes by someone who the manager considers to have the necessary skills, and appointment of an IMCA or appropriate person as the Care home Manager decides. The Bill is completely and utterly blank on the issue of Rights. It does not even include consultation with P.

Protection often comes with DoLS by challenges to the care home documentation. Somehow the intervention of an independent outsider allows the care home to look again at their risk assessments, to consider whether restrictions can be reduced and other measures can be tried. Many times I have seen this to good effect.

Although the Bill is about the protection of P there is an element of additional concern to me and that is the vulnerability the local authority will be exposed to. The plan that someone else conducts assessments on which the local authority must rely and yet it is the Local authority who will be sued in the event of any challenge. This poses a high risk to local authorities.

Safeguards: Article 5 requires that anyone detained is informed of their detainment in a manner they can understand. The Bill does not even require that P is given a copy of the authorisation record. It does not require that P is told of the options to appeal and I see the appointment of IMCA and the identification of objection to be significantly watered down. The Bill requires the care home manager to say whether the person is objecting, not objecting or they can't tell whether they are or not! This is where the detail ends. The identification of objection and the need to challenge via the Court of Protection is an extremely complex decision. Experienced BIAs struggle to correctly interpret case law and make the difficult judgement call about objection. Is it fair, right or proper to ask a care home manager to do this? As this is the route to being assessed by an AMCP this is essentially the key safeguard.

I am aware that this Bill seeks to avoid getting into the post *Cheshire West* crisis by being permissive with the detail being contained in a new Code of Practice. I agree this approach can be helpful. However some important details in my opinion must be in primary legislation and some of these must be to consult P, to inform P of the outcome and to explain to P their rights as well as strengthening the AMCP role.

Is it all doom and gloom? No it isn't and I don't want to give the impression that I am opposed to all of this Bill. There are good things in here. It has provided a simplified process of proportionate assessments, without being overly prescriptive, a simple pre authorisation review and in the case of any objection that review being carried out by an AMCP. It attempts to focus resources to those in

most need and leaves the door open for practice to develop around the AMCP role.

However I feel that there are some key amendments which are absolutely necessary to strengthen the Bill.

Do I think that this is something which care home managers should be doing, “No I don’t;” but do I have a workable and affordable suggestion to put forward instead - “No I don’t”.

[This is a shortened version of a [guest blog](#) appearing on The Small Places website run by Lucy Series]

Stephen Ward (Trust MHA and MCA lead)

1. *Definition of ‘deprivation of liberty’*

The failure to provide for a definition of the term ‘deprivation of liberty’ is an unfortunate omission, which will undermine the objective of creating a clearer and simpler process. The Joint Committee on Human Rights has made a strong argument in favour of a statutory definition.

The ‘acid test’ as formulated by the Supreme Court has widened the scope of the term ‘definition of liberty’ far beyond what I think was the intention of Article 5 of the European Convention on Human Rights. The way it is applied in practice, in particular the question “*if P were to try and leave, would you stop them?*” brings into the scope of the current DoLS many people whose admission for care and treatment is clearly in their best interests and involves no restrictive measures or objections. Many people who fall within the acid test are objectively content with their care arrangements, benefitting from the support available to have a safe and fulfilled life and whose families are in agreement with the arrangements. In such cases it could be argued that applying the DoLS process is an unwarranted interference by the state into family life.

As the *Ferreira* case has shown, it is possible to distinguish between constraints on movement that

are imposed by the care home or hospital and those that arise from the person’s circumstances.

I believe any scheme that does not have a more restricted definition of deprivation of liberty will be impracticable to implement because of the sheer number of people included. A definition of deprivation of liberty should take account of the cause of restrictions on movement (ie only those imposed by an authority) and exclude arrangements for those who are clearly content with arrangements.

2. *Unsound Mind / Mental Disorder*

Whilst acknowledging that the ECHR uses the term ‘unsound mind’ this is not an appropriate term for modern legislation. It is not in common use in clinical practice and therefore there is no clear understanding of its meaning.

Given that the Liberty Protection Safeguards apply only to those lacking mental capacity, and that the definition of lacking capacity in section 2 of the MCA includes the cause ‘*impairment of or disturbance in the functioning of the mind or brain*’, there should be no need to additionally demonstrate ‘unsoundness of mind’.

The current provisions requiring a medical assessment to confirm the presence of mental disorder, that is compliant with the requirements of DoLS, result in significant costs for Local Authorities, as most DoLS assessments will involve the payment of a fee to a doctor for a report, the details of which are already available from previous reports or statements.

Removing the need for specific DoLS medical assessment is welcome, but the current bill does not provide clarity on what is required to confirm the presence of ‘unsoundness of mind’.

3. *Harm to self or others, Best Interests, Necessary and Proportionate*

The current scheme requires a deprivation of liberty to be necessary to prevent harm to the person,

proportionate response to the risk of harm and in the person's best interests. The proposed LPS makes a number of changes to this requirement:

1. Harm to self: the LPS do not explicitly require confirmation of risk of harm to the individual concerned. It is a broader requirement, that the arrangements are *necessary and proportionate*. This makes the scheme more flexible to include people requiring restraint to protect others from harm.
2. The absence of 'Best Interests' as an explicit requirement for approving a deprivation of liberty is a serious omission and a significant departure from both DoLS and the scheme proposed by the Law Commission. Under DoLS the best interests requirement provided for an independent scrutiny of care arrangements and was seen as the most positive aspect of an unsatisfactory, bureaucratic process. The Law Commission proposed making the views of the individual the central aspect of any determination of best interests. The LPS makes no reference to a person's best interests, except in relation to the appointment of IMCAs.
3. My greatest concern in this context though is making care home managers responsible for determining that the relevant person lacks mental capacity and that care arrangements are necessary and proportionate. Care homes, especially those run as small business, not large organisations, are ill equipped to undertake effective assessments for a number of reasons:
 - a. They have a vested interest in confirming existing care arrangements and are therefore not independent or objective.
 - b. Past experience of their application of DoLS shows a poor understanding of the principles of the MCA and the concept of deprivation of liberty.
 - c. In my experience care homes are motivated by the protection imperative and

are risk averse. They frequently identify a lack of capacity and determine best interests solely on the basis that the relevant person exposes themselves to risk of harm.

- d. Greater scrutiny of the care home's assessment of risk of harm and that arrangements are necessary and proportionate will be dependent on the care homes identifying the relevant person's objection to arrangements. Care homes again are ill-equipped to identify anything but overt requests or attempts to leave as an objection.

4. *The Role of Reviewer*

The LPS provide no clear requirements on who can undertake the role of reviewing assessments provided by care homes on behalf of the Responsible Body. Given the lack of independent assessment of the relevant person's needs up to the point of review and authorisation it is essential that the reviewing role in the Responsible Body being undertaken by a professionally qualified person of appropriate seniority. Key knowledge and skills that such reviewers must have is:

1. Legal knowledge of mental health legislation;
2. Practice knowledge of the application of mental health legislation and the Care Act.

5. *Excluded arrangements*

One of the most problematic aspects of the current DoLS is the eligibility assessments, which creates a complex interface between the MHA and MCA/DoLS. The Law Commission recommended resolving this interface by making the new scheme unavailable for all treatment of mental disorder in hospitals. The LPS provide for an even more complex interface which will repeat the current difficulties in practice.

One of the key difficulties that arises from the current eligibility assessment is the difference in

views between DoLS assessors and Mental Health Act assessors. Assessors applying the MHA are often still in the mind-set that caused the original *Bournewood* case. They over emphasise the restrictive effect of the MHA and fail to recognise the protection afforded to the relevant person. Patients are deemed not detainable on the basis that treatment could be provided outside hospital, but in reality there is no alternative placement available. Once discharged from section and assessed under DoLS they are deemed ineligible, unless they are completely compliant with arrangements. Any expression of objection or resistance has to be interpreted as an objection.

This difference in view between MHA assessors and DoLS assessors can lead to an impasse, and the relevant person being detained unlawfully with no legal means of challenge.

The proposed LPS do not resolve this, as the definition of ineligibility is if anything more complex than the current Schedule 1A.

6. Approved Mental Capacity Professional

The development of BIAs to Approved Mental Capacity Professionals as proposed by the Law Commission is a generally positive development. In the current Bill their role is however much too restricted. Their involvement is only triggered where the care home identifies an objection by the relevant person. The wide discretion for the Responsible Body to use AMCPs has not been transferred from the Law Commission proposals.

The Law Commission proposed that AMCPs would be equivalent in professional status and expertise to the Approved Mental Health Professional. However the difference in training between the current BIAs and AMHPOs is considerable (5 days at University and no practice placement for BIAs cf. 5 months full time classroom and independent study and practice placement for AMHPs). This will need to be addressed in regulations to ensure that AMCPs are properly trained for the role of scrutiny.

7. Impact Assessment

From the financial impact assessment I note two areas of concern: the very low level of training needed by care home managers to enable them to fulfil their new roles and the lack of any costs for Responsible Bodies in reviewing and authorising arrangements.

As stated above, many care homes currently have a poor understanding of their roles and responsibilities under the MCA and few have a good grasp of the concept of deprivation of liberty, let alone the legal processes involved in authorisation. A half day training session will allow for little more than outlining the new process and information care homes must provide about arrangements. What most managers really need to provide effective safeguards of residents' rights is a detailed understanding of the MCA, the philosophy that informs the principles and how to undertake person centred, rather than risk focussed, mental capacity assessments and best interests decisions.

Whilst Local Authorities will have resources in place for the current DoLS process, which can be re-deployed for LPS processes, other Responsible Bodies, ie. CCGs and Trusts, do not have such resources. They will need to develop systems and processes, train and deploy staff to review and authorise arrangements and there will be costs to this that have not been accounted for.

The low cost and the headline '£200 million savings for local authorities' begs the question whether this may have been a primary aim?

8. Summary

In conclusion the LPS as proposed by the current Bill falls far short of what is needed to provide effective safeguards of vulnerable adults. I welcomed much of what was proposed by the Law Commission as a way forward, but this bill changes that proposal beyond recognition. In particular it fails to provide:

- a process that is integrated with care management;
- approval of the deprivation of liberty before it occurs;
- proper independent scrutiny of restrictive arrangements ;
- a more effective process for challenges.

Gary Haigh (Local Authority Practice Development Manager)

I have been involved in DOLS on behalf of a supervisory body from 2008, firstly being concerned with the lack of applications and then trying to cope with the avalanche of referrals after the *Cheshire West* judgment.

I am definitely ready to see the legal process amended. I could see, albeit with some reticence, the Law Commission's attempt to keep a level of scrutiny at the commissioning stage and incorporate a DOL in to a care plan. This then was to allow for higher levels of scrutiny where it was needed.

Since the government's version has come out I have become extremely concerned that the duty of authorising a DOL is passed to care home managers. Indeed they will decide if P will have an advocate.

Although assured this is Article 5 compliant, I cannot see how it can be if the jailor becomes the judge and jury and decides on whether P can have a right of appeal. It falls well short of Magna Carta, let alone Article 5.

Care homes and managers have a commercial vested interest, and from my experience many have scant knowledge of the MCA. Severely disabled people object in different ways and certainly different to any that have been stated by the Law Commission (second draft at least). For example in *Bournewood*, HL's way of objecting was to self-harm; Steven Neary was by an increase

in aggressive behaviour. The managers responsible perceived this as a need to keep them in this level of care for their own safety, mistaking their reaction to their environmental circumstances with "*unstable mental health*." We all know how this changed when discharged. How does all this not lead us back down the grim corridors of Bournewood?

A quick view on hospitals – I am not sure what the new Mental Health Act will look like but I can certainly predict that LPS will be used when people should be sectioned under the MHA. It will be seen as a quick, easy process. Will they then of course be to appeal this?

It does not worry me in the slightest if I do not have a job when the new legislation is implemented. I am very concerned however about people inappropriately placed into care, deprived of their liberty without recourse to appeal their detention. DOLS and the use of conditions (not present in the new draft legislation) can make a massive difference to the level of restrictions and quality of life. This will be sadly eroded if the current bill remains as it is.

Martin Sexton (Local Authority MCA/DOLS team manager)

I'm most concerned about the "care home manager" provisions that have been included in the Bill. I think these are unworkable and will lead to a situation that is worse than DOLS. With the best will in the world the care home managers will not be able to discharge this function and it would be dangerous for them to try.

The care home manager will have an unavoidable conflict of interest. The refusal of an LPS authorisation would probably mean that P would have to move, so there is a built-in incentive for the manager to play down any objections or problems.

I don't see how the care home manager will be able to make an argument that the placement is "necessary and proportionate". How will they know

what the alternatives are, and how will they evaluate them?

The information on mental capacity and unsoundness of mind will have to come from health or social care services. So they should co-ordinate the LPS authorisation process as they would for other care settings.

I am very concerned that the proposals do not include an automatic right for P to be supported by an appropriate person or an advocate. How can it be right that the care home manager - the person detaining P - gets to decide the level of support that P should have?

If these provisions stay in the Bill then it's ridiculous to suggest (as the Impact Assessment does) that the care home managers will be able to implement LPS after half a day's training. This is nowhere near enough, even for the most able managers.

If the Bill stays as it is, then at best responsible bodies will be deluged by poorly written and inadequately evidenced applications for LPS. These will bounce backwards and forward between the care homes and the independent reviewers, leading to significant delays and costs. It would be better to keep DOLS than to bring in such a system.

The worst case is that care home managers shy away from applying for LPS because of the challenges, and we end up where we were before the *Bournewood* case.

The answer is to make LPS work in care homes in the same way as it will in other settings, i.e. the responsible body co-ordinates the process. That's what's going to happen anyway as social workers and care co-ordinators will have to step in to rescue the care home managers.

I have some concerns about other aspects of the Bill:

- “unsoundness of mind” – this term is attracting a lot of criticism and I understand some doctors

have stated that they will not use it. “Mental disorder” worked for DOLS so why can't it be used in LPS?

- Necessity and proportionality – what can we say at this stage about how these terms will be interpreted by the courts? I presume that DOLS case law will still be relevant as LPS will be the successor scheme to DOLS and will be intended to provide the same level of Article 5 protection. Is this something that should go in the Bill or can it go in the Code of Practice?
- Responsible bodies having a power (rather than a duty) to authorise arrangements – how wide is the scope of this? Will RBs be able to just say Yes or No, or will they have the power to delete (or add) line items to a support plan? Again, is this something for the Code or does it need to go into the Bill?
- Paragraph 45 – this reads to me as though someone with LPA for health and welfare can agree to P being detained under LPS when P is objecting and the Mental Health Act is available. Is my reading correct? If it is, then this should not be allowed even if the proposed section 29A is not reinstated.

I'm also concerned about the following omissions from the Bill:

- The omission from the Bill of the Law Commission's proposed changes to MCA sections 4 – 6, 26 and 29 is a significant missed opportunity. I think they would provide greater clarity for professionals, and would protect professionals as well as P.
- The omissions re: the status of AMCPs are also of concern. These sections should be re-instated.
- The age limit should be re-instated as 16 and upwards. The current legal framework is unnecessarily complex and expensive and doesn't deliver any obvious benefit to young people.

- The Bill should include an explicit requirement to consult P. It's there implicitly because the responsible bodies have to respond to any objections from P. But it should be there explicitly.
- Finally, re: the suggestion that the Bill should define "deprivation of liberty", this seems to be driven by the concern that too many people living in their own homes would be subject to LPS and would experience unnecessary state intrusion in their lives. To respond to this, rather than trying to re-define deprivation of liberty, is there a way of re-defining "responsible body" to as to focus on accommodation arrangements? In other words, if P's accommodation hasn't been arranged by a "responsible body", could the care arrangements be excluded from the scope of LPS? The person would still be covered by the safeguarding provisions of the Care Act so they wouldn't drop off the radar completely. There would still be some cases where the responsible body had not arranged the accommodation but a legal framework would still be needed. Could these be handled under the inherent jurisdiction instead of LPS?

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