APPENDIX 2

ISLE OF WIGHT COUNCIL

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DEPRIVATION OF LIBERTY SAFEGUARDS

ADVICE

A) INTRODUCTION

1. I am asked to advise the Isle of Wight Council ("IOWC") in respect of the Mental Capacity 2005 Act ("the Act") and the Deprivation of Liberty Safeguards ("DOLS") that are set out in Schedule A1 of the Act.

2. In particular, I am asked to advise IOWC as a supervisory body as to the issues arising from the significant backlog in applications for authorisations for deprivation of liberty that currently exists and which has existed for a number of years since the decision of the Supreme Court in ***CHESHIRE WEST AND CHESTER COUNCIL V P; SURREY CC V P, also known as P V SURREY CC; P V CHESHIRE WEST AND CHESTER COUNCIL [2014] UKSC 19*** ("Cheshire West").

3. I am asked to advise the IOWC as to the risks that it faces due to the backlog and delays in considering and granting standard authorisations under Schedule A1 of the Act and how those risks can be reduced and/ or managed.

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4. I am also asked to advise as to written communications to care homes and families of those persons in care homes that are being deprived of their liberty without appropriate authorisation in place and the IOWC's intentions as to how to deal with the delays.

5. I confirm that I have practiced in the Court of Protection since 2008, representing local authorities, patients and families in various types of applications and cases involving the Act.

6. In particular, I confirm that since 2015, I have been involved in many applications to the Court of Protection under section 21A of the Act, in which patients through their litigation friends challenge the authorisations granted by local authorities under Schedule 21A. Some applications have been brought by local authorities themselves when there has been a lack of challenge on behalf of the patient, by patient's relevant person's representative ("RPR") or the patient's family.

7. I appear regularly before the Court of Protection sitting in Bournemouth, Southampton, Portsmouth and Newport, Isle of Wight. I have appeared in before the Court of Protection in London over the years but this has now reduced due to the significant increase of Court of Protection nominated judges in provincial courts. A significant amount of my instructions are from local authorities although I am also instructed to act for patients through professional litigation friends, including the Official Solicitor. I have also acted for family members who bring challenges to the placement of a relative.

B) CONFERENCE WITH COUNSEL

8. On 14 November 2017, I met with Mr Roger Merry, Solicitor, Mr Stephen Ward and Mr Terry Corry of the IOWC. I am grateful for their attendance at Chambers.

9. During the conference, I was able to share my experience in dealing with applications under the Act, particularly those under section 21A over the last

two to three years or so. I was able to give guidance, in particular as to the approach of the Court of Protection and the professionals dealing with such applications in respect of potential damages for breaches of liberty under article 5 of the European Convention of Human Rights ("ECHR") and the Human Rights Act 1998 ("the 1998 Act").

10. I was able to consider the advice already provided by Mr Merry and Mr Drake, in respect of the risks faced by the IOWC.

11. I now provide my guidance and advice in writing. I apologise for the inordinate delay in providing this written advice.

C) DEPRIVATION OF LIBERTY AND THE SAFEGUARDS

12. Article 5 of the ECHR contains an express prohibition against depriving a person of his liberty unless a legally prescribed procedure is followed in order to achieve a limited number of aims specifically set out at sub-paragraphs (a)–(f) of Article 5(1). I think it is important to be reminded of Article 5 and what it provides and I set it out below with my emphasis in bold.

Article 5

Right to liberty and security

1. ***Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:***
(a) the lawful detention of a person after conviction by a competent court;
(b) the lawful arrest or detention of a person for non-compliance with the lawful order of a court or in order to secure the fulfilment of any obligation prescribed by law;
(c) the lawful arrest or detention of a person effected for the purpose of bringing him before the competent legal authority on reasonable suspicion of having committed an offence or when it is reasonably considered necessary to prevent his committing an offence or fleeing after having done so;
(d) the detention of a minor by lawful order for the purpose of educational supervision or his lawful detention for the purpose of bringing him before the competent legal authority;
(e) ***the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts***

> ***or vagrants;***
> *(f) the lawful arrest or detention of a person to prevent his effecting an unauthorised entry into the country or of a person against whom action is being taken with a view to deportation or extradition….*
>
> *4. Everyone who is deprived of his liberty by arrest or detention* ***shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.***
>
> *5.* ***Everyone who has been the victim of arrest or detention in contravention of the provisions of this Article shall have an enforceable right to compensation.***

13. The circumstances in which a deprivation of liberty may lawfully occur are, therefore, entirely circumscribed by the provisions of Article 5.

14. Article 5(1)(e) permits ***'the lawful detention of persons … of unsound mind, alcoholics, drug addicts or vagrants'.*** The wording may be rather out-dated but such persons would include those that suffer conditions that affect their mental capacity as is now defined by the Act.

15. A deprivation of liberty that does not fall within the exceptions to Article 5(1) will not accord with the Convention. Such deprivation will amount to breach of the person's Article 5 right and consequently, that entitles the unlawfully detained person to seek compensation/ damages.

16. Article 5 of the ECHR was considered in a case involving the deprivation of liberty in ***HL v UK (2005) EHRR 32***. The patient, a young man with severe autism and learning disabilities had been held in a locked ward at Bournewood Hospital for some months. The hospital did not seek to compulsorily detain the patient under the Mental Health Act 1983. Instead the hospital relied on the fact that the patient was compliant and did not resist detention arguing that he was being treated informally. Carers tried to see the patient and seek his release but the hospital refused. The European Court of Human Rights ("ECtHR") held that the patient had been deprived of his liberty contrary to Article 5(1) and the court made the point that there was no procedural safeguards in place or any means of reviewing the detention speedily by the

Court.

17. The Bournewood case led to the Mental Health Act 2007 ("the MHA 2007") which introduced a new safeguarding procedure set out in Schedule 1A of the Act (DOLS). It still surprises me that the legislators did not think of this issue when they introduced the 2005 Act in the first place. Nevertheless, Schedule A1 provides a procedure for the authorisation of a person's deprivation of liberty. Section 21A of the MCA 2005 confers jurisdiction on the Court of Protection to review certain decision taken under the provisions of Schedule A1. The provisions came into effect on 1 April 2009.

18. The safeguarding procedure applies to persons who lack capacity to make decisions as to their residence and care and who are deprived or are likely to be deprived of their liberty for the purpose of being given care or treatment in a hospital or care home. There are certain six requirements that need to be met and a best interest assessment must be made to consider whether or not it is in the patient's best interests to reside and to be cared for with restrictions which amount to his or her deprivation of liberty.

19. No one can deprive a person who lacks capacity of his liberty unless it is authorised by a supervisory body (or by the Court of Protection as a declaration under section 16(2)(a)).

20. A clear understanding of the circumstances which may amount to a deprivation of liberty is a crucial first step as outlined above, both for those who may be required to act, or make assessments, in accordance with the safeguards, and interested persons who may wish to challenge or review authorisations made.

21. More importantly, understanding of the fundamental right to liberty is required by all persons dealing with persons lacking capacity, whether they are carers, professional carers, health worker, and social and support workers. This understanding is required along with a proper understanding of the provisions and principles in sections 1 to 4 of the Act particularly in terms of acting in the patient's best interest and to do so in the least restrictive way.

22. Indeed every local authority as a supervisory body or in its capacity as providing adult social care, health agencies and care providers need to be fully appreciative of the right to liberty and the seriousness of implications of any infringement of the right unlawfully, both for the patient and on those causing the infringement or failing to address it, consider it, assess it or authorise it, inadvertently or otherwise.

23. A failure to appreciate the circumstances in which such a deprivation might be held to exist could result in unauthorised, and therefore unlawful, detentions. There is no doubt that DOLS under Schedule A1 is a very important and vital checking system to ensure that patients in care homes and hospitals are not deprived of their liberty unnecessarily and without justification. It is not a "rubber stamp" process.

D) CONSEQUENCES OF UNLAWFUL DEPRIVATION OF LIBERTY

24. The most serious impact of unlawful deprivation of liberty is, of course, upon the patient. Problems might be as follows:
    a. The patient might have to live his life in a manner that is unnecessarily restricted and that might have an adverse impact on the quality of life and the fundamental ability to make choices – choices that many of us take for granted.
    b. The placement and/ or care might have negative impact upon the patient's emotional and physical wellbeing.
    c. Issues or problems in terms of residence and care might be not be addressed and/ or resolved.
    d. Health issues might not be addressed properly, particularly in terms of mental health.
    e. The care setting might not be ensuring that the patient is able to undertaken some appropriate activities. Opportunities to go out into the community or do something of interest might not be attempted or even thought about.
    f. Contact with family members might not be taking place or taking place

frequently enough.

25. On the other side of the coin, considering a local authority such as the IOWC, the potential consequences are:
    a. Claims made against the local authority for damages for breach of article 5/ unlawful deprivation of liberty. Those claims are normally civil claims brought in the county court or High Court.
    b. Where the court finds that there have been <u>substantive breaches</u> of a patient's liberty, then it is likely to award substantial damages. There is no fixed sum or rates but various cases in which damages have been agreed and approved by the Court of Protection have seen patients receive sums of around £3,000 to £4,500 per month:
        i. ***London Borough of Hillingdon v Neary [2011] EWHC 3522 (COP):*** a period of 12 months' detention resulted in an award of £35,000.
        ii. ***A Local Authority v Mr and Mrs D [2013] EWCOP B34***: District Judge Mainwaring-Taylor approved an award of £15,000 plus her legal costs to Mrs D for a period of 4 months' unlawful detention together with £12,500 to her husband, together with his legal costs.
        iii. ***Essex County Court v RF & Others [2015] EWCOP 1:*** District Judge Mort gave an indication that the level of damages for the unlawful deprivation of an incapacitated person's liberty was between £3,000 and £4,000 per month.
    c. My starting point for guidance purposes is a sum £100 per day but his would depend on the facts of the case.
    d. Local authorities may have to agree to waive any fees payable by patient in respect of the care home in which he was detained for the period of his or her unlawful detention.
    e. Local authorities may have to agree to exclude the patient's damages award from means testing in relation to the patient being required to pay a contribution to his community care costs;
    f. Local authorities would face orders to pay of all the patient's legal costs, to be assessed on the standard basis. These could be anything up

to £50,000 plus VAT in contested claims, possibly more.

26. Factors which might make a case more serious with potentially higher damages are:
    a. Removing a person from his home (especially his long-standing home) when there are clear expressions by the patient that he did not wish to be placed elsewhere.
    b. Assessments indicating that the patient could return home with a package of care but such assessments being ignored by the local authority or the local authority has dragged its feet in putting potential arrangements/ package of care in place.
    c. Removing a person from his home when the spouse and/ or family are willing to engage and work with a package of care but the local authority failing to attempt such a proposal when it would have been reasonable to do so.
    d. Failing to address clear expressions of discontent by a patient and doing very little to consider alternative and least restrictive options.

E) IMPACT OF CHESHIRE WEST

27. After the Cheshire West decision in March 2014, despite it involving patients who were not in the typical care home or hospital setting, and therefore Schedule A1 authorisations did not apply, the Supreme Court's judgment as to deprivation of liberty, the test of such deprivation ('continuous supervision and control'), the fact that a patient's compliance to the deprivation is irrelevant and a "***gilded cage is still a cage***", resulted in local authorities as supervisory bodies and care providers as managing bodies reviewing their approach in terms of patients in care homes in particular. I have a sense that hospital trusts did not panic so much.

28. The Cheshire West case resulted in over 1066% increase in number of

applications for authorisation being made in year April 2014 to March 2015[1]. The increase has continued albeit at a reduced rate. The mass influx of applications along with some delays in relevant supervisory bodies and professionals getting to grips with the ins and out of the Supreme Court's decision, resulted in huge backlogs in Schedule A1 applications for authorisation being dealt with.

29. Psychiatrists and best interest assessors found themselves weighed down with requests to do mental capacity/ mental health and best interest assessments. With the authorisation process, it is right to say that many local authorities' DOLS teams have struggled in dealing with the increase in applications. Many local authorities have not provided additional resources for the DOLS teams to manage and deal with the applications. DOLS teams have, in essence, had to take the fire fighting approach and deal with urgent or the most potentially contentious applications. This has resulted in many cases being left unattended. Some patients have sadly died before the applications to authorise their deprivation of liberty have been dealt with.

30. Applications relating to deprivation of liberty increased from:
    a. 109 in 2013 to
    b. 525 in 2014 to
    c. 1,497 in 2015.

31. In the quarter April 2016 to June 2016, 743 section 21A applications were made as follows;
    a. 528 (71%) came from a Local Authority,
    b. 179 (24%) from solicitors and
    c. 36 (5%) from others including clinical commission groups, other professionals or applicants in person.

32. Indeed, from my perspective as a practitioner and considering the authorities

[1] In the year before, 2013 to 2014, the increase in the number of applications for authorisation was only 10%. In 2015 to 2016, the increase in number of applications fell to around 60% on the previous year.

on the south coast, court applications under section 21A only really began to be "get going" in 2015 onwards which seems to be supported by the statistics above. Whilst there was an expectation of the number of applications to the court increasingly suddenly and uncontrollably, this was not the case.

33. There certainly has been a large increase of section 21A applications in all regions, this now being the most popular type of application. The increase continues with section 16 (welfare applications) being relatively steady as at April 2017[2].

34. The increase in section 21A application has been overwhelming for already overstretched social workers who have to spend significant time in gathering and preparing extensive witness evidence and reports for court cases and trying to find their way in the world of court proceedings. However, my overall impression is that local authorities have just about kept their chins just above water in terms of court applications but it has been a steep learning curve for the social work teams and their managers.

35. Indeed Mr Merry informed me that the IOWC has only been involved in four applications under section 21A. (There have been around 20 other section 16 welfare applications where there have been disputes between family members as to where a relative should live etc).

36. I was surprised with this low number of applications under section 21A compared to the level of applications involving other local authorities with which I deal. In discussions with Mr Merry, we agreed that the possible reasons for such limited court applications being brought under section 21A on the IWOC are due to:
    a. the lack of specialist Court of Protection lawyers on the island. There is no law firm on the Island with a specialist lawyer in this field.
    b. There is a good working relationship between the advocacy service on the Island and the IOWC adult social services. Southern Advocacy is

[2] Source: Court of Protection Minutes of Court Users Group Meeting 26 April 2017 – chaired by Senior Judge Hilder.

the organisation that provides section 39D independent mental capacity advocates (section 39D IMCA") or relevant person's representative ("RPR") for patients. Jan Gavin at Southern Advocacy on the IOW has a good rapport with the adult social services and the care homes. She takes a conciliatory approach, working together approach rather than pursuing an adversarial approach at all times. I have professional experience of Jan Gavin and she is in effect the type of advocate that will take on patient's cases willingly but she will be practical and she aims to reach solutions with the IOWC and care homes without resorting to court proceedings. That approach probably results in much swifter solutions for the patient since court proceedings will inevitably take some time to reach any certain conclusions.

37. After Cheshire West, I did expect to see a large increase also in claims for unlawful deprivation of liberty. However, it appears that has not been such increase. This is despite the large increase in section 21A applications, which might result in disclosure of unlawful deprivation.

38. I have been involved in a few section 21A applications where there has been reference or some mention on the patient's behalf that unlawful deprivation might have occurred and the patient's lawyers would be considering the evidence to determine if any claim should be made for damages. The cases have not resulted in any such claims or even any requests for damages from the local authorities during pre-action negotiations. There are no doubt cases around the country that have resulted in local authorities, without formal admissions, agreeing to pay some damages to patients in order to avoid potentially meritorious court claims.

39. There seems to be no official information as to reasons for the lack of damages claims. My views as to the potential reasons are as follows:
    a. Whilst patients are provided with non-means or merits tested public funding for section 21A applications, public funding for damages claims are not readily available and would be means and merit tested.
    b. Many patients would not have the monies or assets to enable their

litigation friends to seek legal advice and to proceed with civil proceedings for damages.

c. Other sources of funding, such as conditional fee arrangements are not in the forefront of the minds of those lawyers dealing with patients under the Act. Such funding issues are often used for personal and clinical injury cases and are dealt with specialist lawyers in those fields or civil litigation generally.

d. Those lawyers dealing with section 16 and section 21A applications for patients and advocates, IMCAs and RPR are very experienced in terms of welfare issues and the more practical effects of deprivation of liberty but in terms of damages and civil claims, their knowledge and confidence in considering such claims are often very limited.

e. Attorneys and deputies for property and affairs often do not even think about the need to consider claims for damages and even if they do, they will be concerned about committing the patient's assets and monies in pursuing such litigation, which will not have any guaranteed positive outcome or substantial damages.

f. I think there is some element of professionals and the court focusing on the patient's care and residence and practical arrangements to ensure their quality of life is improved as soon as possible due the fact that a patient is very elderly and may not have much more in terms of life expectancy to deal with claims for monetary damages.

F) DOLS AUTHORISATIONS AND THE BACKLOG

40. I am informed that the IOWC has nearly 800 DOLS applications for authorisation that have not been completed. The applications that are not addressed do go back to 2014. This might mean that there are patients being unlawfully deprived of their liberty for a long period of time and certainly for 3 years or more.

41. As a general guidance[3], based on information provided by local authorities in

[3] Source: ComCare.co.uk.

England, there are around 143,000 outstanding or incomplete applications for authorisation. The statistics suggest that the length of time to complete a DOLS application (which should be 21 days) is currently running at 120 days in the year 2016/2017 whereas it was 83 days in the year 2015/2016. This indicates that local authorities/ supervisory bodies are continuing to struggle to process Schedule A1 applications.

42. Many authorities have simply prioritised the applications that are urgent or very contentious. This has resulted in others not being addressed for a long time or at all.

43. In the year 2016 to 2017, there was an increase of 11% in the applications for Schedule A1 authorisation. Whilst this is nowhere near the 1066% increase in 2014/2015, there is an ongoing increase nevertheless.

44. Due to the impact of Cheshire West, four local authorities applied for a judicial review and sought declarations that the Government's failure to meet the substantial costs had created an '*unacceptable risk of illegality'* which was in breach of the policy constituted by the 'new burden doctrine'. This was the case of ***R (on the application of Liverpool City Council and others) v Secretary of State for Health [2017] EWHC 986 (Admin)***.

45. They also sought a mandatory order requiring the Government to remove the risk of illegality and to comply with the new burden doctrine. The local authorities' application was rejected by at first instance, the judge ruling:
    a. That the application had not been made promptly and within 3 months for judicial review claims and he refused to extend time.
    b. On the issue of *'unacceptable risk of illegality'* there was no such wide-ranging principle. The councils were not able to establish that they were not able to meet the costs of complying with their duties because these obligations could be met by diverting funds from other parts of the council's budget. The councils were not so underfunded that they could not comply with their statutory duties. Therefore there were no grounds

for contending that the Government's decision on funding created any risk of illegality.

c. There had also not been any breach of the new burden doctrine as there was nothing in the doctrine, which would have led the councils to believe that there would be extra funding made available if a court judgment altered the understanding of what was required by the councils. The note issued by the Department of Health after the decision of the Supreme Court in *Cheshire West* had simply reminded the local authorities what was required of them following that decision. The obligations and duties arose as a consequence of that decision and not one that had been imposed on the local authorities as a result of government decision.

46. It is worth noting that a Law Commission report in March 2017 made recommendations as to the current DOLS (see Appendix at the end of this Advice). A new system was proposed with Nicholas Paines, the Law Commissioner responsible for the project, stating that the current DOLS procedure needs to "*be scrapped and replaced right away*". Needless to say that there is no definitive timetable set out and the Government's response is awaited. It is likely that other matters will distract the Government for the foreseeable future.

G) GUIDANCE

47. I can give very firm guidance to the IOWC as follows:

a. **It is important to ensure that there is an effective working system in place to deal with Schedule A1 applications for authorisations.** It is important for the patients in the IOWC area. It is important for the issue of deprivation of liberty of each patient that lacks capacity and who is restrained in hospital or in a care home. The arrangements must be in the patient's best interests and the least restrictive. Authorisation for the deprivation of liberty is in reality, essential. The process also ensures that conditions can be imposed within the authorisation, which might enhance the patient's life through activities, health and

appropriate medication/ treatment and family and social contact arrangements.

b. **It is important that applications are dealt with promptly and within the timescales provided.** Many patients are elderly and their life expectancies might be reduced by virtue of their mental ill health such as dementia.

c. **Long delays in dealing with applications or cases creates real risks** for both the patient, which is most important but for the local authority in terms of claims for damages or at the very least, significant criticisms from the COP.

48. As to the current backlog, there needs to be a clear strategy in place to deal with the current backlog, which has occurred over the last three years.

    a. There is no doubt that there are **urgent cases** involving actively objecting patients that need to be addressed by way of a Schedule A1 application and possibly court proceedings under section 21A. These must be dealt with as and when they arise.

    b. The **less urgent applications,** however, need to be attended to if only to ensure that the arrangements and deprivation of liberty are in fact in the patient's best interests.

    c. Those **stagnant applications** which have been waiting to be addressed for years might not be stirring at this stage but there is a risk that a few of them come "alive" with court proceedings which could lead in significant damages, legal costs awards which could run into tens of thousands of pounds. Indeed, someone unlawfully deprived of their liberty for 3 years or so with substantive breaches found could achieve damages of around £100,000 with legal costs at the very least; the total burden on the local authority and the tax payer could easily reach £200,000 per case if waiver of any care fee payments were added to the damages settlement. Therefore, these stagnant applications need to be addressed in some methodical way if only to reduce the long outstanding list over a period of time.

49. A formal and well set out strategy as to how to deal with the backlog would hopefully result in:
    a. An effective system to deal with applications for authorisation, which can only benefit the patients in the locality.
    b. It will reduce the risk of section 21A applications going to court or more importantly, avoid claims for damages being issued, which could result in expensive outcomes for the IOWC.
    c. The local authority might be assisted to some extent in any court proceedings where it might face potential criticism for failing to deal with an application for authorisation in a reasonable time.

50. The reality is that in order to clear the backlog, with the aim of dealing with urgent cases as they now arise, the IOWC, like any other authority, needs to apply more resources to enable the DOLS team to carry out their work and duties properly and in good time.

51. Needless to say, the more money and resources applied, the better chance of the historic applications being dealt with and there being a "clearing the decks". Going forwards, the level of applications will probably continue at a relatively high rate but not with the massive hike that was seen in the immediate few years post Cheshire West.

52. I am fully aware that like many other authorities, the IOWC's funding has been restricted more and more over the years. I can state, however, that the Court of Protection or the civil court, in considering a damages claim, will not accept the lack of funding as an excuse or reason to avoid making substantial damages if such an award is found to be appropriate.

Communications with care homes and families of patients:

53. I am asked to advise whether or not the IOWC should send letters to care homes and to families of patients to flag up the delays and backlog and to confirm that attempts are being made to address those delays and backlog.

54. I am of the view that this is a good proposal and such communications would show that the IOWC is actively addressing the backlog and more importantly, it is actively address relevant patients' deprivation of liberty. It provides the sense of transparency, which is always much appreciated, particularly by the court system and society in general.

55. The exercise would go some way to show that the IOWC is not burying its head in the sand or ignoring the problem and that it is making efforts to resolve this countrywide issue in its locality.

56. The exercise could also be very useful to remind care homes, particularly small independent care homes on the Island of the need to check their residents and consider if they need to apply for standard authorisation.

57. The exercise of informing families might give rise to some enquiries but I suspect that most families will simply accept the situation and not raise any particular challenges. The chances are that informing families about the need to assess their relatives who are deprived of their liberty will temper any concerns as to a relative's circumstances. It is often the case that when one is trying to do something proactively, a far better response is achieved from potential complainants and their lawyers.

58. If those instructing me wish me to assist with the drafting of any letters, I can certainly do so but those currently drafted are sensible and reasonable in my view and not much more needs to be included.

59. I hope that the above is of assistance. If those instructing me have any queries, they should not hesitate to contact me at College Chambers.

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5th December 2017

Appendix

LAW COMMISSION REPORT 13 MARCH 2017

The Law Commission has published its consultation report on the operation of deprivation of liberty safeguards after the ***Cheshire West*** case. It carried out review at the request of the Department of Health in 2014 due to the explosion of applications following the decision.

After a public consultation in 2015, the Commission has recommended that the current deprivation of liberty procedure be replaced by **Liberty Protection Safeguards.**

In contrast to DoLS, which simply authorise a 'deprivation of liberty', the new safeguards would

"authorise particular arrangements for a person's care or treatment insofar as the arrangements give rise to a deprivation of liberty. This is an important difference. It focuses attention at the authorisation stage not simply on the binary question of whether a person should be deprived of their liberty or not, but on the question of the ways in which a person may justifiably be deprived of liberty."

Importantly, this would cover more than one setting so that a fresh application would be unnecessary for say a planned admission to hospital.

The Law Commission makes **44 recommendations (**Appendix C of the report. They are summarised in the accompanying press release broadly as follows:

- Enhanced rights to advocacy and periodic checks on the care or treatment arrangements for those most in need;
- Greater prominence given to issues of the person's human rights, and of whether a deprivation of their liberty is necessary and proportionate, at the stage at which arrangements are being devised;
- Extending protections to all care settings such as supported living and domestic settings –therefore removing the need for costly and impractical applications to the Court of Protection;
- Widening the scope to cover 16 and 17 year olds and planned moves between settings;
- Cutting unnecessary duplication by taking into account previous assessments, enabling authorisations to cover more than one setting and allowing renewals for those with long-term conditions;
- Extending who is responsible for giving authorisations from councils to the NHS if in a hospital or NHS health care setting;
- A simplified version of the best interests assessment which emphasises that, in all cases, arrangements must be necessary and proportionate before they can be authorised;

- Recommends a wider set of reforms, which would improve decision-making across the MCA 2005. This is not just in relation to people deprived of liberty.
- All decision makers would be required to place greater weight on the person's wishes and feelings when making decisions under the MCA 2005.
- Professionals would also be expected to confirm in writing that they have complied with the requirements of the MCA2005 when making important decisions – such as moving a person into a care home or providing serious medical treatment.