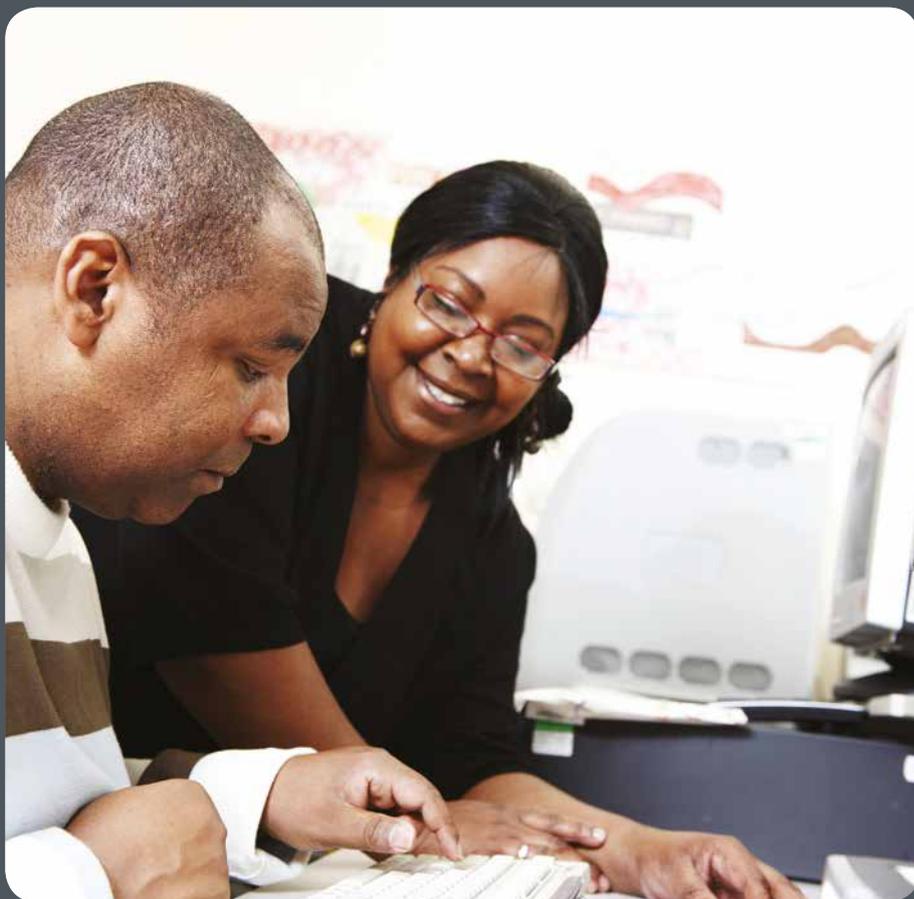


MONITORING THE USE OF THE MENTAL CAPACITY ACT DEPRIVATION OF LIBERTY SAFEGUARDS IN 2013/14



The Care Quality Commission is the independent regulator of health and adult social care in England

Our purpose:

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role:

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care.

THE DEPRIVATION OF LIBERTY SAFEGUARDS

Finding the least restrictive option

Mary is an older person living with dementia in a care home. The home applied for a Deprivation of Liberty Safeguards authorisation because Mary had become distressed and was constantly asking to return to her home where she had lived with her son.

When carrying out the assessment, the best interests assessor identified that it was in Mary's best interests to continue to live in the care home. The authorisation was granted, with a condition that she should be enabled to go out as often as possible.

The care home set up individual outings for Mary where she could take part in everyday activities such as shopping, visiting places that had been meaningful to her, including a visit to the post office that Mary used to manage, and doing things she enjoyed, such as having a glass of wine in a seaside pub or beach café.

By providing Mary with activities that made her less restricted she appeared happier. The home noticed that her visits and telephone calls to her son became positive experiences that both Mary and her son appreciated and looked forward to.

Mr G is an elderly man living with dementia in a care home who became distressed and frequently asked to leave the care home to go outside or to go home. Care home staff were concerned because they were not able to respond to every request to go out. They worried that Mr G may get lost if out alone and they were anxious about the level of his road safety skills. The care home manager was concerned that Mr G did not have capacity to go out safely alone. However, his daughter felt that her father was able to make an informed choice and should be allowed the freedom to leave the care home as and when he wished.

A multidisciplinary team became involved, with a lot of input from Mr G's daughter and other relatives. Mr G was formally assessed as not having capacity to understand the safety issues of leaving the care home. The care home requested a Deprivation of Liberty Safeguards authorisation, and this was granted.

The care home staff learned that before moving into residential care Mr G always had a daily walk to the paper shop before returning home to read his paper over coffee. This insight helped the care staff to realise that Mr G was trying to continue with his daily routine of walking to the paper shop. Staff ensured Mr G could go to the paper shop as part of his daily routine at the care home. He stopped asking to go home, and care staff noticed he was more settled and happier in the care home.

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FOREWORD



In this, our fifth annual monitoring report on the Deprivation of Liberty Safeguards, we break with tradition. As always, we review the use of the Deprivation of Liberty Safeguards in the most recent completed year, in this case 2013/14. But this year, we decided to look back at the first five years of their implementation, and also to describe the current ways they are being used.

We do this because March 2014 was a landmark in the history of the wider Mental Capacity Act (MCA) and within that the Deprivation of Liberty Safeguards.

Great changes have followed the House of Lords post-legislative scrutiny committee report on the MCA, and the Supreme Court judgement, both of which occurred in March 2014.

The House of Lords reported on how well the MCA was embedded in our culture, particularly in health and social care. They found that that the prevailing cultures of paternalism (in health) and risk aversion (in social care) have prevented the Act from being widely known or embedded. The empowering ethos has not been delivered. The rights conferred by the Act have not been widely realised. The duties imposed by the Act are not widely followed.

I welcome the extensive and collaborative work, in which we are playing our part, now going on within local authorities, educators, and providers of health and social care to address these findings.

The Supreme Court then clarified what had become very complicated case-law about deprivation of liberty. It ruled that people lacking mental capacity to consent to the arrangements needed to give them necessary care or treatment are deprived of their liberty if they are both:

- Not free to leave, and
- Subject to continuous supervision and control.

It recommended “erring on the side of caution” in use of these Safeguards, because of the vulnerability of many people who might be deprived of their liberty in health and social care settings, and because of the protection given by the assessment and review process.

Use of the Deprivation of Liberty Safeguards is rising greatly since the judgement. I welcome this growing understanding of deprivation of liberty, and I also endorse the Court’s clear statement that we should not regard the need for such checks as in any way stigmatising of them or of those providing the care. Rather, use of the Deprivation of Liberty Safeguards is a recognition of the equal dignity, and status as human beings, of the most vulnerable among us.

Both the House of Lords and the Supreme Court criticised the Deprivation of Liberty Safeguards for their bewilderingly bureaucratic complexity. I have considerable

sympathy with this view, and welcome the decision by government to ask the Law Commission to look for a framework that is simpler, while still protecting people's rights.

Whatever changes may arise, we must all continue to focus on the vulnerable people at the heart of the process, whose wishes about how they are cared for should, where possible, be honoured and whose rights must always be protected. As highlighted by the House of Lords, this can only be done by embedding the empowering ethos of the MCA, including the Deprivation of Liberty Safeguards, in all health and care settings.

To help us achieve this, I encourage you to take the messages from the report and apply them within your organisation.

David Behan
Chief Executive

SUMMARY

The Deprivation of Liberty Safeguards were introduced in 2009. They are part of the Mental Capacity Act 2005 (MCA). They are used to protect the rights of people who lack the ability (mental capacity) to make certain decisions for themselves. The MCA provides the essential framework of guidance for people who need to make decisions on behalf of someone else. It sets out who can take decisions, in which situations, and how they should go about this – making sure they act in the person’s best interests and empowering people to make their own decisions wherever possible.



The Deprivation of Liberty Safeguards are set firmly within the empowering ethos of the Mental Capacity Act (MCA). They encourage all health and social care providers to put liberty and autonomy at the heart of care planning, to avoid wherever possible the need to deprive people of their liberty.

This year marks the fifth anniversary of the introduction of the Deprivation of Liberty Safeguards. It is both striking and concerning that over the last five years we have seen the same themes recurring including, until recently, persistently low numbers of applications for authorisation of the Safeguards. We are also concerned about the continuing lack of understanding and awareness of the MCA, which is a potential barrier to good practice.

Changing landscape

March 2014, however, was a watershed in the history of the MCA including the Deprivation of Liberty Safeguards and marked the start of major changes to the way the Safeguards are used. The House of Lords highlighted the need to improve understanding of the MCA, while the Supreme Court judgement clarified the definition of when people are being deprived of their liberty. It also made clear that people may be deprived of their liberty in community settings, such as supported living and shared lives schemes, not just hospitals and care homes.

The impact of these events has been phenomenal. During the first six months following the Supreme Court judgement, the numbers of requests from hospitals and care homes for Deprivation of Liberty Safeguards authorisation increased at a rate likely to be at least eight times that of 2013/14. In addition, the numbers of applications to the Court of Protection for authorisation relating to community settings are also climbing, and are predicted to climb higher.

Next steps

We welcome the clarity provided by the Supreme Court, and the increase in applications. We also recognise that they present new challenges and are putting additional pressure on providers and particularly on the supervisory bodies (local authorities). At the end of September 2014, there were 19,429 applications where the outcome was still not decided, compared with 359 at the end of 2013/14. While we recognise the pressure local authorities are under, this represents a worryingly high number of people being deprived of their liberty without external scrutiny and authorisation. We expect local authorities to do all they can to assess the backlog of requests for authorisation and prevent its recurrence, for example by using the triage tools created by the Association of Directors of Adult Social Services, and we will monitor their progress throughout the rest of 2014/15.

Based on the recurring themes we have observed over the last five years, we also expect all providers of health and social care to focus on increasing liberty and empowerment for people who use services through care planning that complies with the MCA. Providers must continue to improve staff understanding of the Act and improve their reporting processes to ensure that all deprivation of liberty applications, to the Court

of Protection as well as by using the Deprivation of Liberty Safeguards, are reported to CQC, together with their outcomes.

We expect providers of all adult health and social care to work within the framework of the MCA. Following the revised test supplied by the Supreme Court, it is now clearer and easier for providers to identify where a person is being deprived of their liberty. Where a potential deprivation of liberty is identified, providers must explore alternative ways of providing the care and/or treatment. We expect to see joint working, locally and nationally, to make sure that local authority and NHS commissioning, training and policies take into account the need to avoid deprivation of liberty wherever possible.

We also recommend that local authorities consider using advocacy services for all those subject to the Deprivation of Liberty Safeguards. They should work to provide enough Independent Mental Capacity Advocates (IMCAs) to support the person or their unpaid relevant person's representative to challenge an authorisation, if they so desire. Local authority leads should also create good working relationships with their local coroners to ensure that a consistent message is given to providers, and so that they can work together in dealing with the considerable extra activity as a result of the Supreme Court judgement.

CQC is committed to encouraging improvement and raising awareness of the MCA including the Deprivation of Liberty Safeguards. We will continue to listen to people's experiences of the Safeguards, and consider how the MCA is being used by providers as part of our inspections of services for people aged 16 and above. We will make sure that our inspectors have the confidence and competence to recognise good practice, and will use our inspections and reports to encourage improvements in practice. Where necessary to protect users of services, we will take enforcement action to drive improvement. This includes where we find that providers are failing to notify us of Deprivation of Liberty Safeguards applications and their outcomes.

INTRODUCTION

The Deprivation of Liberty Safeguards were introduced in 2009. They are part of the legal framework set out in the Mental Capacity Act 2005 (MCA). The MCA is concerned with protecting and enhancing the human rights of people who lack the capacity to make their own decisions.

Around two million people in England and Wales may lack the capacity to make certain decisions for themselves at some point due to illness, injury or disability. Another six million people will be involved in their care and support, including family, friends and staff working in health and social care.



The aim of the Deprivation of Liberty Safeguards is to protect the human rights of people who lack the capacity to make decisions for themselves in certain settings when the restrictions on their freedom, imposed in their best interests, mean that they are deprived of their liberty.

Although the number of people who are subject to the Deprivation of Liberty Safeguards has until recently been relatively small, people who need assessment for them are often among the most vulnerable in society. They include people with severe learning disabilities, people with dementia, and people who have brain injuries and other conditions that affect cognitive functions.

Our role in monitoring the Deprivation of Liberty Safeguards

Under the Mental Capacity Act (MCA), we are responsible for monitoring the way hospitals and care homes operate the Deprivation of Liberty Safeguards. We do this by undertaking visits in accordance with our existing programme of inspections and reporting on our findings annually.

We have no direct enforcement powers associated with this role. However, if we find that the Safeguards are not being used correctly, we can take action against providers under the Health and Social Care Act 2008. A number of the Health and Social Care Act regulations contain references to elements of the MCA including the Deprivation of Liberty Safeguards – for example, in the regulations dealing with consent, safeguarding, and general care and welfare.

In July 2014, the Department of Health published the new fundamental standards. These new standards will replace the existing quality and safety regulations and are clearer statements of the standards below which care should never fall. The standards now include more specific references to the MCA. They will allow us to target improvement and enforcement measures on these areas of care practice.

Setting the context

This is our fifth year of reporting on the Deprivation of Liberty Safeguards. As a result, we thought it would be an appropriate time to reflect on the past five years since the Safeguards came into effect, as well as report specifically on practice during 2013/14. By looking back over the past five years, we intend to show how well the Safeguards have been used in hospitals and care homes, and what progress has been made to improve their implementation.

The report also looks at changes in the wider landscape during 2013/14 and beyond. This includes the report of the House of Lords MCA post-legislative scrutiny committee (page 32) and the landmark Supreme Court ruling (appendix A), and the impact that these have had and will continue to have. Most notable is the surge in applications to deprive people of their liberty in hospitals and care homes, and the potentially large increase in requests for applications in community settings, such as supported living and shared lives schemes.

We reflect on the work that is being undertaken by organisations such as ourselves, the Department of Health and NHS England to make sure that the MCA and Deprivation of Liberty Safeguards are embedded in health and social care activities across all sectors.

Listening to people and taking account of their views and experiences of health and social care remains central to our work. This year, we have continued to build on our approaches for capturing people's experience of being subject to the Deprivation of Liberty Safeguards. We reflect this throughout the report with examples of the use of these Safeguards, and look at what this tells us about the experience of the person at the centre of the process.

Better understanding of the experience of people subject to the Deprivation of Liberty Safeguards

In previous reports we have described the challenges we face in gathering views directly from people who have experienced the Deprivation of Liberty Safeguards. This year, we have continued to explore different approaches to capturing the experience of the person as follows:

- We asked Independent Mental Capacity Advocates (IMCAs) to tell us about the experience of the person through our annual online survey.
- We asked IMCAs to help us contact people who would be willing to speak with us about their experience of the Deprivation of Liberty Safeguards.
- We asked local authorities what information they may be able to share with us about people's direct experiences.
- Our involvement team asked our partner agencies to put us in touch with people or their representatives who may be able to speak with us about their experience.
- We spoke with two paid relevant person's representative (RPRs), other relatives of someone subject to the Deprivation of Liberty Safeguards and to someone who had been subject to an authorisation, now lifted.
- We sought the views of care providers.

Case study: Importance of assessing mental capacity



John is a 68-year-old man with dementia who lived in a care home and was subject to a Deprivation of Liberty Safeguards authorisation. John was very angry that he was not able to live at home with his wife.

The Independent Mental Capacity Advocate (IMCA) appointed under MCA section 39D said, “On visiting John he made it very clear how upset and angry he was at not being allowed to return home. Through explaining to him what the authorisation was and why he was subject to it, he gained an understanding of the process and reasons for an authorisation. John made it clear he wished to appeal his Deprivation of Liberty Safeguards authorisation.”

This began with asking for a review by the supervisory body as the IMCA believed John

may have had capacity. However, John was reassessed and still deemed to lack capacity, on the grounds of failing to demonstrate insight into his needs and lacking the ability to weigh up information relevant to the deprivation of liberty. John and the IMCA discussed the new capacity assessment. John was very unhappy and made it very clear he wanted to appeal further, to the Court of Protection. This was undertaken by the supervisory body.

As the documents for the appeal were being prepared, the Deprivation of Liberty Safeguards authorisation was due to expire. On reassessing John, the best interests assessor found him now to have capacity. This meant there was no legal authority to deprive him of his liberty, and the authorisation ended. John is now preparing to return home.

Case study: Deprivation of Liberty Safeguards used to increase autonomy



Jo is in her early twenties, lives in a small care home, and has a diagnosis of learning disabilities and a probable personality disorder. She lacked the mental capacity to agree where to live or the restrictions needed to meet her health and wellbeing needs.

She was subject to authorisation under the Deprivation of Liberty Safeguards for about two years. Jo told us that when she was calm she had worked out an ‘advance statement’ with her ‘rep’ (paid representative appointed under the Safeguards). This statement contained Jo’s instructions to her care staff. Advance statements are not legally binding, but those making best interests decisions must take them into account. Jo’s statement explained that, leading up to key dates for her, she wanted them to restrict her access to the telephone and to stop her

from going to certain places. Jo said that the authorisation helped her to keep control during times when she found it hard to control her own behaviour.

Jo acquired the mental capacity to manage her own decisions with support, and the authorisation was ended. She said, “It was kind of scary when they wanted to take it off, since it made me feel happier and safe to have it: it was like a protection that people had to go through before they could get to you.” But in spite of her worries, ending the authorisation has worked really well. She remembers with pleasure how she learned from talking to her representative how to work with her carers on her own care plans, so that now she is the one deciding how her care plans should work.

Case study: Promoting liberty



Mr F moved into a nursing home for a planned short stay while building adaptations were carried out on his property. He chatted with CQC inspectors about how he had “escaped from the home” before, and his future plans for escape. The care home manager confirmed that Mr F had previously left the care home and walked to his daughter’s house. The care home had applied for

a Deprivation of Liberty Safeguards authorisation to prevent Mr F from leaving the home again. The best interests assessor found that Mr F had capacity to make the decision to leave the home, and judged that the service had been overly restrictive in preventing him from leaving. The request was not authorised and Mr F has now returned home.

The IMCA perspective on the person’s experience

Seeking the views of the person is an important step in assessing what is in their best interests. This should include finding out about the person’s past wishes and feelings (including any advance statements), any beliefs and values, and any other factors the person may consider if they were making the decision for themselves.

IMCAs have a crucial role in protecting the rights of people subject to the Deprivation of Liberty Safeguards. As part of this role, they are well placed to understand the experience of the people at the heart of the process, those for whom an authorisation has been sought. In response to our annual online survey of IMCAs, they gave us examples of good practice in person-centred planning, communication and good record keeping, which are critical to the best interests process and finding the least restrictive option.



Good practice example

A care home found out ahead of the person moving in, what their preferences were in terms of how to welcome them, what would make their room more acceptable and importantly they agreed to the person bringing their cat. Although the restrictions still applied, and a standard authorisation was in place, the home constantly sought ways to lessen the restrictions and enable community involvement for the person.

While there was much good practice, IMCAs also gave several examples of poor practice when people’s views had not been considered. One IMCA told us that they had been involved in representing a lady in a care home where she had been lawfully deprived of her liberty for the previous 18 months. The IMCA thought that the home had not done enough to make sure that her care plan represented her wishes and feelings about day-to-day activities and personal care, and staff often ignored her wishes and preferences. As a result, she had been extremely unhappy, which led to the case being taken to the Court of Protection when this could probably have been avoided.

In another care home, advocates had supported the person for many years. He was a reclusive and reticent gentleman and care home staff interacted with him to meet his

daily needs. However, it appeared no one had asked him recently how he felt about being at the care home. It was only when discussing with external professionals, who asked specific questions about his wishes and feelings, that his views came to light.

Views of a relative

Tim V told us about his experiences of the Deprivation of Liberty Safeguards. He lives abroad, although is often in England. His mother, who was then 99 years old, fell out of her chair and was admitted to hospital. When she was ready to leave hospital, Tim was told she would have to go into a nursing home. He said:

“At this time, her bouts of confusion were coming and going; she had hearing difficulties but often seemed her old self. I found a pleasant care home: she didn’t like the idea but accepted admission. Staff were helpful, I would Skype them and they’d hold the screen for my mother so that we could have chats.”

But Mrs V became very unhappy in the nursing home, telling visitors and staff that she was being kept prisoner. The home applied for authorisation to deprive her of her liberty.

“I rapidly realised there was a complicated process, full of acronyms. But I didn’t find it burdensome because the conversations with the best interests assessor (BIA) were so pragmatic, so practical, so full of common sense. I am sure I couldn’t have got my mother home without his help.

“The BIA and I shared a laugh when he told me about his first visit to my mother. He’d told her his name when he first arrived, and asked her, after about 10 minutes, if she could remember it. She rounded on him and said, “Your name doesn’t matter, young man, your job is to get me out of here – get on with it!”

Mrs V was very keen to return to her own cottage, which was still available for her. The BIA identified that a return home, with support, was less restrictive than keeping her in the nursing home where she didn’t want to be, and that this option hadn’t been tried. He tackled head-on the issue of ‘risk’ that kept coming up, telling Tim that judges say there’s no point in making a person completely safe if it makes them immensely unhappy. Mrs V told her son how happy she was to be back in her familiar surroundings, seeing old friends, and that she felt more comfortable. Tim said, “She’s now 101 and still at home, I think she may be on the last lap. I’m glad, perhaps selfishly, that she’s where she wants to be.”

01 RECURRING THEMES: 2009 TO 2014

Key points:

- It is both striking and concerning that we have seen the same themes recurring in our reports over the last five years.
- From 2009 until the Supreme Court judgement on deprivation of liberty in March 2014, there have been consistently low numbers of Deprivation of Liberty Safeguards applications compared to the 21,000 initially predicted by the Government. This could suggest, as we highlighted in last year's report, that providers were not recognising when someone was being deprived of their liberty, so not seeking authorisation.
- We continued to see regional variations in application rates. This could indicate a lack of understanding about the Mental Capacity Act (MCA). Over the last five years we have also found a wide variation in practice and training in health and social care organisations.
- Lack of understanding about, and awareness of, the wider MCA continues to be a barrier to good practice.
- Providers are failing to notify CQC when they apply for authorisation to deprive someone of their liberty. Since 2011, we have received notifications for just 37% of applications to supervisory bodies. This is unacceptable and we will be taking action where this problem persists.



It is now five years since we began reporting on the use of the Mental Capacity Act (MCA) Deprivation of Liberty Safeguards. It is striking and concerning that we have seen the same themes recurring in our reports, until the Supreme Court judgement in March 2014 took effect, which clarified the test for recognising when people are deprived of their liberty. This section outlines these themes and highlights our key findings from the first five years.

Low numbers of applications

When a care home or hospital needs to provide care or treatment in someone's best interests in a way that deprives them of their liberty, they must apply to the local authority for authorisation. Lower than predicted numbers of applications (see page 16) may mean that some care homes and hospitals are not recognising these situations. Conversely, it may mean that providers and local authorities, as some have argued anecdotally, are recognising when a person is, or is at risk of, being deprived of their liberty, and that they are reducing any restrictions so that there is no deprivation of liberty. In last year's report, we said we were concerned that there could be people who were not receiving the protection of the Deprivation of Liberty Safeguards because the hospital or care home had neither sought an authorisation nor tried to find ways to reduce restrictions on their freedoms.

The MCA Code of Practice is clear that a decision about when a deprivation of liberty is taking place is ultimately a legal one. However, on a day-to-day basis it is ordinary health and care professionals who have to make these decisions. Until the Supreme Court ruling in March 2014, professionals had no clear guidance about how to decide when a deprivation of liberty had occurred. This may also have contributed to the low numbers of applications. However, the Supreme Court 'acid test'¹ now provides a clearer framework for decision making. It also highlights that deprivation of liberty is far more widespread in health and social care than was generally recognised.

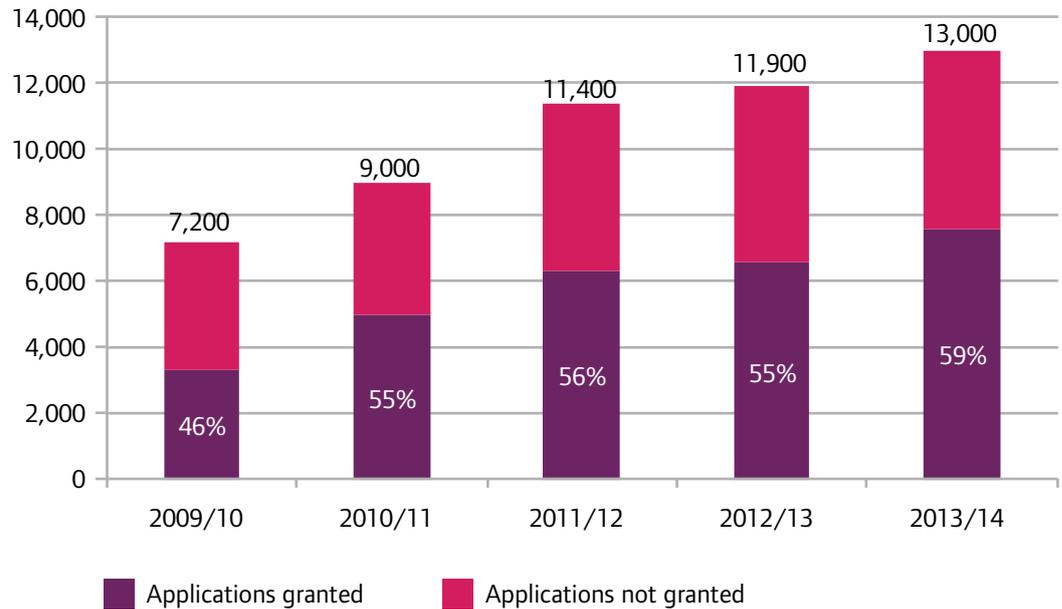
Applications: April 2009 to March 2014

Since the first year of implementation, when the initial number of Deprivation of Liberty Safeguard applications was far lower than expected by government (7,200 compared with the predicted 21,000), numbers have climbed steadily without ever reaching original predictions² (reaching 13,000 in 2013/14, Figure 1). This pattern of rising applications is also contrary to government predictions that applications would fall at a constant rate between 2009/10 and 2014/15, as providers became better at avoiding the need to deprive people of their liberty.

1 *P v Cheshire West and Chester Council and another*, [2014] UKSC 19. See also appendix A.

2 Impact Assessment of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards to accompany the Code of Practice and regulations: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_084982

Figure 1: Number of Deprivation of Liberty Safeguard applications per year in England, 2009/10 to 2013/14³



Applications granted

Originally, the Department of Health impact assessment predicted that only a quarter of all applications for deprivation of liberty would be granted. Since April 2009, however, around 40% to 60% of authorisations have consistently been granted. In the majority of cases, the reason for not granting an authorisation has been that, in the opinion of the best interests assessor, the person was not in fact deprived of their liberty. However, it is still a sign of good practice that the requests for authorisation were made; the decision is one for the assessors, not the providers, who should request authorisation whenever they suspect that they may be depriving someone of their liberty. This is so that the care can be examined independently, to make sure that it is in the best interests of the person, that any restriction on freedom is proportionate to the likelihood of harm to the person and the severity of that harm, and that a less restrictive option cannot be identified to meet the person's needs.

Overall, the proportion of applications granted has increased since 2009. While this levelled off between 2010/11 and 2012/13, there was another increase in 2013/14 (figure 1). There were no marked variations in the number of applications granted per region in 2013/14.

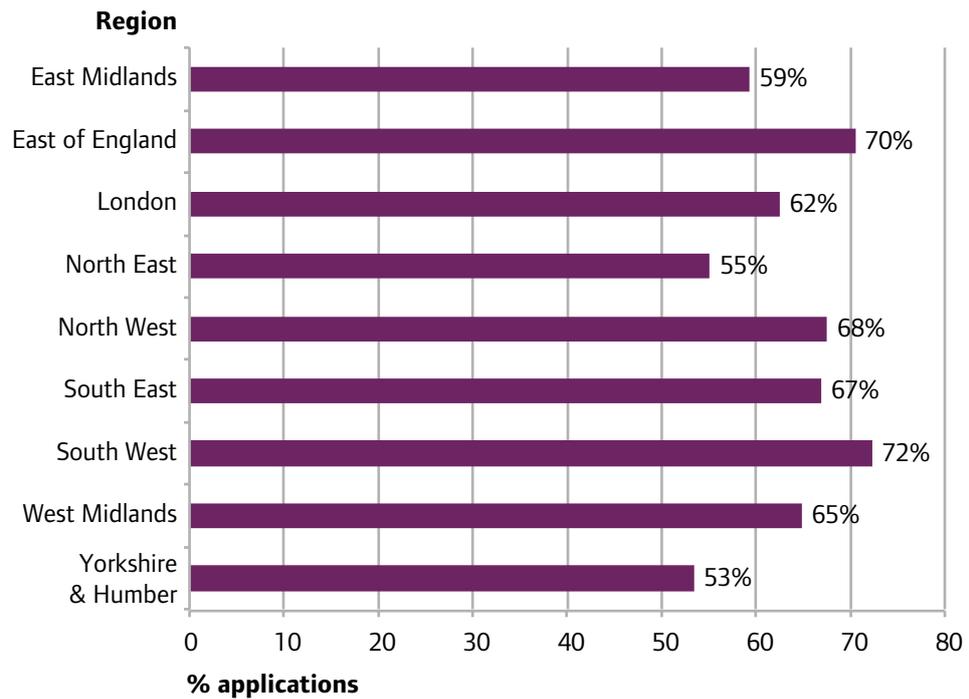
Before the Deprivation of Liberty Safeguards came into effect, it was expected that the majority of requests for authorisation would be made before they were needed. However, over the past five years the majority of initial applications were accompanied by an urgent authorisation. This is needed when the managing authority (care home or hospital) recognises that it is already depriving a person of their liberty, without this being foreseen. While this is not ideal, we recognise that it is not always possible to

³ Figure 1 only includes applications that have a completed date within the reporting year. The number of applications has been rounded to the nearest 10. Data source: www.hscic.gov.uk/catalogue/PUB15856

make these applications in advance. We would, however, recommend that providers undertake regular assessments of people and their care plans to mitigate against this.

In 2013/14, the East of England and South West had the highest proportion of applications with urgent authorisation. The North West and South East also had higher proportions, while the North East, and Yorkshire and Humber had the lowest proportion (figure 2).

Figure 2: Proportion of Deprivation of Liberty Safeguards applications with urgent authorisation by region in England, 2013/14⁴



Applications by service type

In its 2009 impact assessment, the Department of Health predicted that 80% of all applications would be from care homes rather than hospitals. This has consistently been the case over the past five years. The highest number of applications came from care homes, particularly nursing homes, and the lowest number of applications came from specialist mental health hospitals (figure 3).

Application rates across age groups

It is evident that older people are more likely than younger people to be subject to an application for deprivation of liberty (figure 4). In 2013/14, the rate of applications for people aged 85 and over was far higher than those for people aged 18 to 64. The rate of applications for people aged 85 and over has nearly doubled since 2009.

⁴ Figure 2 only includes applications with a completed date within the reporting year. The figure is based on 13,000 applications and percentages are rounded to nearest whole number. Data source: Health and Social Care Information Centre (HSCIC).

Figure 3: Number of Deprivation of Liberty Safeguards applications per CQC service type, 2013/14⁵

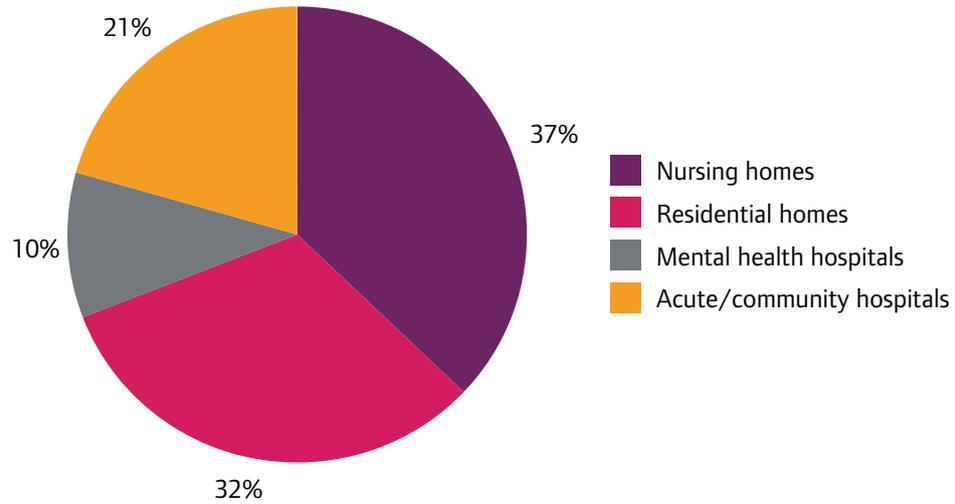
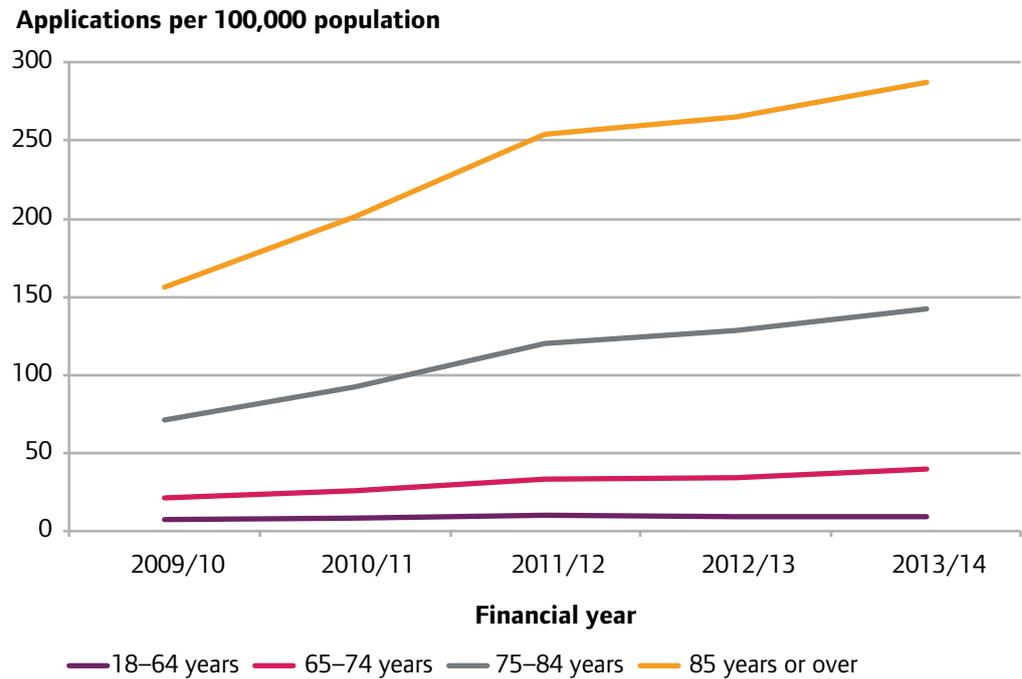


Figure 4: Rate of Deprivation of Liberty Safeguards applications per 100,000 population across age groups in England, 2009/10 to 2013/14⁶



5 Data source: Health and Social Care Information Centre (HSCIC) and CQC. Caveats:
 • Only includes applications that have a completed date within the reporting year.
 • Based on 12,700 applications received by HSCIC with a CQC ID number.
 • Applications rounded to nearest 10.
 • Analysis by HSCIC includes double counting of applications where the location has more than one applicable service type: a number of service types matched by the HSCIC have been excluded from the analysis due to double counting and relevance, for example diagnosis/screening and dentists.

6 Figure 4 only includes applications that have a completed date within the reporting year. Data source: HSCIC and Office for National Statistics (ONS): www.ons.gov.uk/ons/taxonomy/index.html?nscl=Population

Regional variation

Since 2009, we have continued to see regional variations in application rates. The Deprivation of Liberty Safeguards are most often used to protect the rights of older people, who may be living with dementia. We would therefore expect to see more Deprivation of Liberty Safeguards applications in parts of the country with a relatively older population. However, even adjusting the figures to take account of demographic factors, for example the relatively young population of London, variations have persisted and it is difficult to draw conclusions as to why. Potential reasons could include inconsistencies in practice and the levels of understanding within both managing authorities (care homes and hospitals), and supervisory bodies (local authorities).

Geographical disparity

In general, the rate of applications per 100,000 adult population has increased since 2009 across all the regions, except for London (figure 5). Nevertheless, as discussed above, we continued to find geographical variation in the application rates. This variation persisted even when demographic factors were taken into account. Following the Supreme Court ruling and the House of Lords scrutineer committee report (see section 2), which have led to a vastly increased awareness of the Safeguards, we would hope to see less difference in the next reporting year.

Figure 5: Deprivation of Liberty Safeguards applications per 100,000 population by region in England, 2009/10 to 2013/14⁷



Understanding the MCA

There is a widespread lack of understanding among providers and professionals about the MCA. This includes failing to recognise when a person is being restrained, or when someone might be deprived of liberty. Over the past five years, we have found a wide variation in practice, understanding and training in organisations across health and adult social care.

Unrecognised deprivation of liberty

Since our first monitoring report, we have continuously raised concerns that people are being deprived of their liberty without the deprivation being recognised or authorised. We have identified that a low level of understanding and improving practice is an ongoing concern which must be addressed. However, since March 2014 numbers of requests are now surging. This is thanks largely to the clarity provided by the Supreme Court in their ‘acid test’: people lacking the mental capacity to agree to the arrangements for necessary care or treatment are deprived of their liberty if they are not free to leave, *and* if they are under continuous supervision and control.

Failure to notify CQC

Providers are required by law to notify CQC of applications to deprive a person of their liberty and their outcome.⁸ For the past three years, since this requirement came into

⁷ Figure 5 only includes applications that have a completed date within the reporting year. Rates have been rounded to nearest whole number. Data source: HSCIC and ONS.

⁸ Regulation 18 (4A) (4B) and (5) of the Care Quality Commission (Registration) Regulations 2009; these Regulations are not affected by the introduction of the new fundamental standards.

force, providers in care homes and hospitals have failed to notify us consistently when they have used the Deprivation of Liberty Safeguards. When we are not notified, our ability to fulfil our duty to monitor the Safeguards, and make sure that people's rights are being protected, is significantly reduced.

Since 2011, we have received notifications for just over a third (37%) of the applications received by supervisory bodies. This is unacceptable. Using our powers under the Health and Social Care Act we will take action where we find that this problem persists. We have also started to explore why this is happening.

Previously, we have highlighted persistently low rates of notification and suggested a lack of awareness about the Safeguards and a need for training for care staff as possible reasons for low numbers of notifications. During 2013/14, we also looked at the arrangements in place for providers to submit statutory notifications to CQC, not just those relating to deprivations of liberty. This review is still in progress at the time of writing, so changes to our systems are yet to be introduced. However, we hope that they will improve how we capture data and the way we use it for regulatory purposes.

In addition, during 2013/14 we undertook more targeted enforcement action against providers who failed to make statutory notifications. For example, we issued a number of fixed penalty notices to providers without a reasonable explanation for not making important notifications.

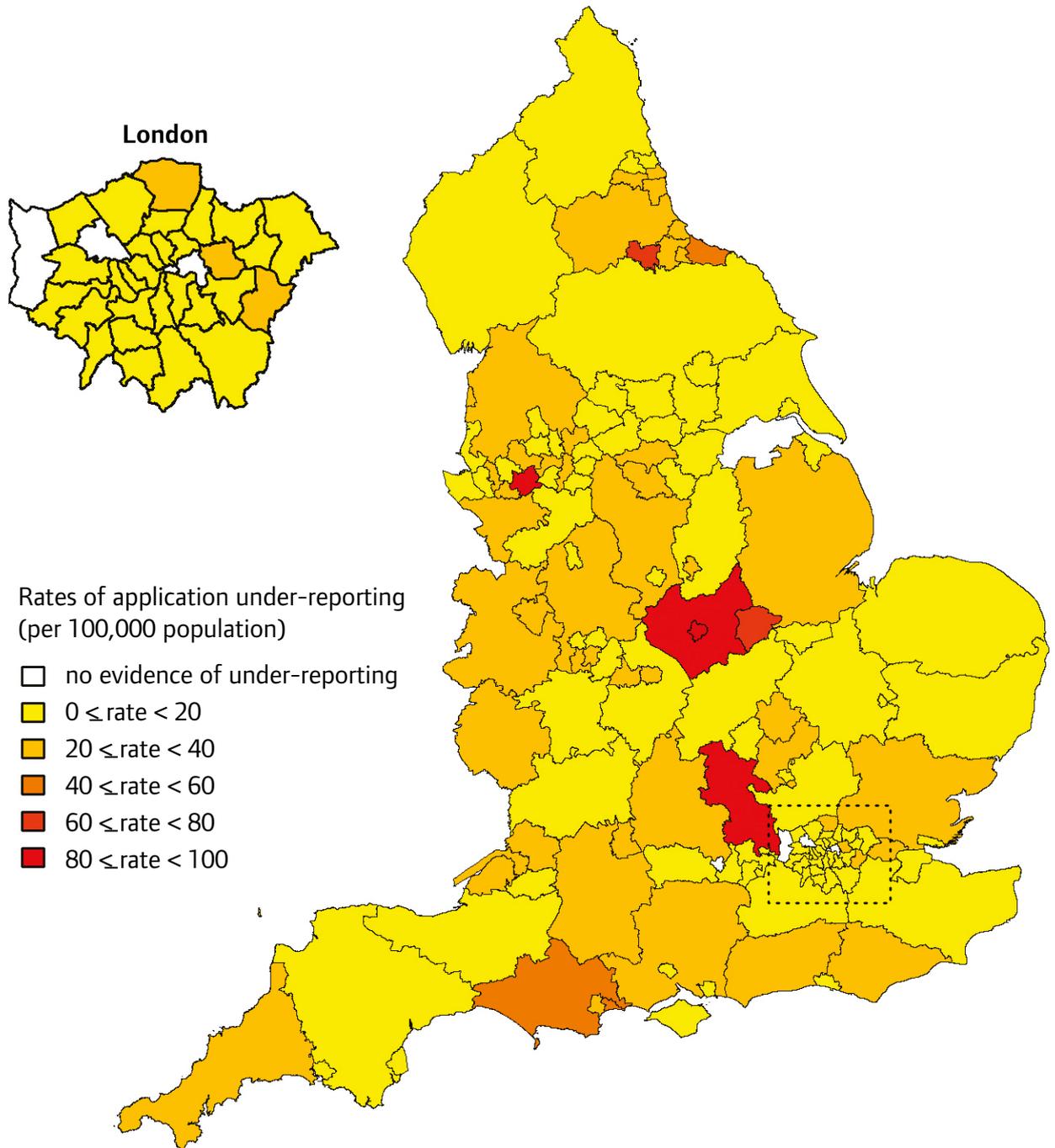
Despite these efforts to encourage providers to notify us of applications and their outcomes under the Safeguards, the majority are still failing to do so (figure 6).

From October 2014, the way that we regulate relevant care providers has changed. We look at whether the service is safe, effective, caring, responsive to people's needs and well-led. One of the areas we look at under 'well-led' is the provider's record in making required notifications. We are confident that this will encourage further improvements in the levels of notifications we receive.

This year, we also examined the notifications we received in 2013/14 in detail to look more closely at the variation in reporting by local authority area. This has enabled us to highlight areas of the country that make higher and lower numbers of notifications which fall outside the national averages.

We will share the regional information with our inspection teams and ask them to remind providers of their responsibility, and to check that they are complying with the requirement to notify us of applications and their outcomes.

Figure 6: Under-reporting of Deprivation of Liberty Safeguards to CQC in 2013/14⁹



9 Data sources: CQC Deprivation of Liberty Safeguards notifications, HSCIC Deprivation of Liberty Safeguards collection, ONS mid-2013 population estimates. The colour grading shows levels of underreporting to CQC by providers within local authorities, with the worst examples being in red.

Reporting deaths to the coroner

From July 2013, coroners have had a legal duty to investigate all deaths that they are made aware of, where they have reason to believe the person died in state detention.¹⁰ ‘State detention’ is defined as “a person who is ‘compulsorily’ detained by a public authority within the meaning of section 6 of the Human Rights Act 1988”, which extends to deprivation of liberty orders, whether authorised by the Court of Protection or by use of the Deprivation of Liberty Safeguards.¹¹ This means that where a coroner is aware that a person subject to a deprivation of liberty authorisation has died, they have a legal duty to investigate it.

In December 2014, the Chief Coroner issued new non-binding guidance to all coroners.¹² In the guidance, he clarifies that in many cases when a person subject to an authorisation dies naturally, in circumstances which are uncontroversial, the inquest may be a ‘paper’ inquest, decided in open court but on the papers only, without witnesses having to attend. Intelligent analysis of relevant information (without the need for a post-mortem examination) may be the best approach. He suggests, rightly, that bereaved families should have all of this explained to them in advance. He encourages senior coroners to work closely with the Deprivation of Liberty Safeguards lead in their local authority, to work together to deal with this extra activity.¹³

Care providers have told us of families experiencing distress when delays occur following someone’s death while subject to the Deprivation of Liberty Safeguards. In particular, they highlighted the situation of people for whom swift burial following death is a cultural norm, and that this is not permitted in these circumstances.

Comment from a care provider: Deaths in custody

“As far as we are aware, when a person under Deprivation of Liberty Safeguards passes away, the coroner has to be informed as, technically, it has to be treated as a ‘death in custody’. This means that we can’t prepare the body for the family to view at the home. It also means that an otherwise good death is tainted for the family, as they await the instructions from the coroner and consent to care for the body.”

10 Coroners and Justice Act 2009, Part 1.

11 Chief Coroner’s guidance No. 16 Deprivation of Liberty Safeguards: www.judiciary.gov.uk/wp-content/uploads/2013/10/guidance-no16-dols.pdf

12 Chief Coroner’s guidance No. 16 Deprivation of Liberty Safeguards.

13 See Department of Health letter to MCA-Deprivation of Liberty Safeguards leads, January 2015: www.mentalcapacitylawandpolicy.org.uk/wp-content/uploads/2014/04/DH-Letter-to-MCA-DoLS-Leads-14-January-2015-FINAL.pdf

Part of the challenge in responding to the Supreme Court judgement is in raising awareness with our partners of the true nature of the Deprivation of Liberty Safeguards. For example, it is not the authorisation that causes a deprivation of liberty, rather the authorisation makes sure that any deprivation of liberty is in the best interests of the individual concerned, can be challenged, and will be regularly reviewed.

We recommend that local authority leads for the MCA and Deprivation of Liberty Safeguards create good working relationships with their local coroners. This is likely to be of great benefit to ensure that a consistent message is given to providers and so that they can work together in dealing with the considerable extra activity as a result of the Supreme Court judgement.

Use of the Deprivation of Liberty Safeguards

Case study: A positive experience of the Deprivation of Liberty Safeguards



Mr J lived with dementia in a care home where he liked to go out, both on his own and with his wife. He could become agitated and physically aggressive when he was out and sometimes overpowered his wife to avoid returning to the care home. The care staff assessed Mr J as lacking capacity to decide to leave the care home. They applied for a Deprivation of Liberty Safeguards authorisation, which was granted. Care staff worked with Mr J and his wife to understand his life story and find out what would make him happier. At the same time Mr J was prescribed medicines that made him feel less

agitated. The care home discovered that Mr J had been a firefighter and relished the responsibility of keeping people safe. Care staff supported Mr J to check the environment for safety and standards and also involved him in practical daily living tasks. They also found he enjoyed going out for walks and to the pub with a male staff member.

Staff found that Mr J was happier and asked to leave the care home less frequently. The Deprivation of Liberty Safeguards authorisation has now been issued for three months.

Under Schedule A1 to the MCA, local authorities (known as ‘supervisory bodies’) are responsible for reviewing and authorising deprivation of liberty applications from providers. They have a crucial role in making sure that people who lack mental capacity are only deprived of their liberty when it is in their best interests, and when there is no less restrictive way to provide their care or treatment.

In last year’s report we committed to continuing to build on our collaborative relationships with local authorities, to promote improvements in compliance with the MCA across the health and social care system. As part of this commitment, we conducted a survey of local authorities to gather information about how they carried out the role of the supervisory body. Our survey consisted of two parts: a focus on their work during the year 2013/14, and the impact of the Supreme Court’s ‘acid test’ of the deprivation of liberty.

This year we also repeated our online survey of Independent Mental Capacity Advocates (IMCAs), and had 26 responses. We have set out the key findings from both surveys below.

Deprivation of Liberty Safeguards process

Once a standard authorisation is granted, the supervisory body must appoint a relevant person's representative (RPR) as soon as possible. When appointed, their role is to maintain contact with the person and to represent the person, if needed, in all matters concerning their deprivation of liberty. These matters might include asking for a review, using the organisation's complaints procedure or making an application to the Court of Protection to lift the authorisation.

When the supervisory body has difficulty in appointing a RPR, or the RPR has ended their role, they must instruct an IMCA to represent the person under section 39C of the MCA. The IMCA's role is only to act for a short period of time as replacement until a RPR is appointed.

Relevant person's representative

The RPR has a crucial role in the Deprivation of Liberty Safeguards process, providing representation and support that is independent of commissioners and providers of services.

If a person subject to an authorisation cannot select their representative for themselves (if only informally, by saying, "I want Molly to be involved in anything to do with me"), the best interests assessor will identify someone from those close to the person, including those who may not approve of the authorisation and are likely to challenge it. If the assessor is unable to recommend anyone, the supervisory body must pay a suitable independent person, often commissioned through a local advocacy service.

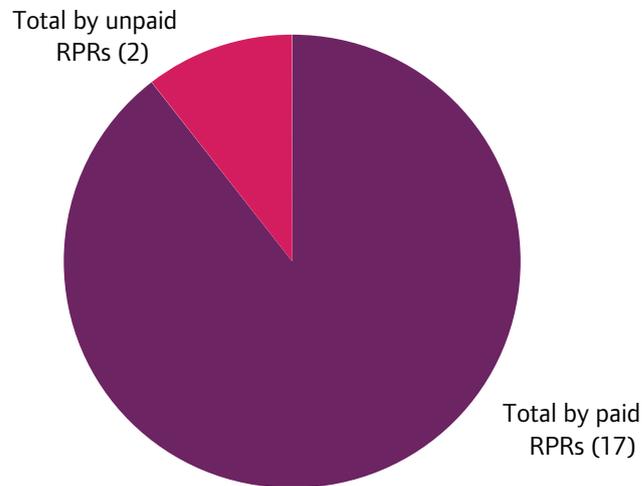
We asked local authorities to comment on the differences between paid and unpaid RPRs. Supervisory bodies said that they would expect a paid RPR to challenge a deprivation of liberty authorisation or care planning for the person more than an unpaid RPR would. They said that paid RPRs do more work with the supervisory bodies, who generally expect them to provide monthly reports. There was also an overwhelming view that paid RPRs had better training, more confidence and understood their role better. However, one local authority found little difference between paid and unpaid RPRs, and two others felt that the RPR system was a weak point in the Deprivation of Liberty Safeguards.

It was evident in the responses from local authorities that paid RPRs, although far fewer in number than unpaid family members, have a better understanding of their role and were more likely to make a request for a review of an authorisation.

Figure 7 shows that this was also the case when making an application to the Court of Protection, with the caveat that our sample size was small. A RPR can support or act on behalf of the relevant person to make an application to the Court of Protection. The right to bring a challenge to the Court of Protection is a fundamental protection for the person at the centre of the process. The number of applications made to the Court of Protection by paid RPRs in our small survey is significantly higher than those made by

unpaid RPRs, even though only unpaid RPRs have automatic access to help from an IMCA to apply to the court.

Figure 7: Number of applications to the Court of Protection made by paid and unpaid RPRs in our sample 2013/14¹⁴



The role of the IMCA when there is no relevant person's representative

As noted above, when the supervisory body has difficulty in appointing an RPR, or the RPR has ended their role, they must instruct an IMCA to represent the person under section 39C of the MCA. The IMCA's role is only to act for a short period of time until a RPR is appointed.

In our survey of IMCAs, we asked how many times they had been appointed under these circumstances. Fifteen out of 26 respondents said that they had been appointed as a section 39C IMCA on 62 occasions. IMCAs also told us that supervisory bodies' use of IMCAs varied, with some quick to appoint RPRs and others routinely using IMCAs to bridge the gap when there were delays in appointing an RPR.

One IMCA commented, "The role is not understood by professionals, who expect long-term involvement. I am often emailing to advise that a paid representative role would be more appropriate if advocacy is required for the term of the deprivation."

Another also said, "There is a need for IMCA services to agree with supervisory bodies how long they will perform the role before a paid representative is instructed if no unpaid person can be appointed. This role is not intended to be long term."

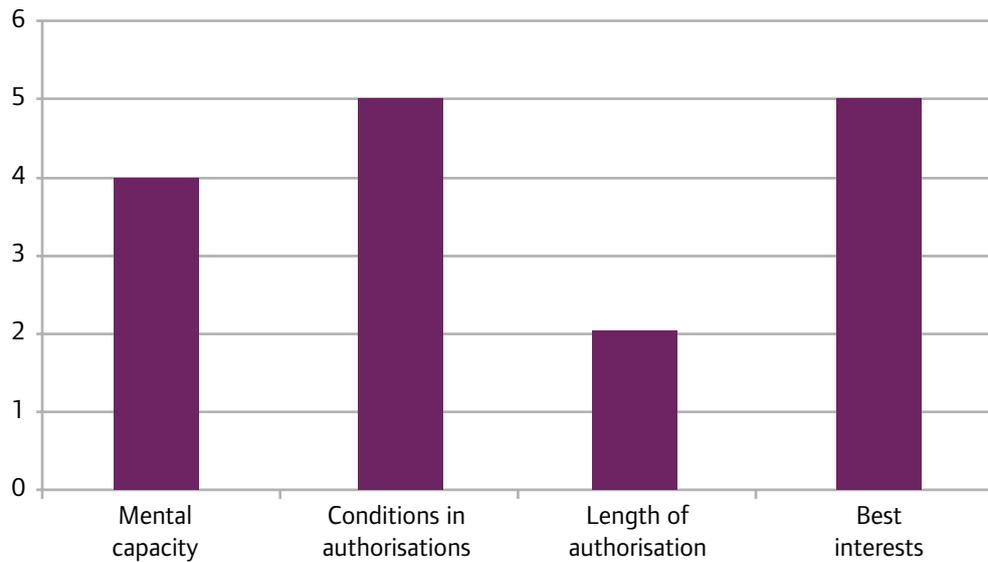
The role of the IMCA in reviewing authorisations

People subject to standard authorisations and their representative have a statutory right of access to an IMCA (MCA, section 39D). The local authority must consider whether the person and their RPR are able to understand and exercise their rights. If there is a risk that they would be unlikely to ask for a review when appropriate, or if they have not done so when it might be thought to be appropriate, then a section 39D referral must be made, even if neither the person nor the RPR has requested it.

IMCAs can support the person or their representative to understand what an authorisation means, help the person to trigger a review, or challenge an authorisation in the Court of Protection. IMCAs can also provide support with a review or with an application to the Court of Protection.

We asked IMCAs whether they had been involved in a review of an authorisation that had been requested by the person or their representative. Forty-two percent of IMCAs who responded said that they had been involved in one or more reviews during 2013/14, related to four of the qualifying requirements in Figure 8.

Figure 8: Types of reviews involving IMCAs in our sample¹⁵



IMCAs told us that, as a result of the reviews they were involved in, changes were made to authorisations in over 50% of those reviewed. In one case, the authorisation was no longer needed following recommendations to ‘fine tune’ the care plan so that the person was no longer deprived of their liberty. In another case, the IMCA reported that the best interests assessor acted on their recommendations and gave the home and local authority six weeks to organise for a person to be moved home with a package of care.

Sometimes IMCAs felt that the review process was not as robust in practice as it should be. One IMCA told us:

“The supervisory bodies in this area are reluctant to carry out a review if the authorisation is due to run out. However, we have had examples of the authorisation with another couple of months to run and the supervisory body still won’t review because ‘it’s so close’. This is all very well, but from the deprived person’s point of view, this is an age!”

The role of the IMCA challenging authorisations

Under section 39D of the MCA, an IMCA must be offered to the person or their unpaid RPR if they, or the local authority, feel they need support to exercise their rights and to challenge an authorisation that has already been granted. Some unpaid representatives

¹⁵ Data taken from the 26 IMCA responses to the Independent Mental Capacity Advocate Survey 2013/14, July 2014.

also need support to fulfil their role and can ask the local authority to provide an IMCA to support them when required.

Local authorities told us of a range of practice in IMCA referrals, with some saying they would only instruct an IMCA if recommended by a best interests assessor. Even where there was disagreement between the person and the representative, some said they did not instruct an IMCA. This practice is to be deplored as if the RPR does not help them to challenge an authorisation, it is hard to see how many people subject to an authorisation can exercise their right to challenge it.¹⁶

These differences in practice echo the findings of the most recent Department of Health report into IMCA use. These found that about a third of local authorities had not made a single section 39D referral all year, including some with over 100 Deprivation of Liberty Safeguards authorisations. The report also showed that there had been a 17% reduction in referrals for a section 39D IMCA (to help challenge an authorisation).¹⁷

Twenty-three percent of IMCAs in our survey said that they had been involved in appealing against an authorisation to the Court of Protection and 46% had been asked to act as a litigation friend.

IMCAs found the process lengthy and dauntingly complex. They felt that there was generally a lack of guidance for IMCAs about taking cases to the Court of Protection and because of this there were unnecessary delays. They felt that they would benefit from clear guidance¹⁸ about the process and how it should be used.

We note that even before the rise in requests for authorisation some local authorities were not always providing the support of an IMCA or promoting their vital role in supporting the person to exercise their rights.

We recommend that local authorities and IMCA providers work together to enable IMCAs to carry out their role to support the person or unpaid RPR to challenge an authorisation to the Court of Protection when it is the person's wish, whatever the IMCA's views on the rightness of the authorisation.

Meeting statutory deadlines

When the supervisory body accepts an application for authorisation it must complete all the assessments required within 21 days. If there is an urgent authorisation already in force, assessments must be completed in seven days.

In 2013/14, 81% of local authorities met these statutory timescales. Within this, they met 78% of those accompanied by an urgent authorisation, and 86% of those where there was just a standard authorisation request.

16 *MH v UK* www.bailii.org/eu/cases/ECHR/2013/1008.html

17 Department of Health. Independent Mental Capacity Advocacy service: sixth annual report. DH, 2014. Figure 7.1, page 33. www.gov.uk/government/publications/independent-mental-capacity-advocacy-service-sixth-annual-report

18 Alexander Ruck Keene. Acting as a litigation friend in the Court of Protection. The University of Manchester, 2014. (Now produced as a Department of Health commission: www.law.manchester.ac.uk/medialibrary/Main%20site/LAC/Acting-as-a-Litigation-Friend-in-the-Court-of-Protection-October-2014.pdf)

However, it is disturbing that, even before the recent surge in applications following the Supreme Court judgement, over 20% of people who were deprived of their liberty under an urgent authorisation had these restrictions imposed for more than seven days, without the full protection of the assessment and authorisation process of the Deprivation of Liberty Safeguards.

Peer group support

We asked local authorities what sources of peer group practice and policy review and support their supervisory body was actively engaged in. Nearly all local authorities reported that their supervisory body took part in regular planned Deprivation of Liberty Safeguards leads network meetings. Over half said that they maintained contact with their neighbouring authority and also used online resources such as forums, newsletters and email circulars to share training and updates. Most supervisory bodies provided regular ongoing training and kept up to date with legal issues.

Supporting providers in hospitals and care homes

Local authorities told us that they offered support to providers of care. Most support was given by telephone, but some said that they offered free training or carried out support visits to the providers. Other forms of support offered included e-learning, newsletters or information on their website. Some local authorities said that they provided quality feedback on applications. We recommend that local authorities provide quality feedback on applications as this may help providers improve their practice.

Barriers to good practice

Last year, 85% of local authorities told us that care homes' and hospitals' poor understanding of their role and function was a barrier to good practice. They also said there was a general lack of understanding and awareness of the MCA and confusion over the Deprivation of Liberty Safeguards.

This year the responses from local authorities were broadly similar, indicating that little has changed over the past year. The main barriers identified this year were:

- Providers do not understand their role and function.
- The design of forms.¹⁹
- A lack of understanding and awareness among providers of the Deprivation of Liberty Safeguards.²⁰
- A lack of understanding and awareness of the MCA in general.
- The seven-day limit on processing standard requests accompanied by urgent authorisations.

19 The Department of Health has commissioned revision of the forms from the Association of Directors of Adult Social Services (ADASS) and these are now available (January 2015).

20 The Government has commissioned a full review of the Deprivation of Liberty Safeguards from the Law Commission.

Last year we also highlighted the need for local authorities, providers and commissioners to continue to undertake activities or urgently initiate activities to raise awareness of the MCA including the Deprivation of Liberty Safeguards. Once again, we urge all those agencies involved in health or social care that might be associated with a deprivation of someone's liberty to continue their efforts to improve practice in this area.

We will continue to encourage these efforts and drive improvement through our inspection and regulation of providers of health and care services.

We have started to consult with provider organisations to encourage improvements in practice, across all sectors. We will continue this work in 2014/15 and report on our progress in our next annual report.

02 RECENT DEVELOPMENTS

Key points:

- March 2014 was a landmark moment for the Mental Capacity Act (MCA). The House of Lords MCA post-legislative scrutiny committee published its findings, which highlighted that the implementation of the Act had not met expectations and reinforced that the Safeguards are overly bureaucratic and complex.
- The same month the Supreme Court handed down its judgement on the case of '*P v Cheshire West and Chester Council and another*' and '*P and Q v Surrey County Council*'. The judgement clarified when a person is being deprived of their liberty.
- Data from the Health and Social Care Information Centre (HSCIC) additional voluntary data collections in 2014/15 show that there has been a substantial increase the number of applications made, with many more applications made in the first two quarters of 2014/15 than the whole of 2013/14.
- Local authorities have been overwhelmed by this vast increase in applications and at the end of September 2014, there were 19,429 applications pending a decision. This is unacceptable and represents a worryingly high number of people who are probably deprived of their liberty without authorisation.



House of Lords Mental Capacity Act post-legislative scrutiny committee

In May 2013, the House of Lords Mental Capacity Act (MCA) post-legislative scrutiny committee was set up to establish whether the MCA is working as Parliament intended. The committee published its findings on 13 March 2014.

The committee found that the MCA (with the exception of the Deprivation of Liberty Safeguards) is held in extremely high regard. However, it noted that its implementation has not been as successful as expected, with a lack of awareness and understanding about the Act. The committee commented in its report:

“For many who are expected to comply with the Act it appears to be an optional add-on, far from being central to their working lives. The evidence presented to us concerns the health and social care sectors principally. In those sectors, the prevailing cultures of paternalism (in health) and risk aversion (in social care) have prevented the Act from being widely known or embedded. The empowering ethos has not been delivered. The rights conferred by the Act have not been widely realised. The duties imposed by the Act are not widely followed.”²¹

The committee found that, historically, CQC had not used its powers in the best way to make sure that the requirements of the MCA were met in practice. However, they acknowledged and welcomed our current commitment to making sure that the MCA is built into the way that we conduct our inspections, whether of hospital services, community healthcare services or adult social care services. As a result of their findings, the committee made 39 recommendations, one of which was directly aimed at CQC. In their recommendation, the committee said that we should include compliance with the MCA as a core requirement that must be met by all health and care providers, and make this clear in our guidance.

Impact of the committee’s report

In June 2014, the Government published its response to the House of Lords committee report *Valuing every voice, respecting every right: Making the case for the Mental Capacity Act*²², which welcomed the committee’s findings.

In particular, the House of Lords report reinforced the widely held view that the Safeguards are overly bureaucratic and complex. In response to this, the Government has asked the Law Commission to review the legal framework both for the Deprivation of Liberty Safeguards and for authorising deprivation of liberty requests in the community as part of their Twelfth Programme of Law Reform.²³ We welcome this initiative.

21 House of Lords Select Committee on Mental Capacity Act, *Mental Capacity Act 2005: post legislative scrutiny*. HL paper 139 (6 para 3).

22 HM Government. *Valuing every voice, respecting every right: Making the case for the Mental Capacity Act*. The Government’s response to the House of Lords Select Committee Report on the Mental Capacity Act 2005. Crown Copyright 2014. www.gov.uk/government/uploads/system/uploads/attachment_data/file/318730/cm8884-valuing-every-voice.pdf

23 Law Commission. Twelfth Programme of Law Reform. 2014. http://lawcommission.justice.gov.uk/docs/lc354_twelfth_programme.pdf

Additional actions by the Department of Health and others

- A new National Mental Capacity Forum was announced by the Department of Health and Ministry of Justice at the end of November 2014, with a focus on forming an alliance of partners and interested parties to raise awareness of the MCA and improve practice.
- The Social Care Institute for Excellence (SCIE) has been commissioned by the Department of Health to collect MCA materials (guidance, toolkits, information materials), to review these, and to put them on a dedicated website so that they are widely available.
- SCIE has also been commissioned by the Department of Health to produce a report on embedding the MCA into care planning.²⁴
- Alexander Ruck Keene has been commissioned by the Department of Health to produce guidance on litigation friends/IMCAs.²⁵
- The Association of Directors of Adult Social Services (ADASS) has been commissioned by the Department of Health to revise the Deprivation of Liberty Safeguards standard forms and produce essential guidance for local authorities to ensure consistency in practice, for example how they assess applications and communicate with the providers making the applications.
- The Law Society has been commissioned by the Department of Health to produce case law guidance.
- A new chapter in the Mental Health Act (MHA) Code of Practice on the MHA/MCA/Deprivation of Liberty Safeguards interface will be published by the end of January 2015.
- A forthcoming publication for people who use services and carers provides a statement of rights given to them by the Mental Capacity Act.
- We are pleased that NHS England's draft standard contract²⁶ (due for publication in early 2015) goes further than we recommended in last year's report, in making sure that the wider MCA is central to commissioning of services.

The Supreme Court judgement

In the same week that the committee published its report, the Supreme Court handed down its landmark judgement on '*P v Cheshire West and Chester Council and another*' and '*P and Q v Surrey County Council*'²⁷ (see appendix A). The ruling confirmed that there are two key questions (the so-called 'acid test') to be answered when a person

24 Social Care Institute for Excellence. Mental Capacity Act. www.scie.org.uk/publications/reports/70-mental-capacity-act-and-care-planning/

25 Alexander Ruck Keene. Acting as a litigation friend in the Court of Protection. The University of Manchester, 2014. (Now produced as a Department of Health commission: www.law.manchester.ac.uk/medialibrary/Main%20site/LAC/Acting-as-a-Litigation-Friend-in-the-Court-of-Protection-October-2014.pdf)

26 Private communications, NHS England, 13/11/2014;12/12/14.

27 *P v Cheshire West and Chester Council and another*, [2014] UKSC 19

lacks the mental capacity to consent to, or refuse suggested arrangements for, care or treatment that is thought to be in their best interests:

- Is the person not free to leave? **and**
- Is the person subject to continuous supervision and control?

If the answer to both questions is 'yes', then the person is deprived of liberty.

The Supreme Court also clarified that the following factors do not determine whether or not someone is being deprived of their liberty:

1. The person's compliance or happiness or lack of objection.
2. The suitability or relative normality of the placement (after comparing the person's circumstances with another person of similar age and condition).
3. The reason or purpose leading to a particular placement.

However, all these factors are still relevant to whether the deprivation of liberty is in the person's best interests, and should therefore be authorised.

The Supreme Court suggested that, because of the extreme vulnerability of people who lack mental capacity, such as those individuals with learning disabilities whose situations were examined in the Cheshire West case, we should "err on the side of caution" in deciding what constitutes a deprivation of liberty for people lacking mental capacity. Authorisation provides a periodic independent check on whether the arrangements made for them remain in their best interests. The Court also clarified that we should not regard the need for such checks as in any way stigmatising of those lacking mental capacity or of those providing the care. Rather, use of the Deprivation of Liberty Safeguards is a recognition of their equal dignity and status as human beings.

Evidence from the first two quarters of 2014/15²⁸

Following the Supreme Court ruling, the Health and Social Care Information Centre (HSCIC) arranged additional voluntary data collections in 2014/15. These were held quarterly and the purpose was to help local authorities to monitor the impact of the ruling, as well as record and quantify any increase in the number of Deprivation of Liberty Safeguards applications.²⁹

In light of the huge rise in use of the Deprivation of Liberty Safeguards, and using these data, we compared the total number of applications made in 2013/14 with the number reported by respondents in the first two quarters of 2014/15.³⁰

Figure 9 shows that the number of applications made in the first two quarters of 2014/15, as a voluntary collection based on the data from 143 local authorities, already exceeded the number made by all 152 local authorities in the whole of 2013/14. It appears from the data that some local authority areas have experienced a substantial

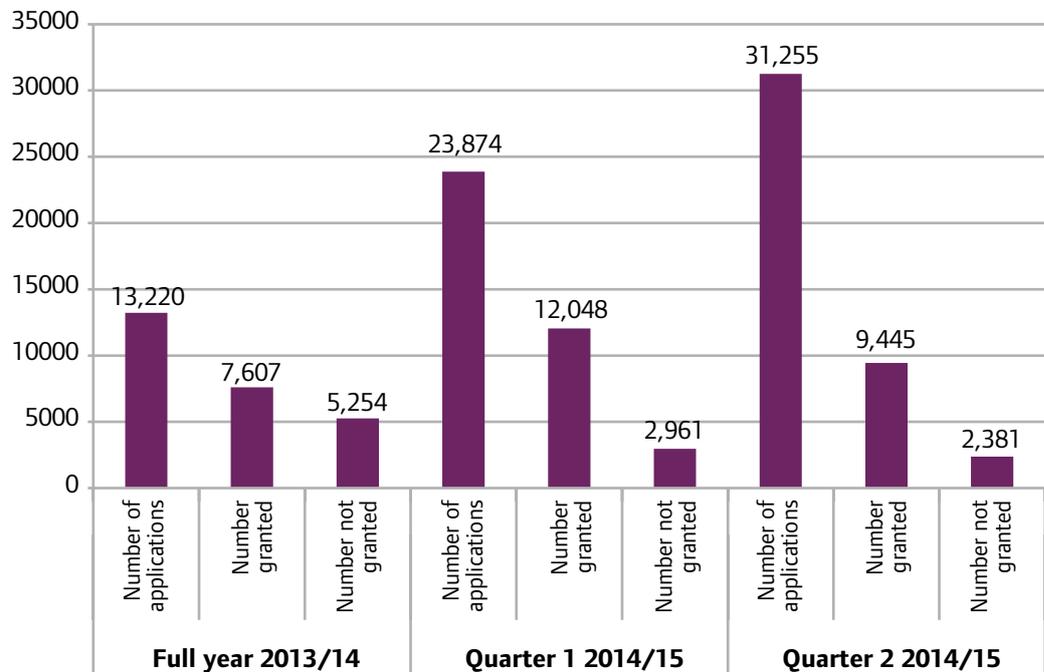
28 Data source: www.hscic.gov.uk/catalogue/PUB15856

29 Health and Social Care Information Centre. *Mental Capacity Act 2005, Deprivation of Liberty Safeguards (England) Quarter 2 Return, 2014-15*. HSCIC, November 2014.
www.hscic.gov.uk/catalogue/PUB15856/dols-q2-1415-data-qual.pdf (page 4).

30 This was a voluntary collection but 143 local authorities out of the 152 provided data.

increase, while others have had little or no increase: this is something to explore further when we have a full year's data.

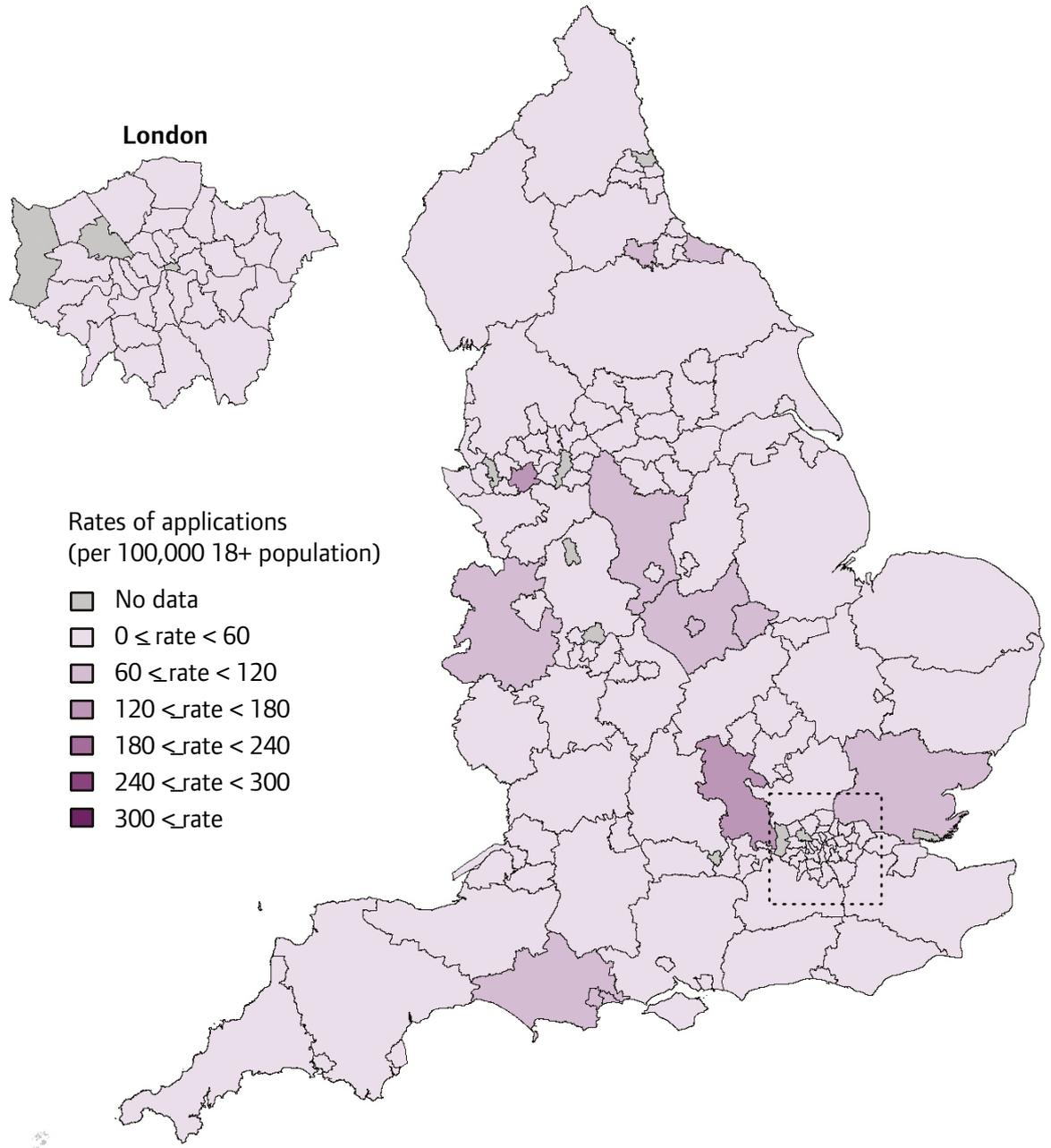
Figure 9: HSCIC Deprivation of Liberty Safeguards applications, 2013/14 full year and Quarter 1 and Quarter 2 of 2014/15³¹



Figures 10a and 10b (pages 36 and 37) shows a great change in practice, which we welcome, among local authorities and providers, following the Supreme Court judgement. Some local authorities with historically low levels of use of the Deprivation of Liberty Safeguards have received high numbers of applications during the first two quarters of 2014/15. The relevance of this will become clearer when we have a full year's data to explore.

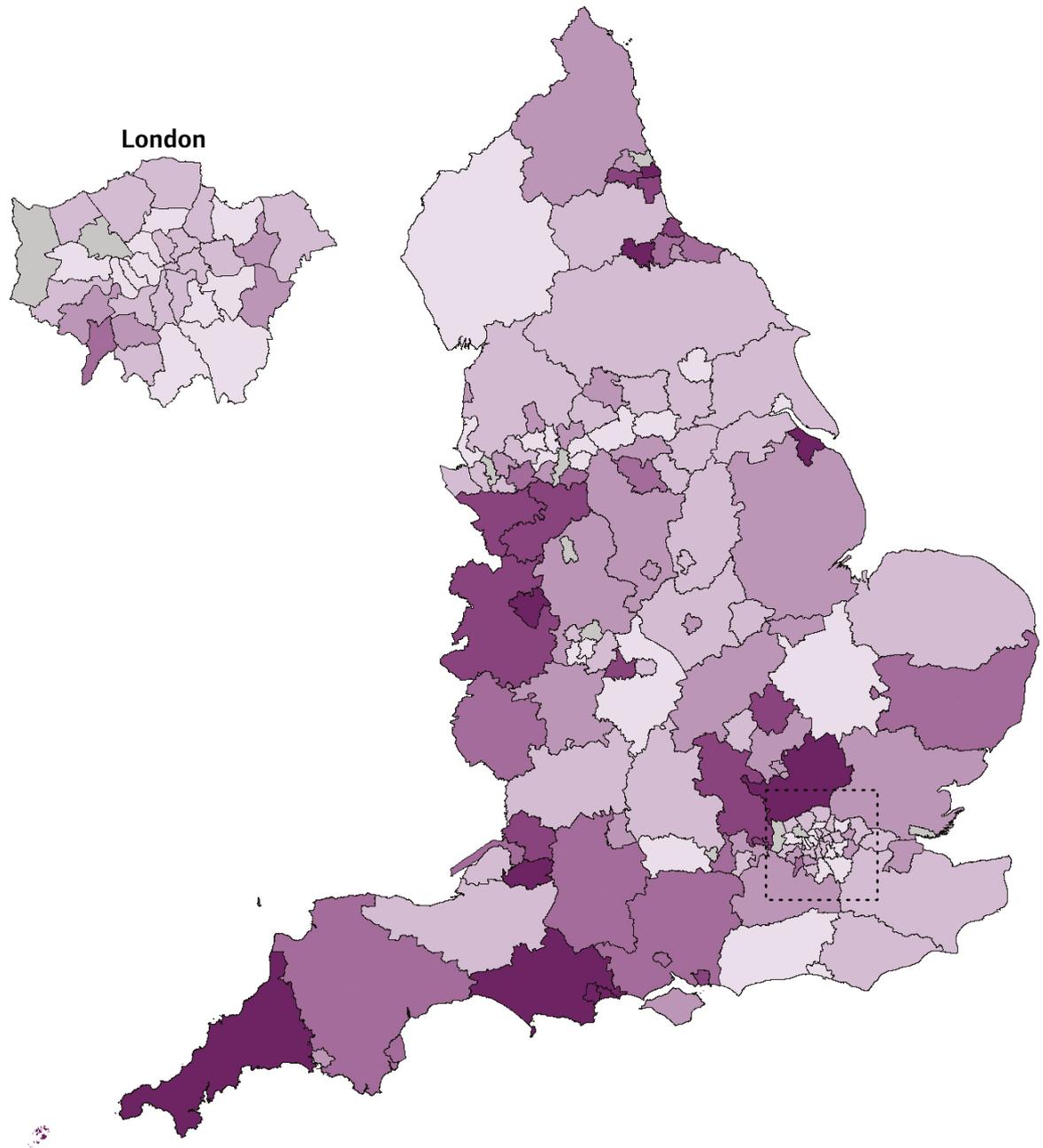
³¹ HSCIC data only includes applications with a completed date within the reporting year. There is a discrepancy in the number of applications and number granted/number not granted. This is made up by the number of applications not yet signed/withdrawn. These total: 359 (Full year 2013/14), 8,865 (Q1 2014/15) and 19,429 (Q2 2014/15). Eleven local authorities have not submitted data for Q1 and 20 for Q2. Data source: HSCIC.

Figure 10a: The rate of Deprivation of Liberty Safeguards applications in 2013/14³²



32 Data sources: HSCIC and ONS.

Figure 10b: The rate of Deprivation of Liberty Safeguards applications in Quarter 1 and Quarter 2 of 2014/15³³ (HSCIC voluntary data collection)



As illustrated in Figures 10a and 10b, the number of applications reported by most (but not all) local authorities in the first two quarters of 2014/15 (55,129) already greatly exceeds the number made by all local authorities in 2013/14 (13,220). At the end of September 2014, there were 19,429 applications where a decision was still to be made, while at the end of 2013/14 there were just 359 where a decision was still to be made. There will always be some applications that are in the process of being assessed on the date of cut-off for data submission. However, the figures from the first two quarters show

just how overwhelmed many local authorities are by the unexpected and vast increase in applications.

While we appreciate the unprecedented and unexpected increase that local authorities have faced, the very high numbers of applications still to be decided represents a worryingly high number of people who are probably deprived of their liberty unlawfully.

In addition, it places a great burden on providers who, although they suspect that they may be depriving people of their liberty, do not have the support of external scrutiny by Deprivation of Liberty Safeguards assessors to find the least restrictive option to meet the needs of each individual. Only by going through the assessment process and an authorisation being either given or refused, can providers be given the security of knowing that their care is lawful and the least restrictive option to meet the needs of each particular individual.

Some providers have told us that local authorities have told them not to put in requests for authorisation, or even returned the applications with instructions to wait until the backlog has cleared. This is not a common action by local authorities, but even rare occurrences are unacceptable.

Not only would this refusal to accept applications mask the true nature of the increased pressures faced by local authorities, it would deny providers the opportunity to provide care lawfully, despite their best efforts to obtain authorisation. Most importantly, it would prevent independent scrutiny of the care arrangements for vulnerable people when those arrangements are thought likely to amount to a deprivation of liberty.

We recommend that hospitals and care homes continue to request authorisations when they think that people are being deprived of their liberty based on the new 'acid test'. However, they must also continue, within the provisions of the wider MCA, to seek less restrictive options to meet the needs of each person.

Case study: Views from care homes on the recent developments



“Deprivation of Liberty Safeguards only has a positive impact if the care regime is poor, i.e. overly restrictive, and where the supervisory authority imposes conditions.”

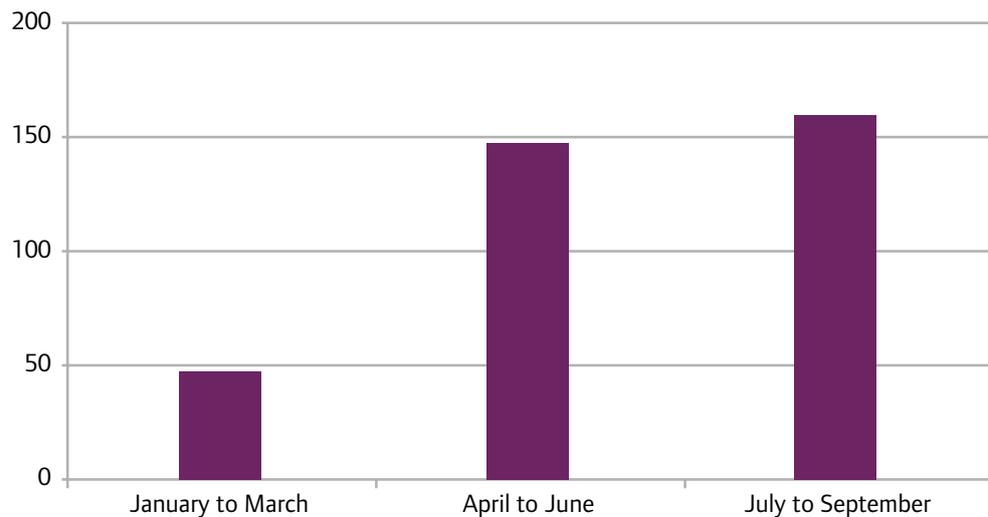
“My personal experience is that of an increasing and unnecessary bureaucratic burden. Where previously we had three residents out of 36 with a Deprivation of Liberty Safeguard, we now have 20, purely because they are subject to constant supervision. In every case, these have been

granted with no conditions applied. It takes a good half day to complete the paper work, and another half day to meet the various assessors, and complete the Regulation 18 forms etc. The Deprivation of Liberty Safeguards authorisations are routinely given for three months, and rarely for a year. This means as a single care home, we are envisaging spending over 100 administration days in the year, just to support Deprivation of Liberty Safeguards applications.”

We understand that some providers are finding the processes associated with the Deprivation of Liberty Safeguards a burden. Nonetheless, we emphasise how vulnerable people benefit when it is recognised that they are being deprived of their liberty. We also emphasise the value of independent scrutiny by best interests assessors. While we welcome the Government's actions to find ways to lessen the burdens associated with the current Deprivation of Liberty Safeguards, primarily the Law Commission's work to consider a replacement mechanism, we are clear that it is our duty to assess compliance with the legal systems in place, which, for the time being, are the Deprivation of Liberty Safeguards.

As with applications to local authorities, the number of applications for deprivation of liberty authorisations to the Court of Protection has also already increased. Local authorities are carrying out audits of people cared for in supported living services, shared lives schemes or extra-care housing. Initial estimates from these audits suggest that the number of applications to the Court of Protection, which are already rising, will soar in a similar way to the Deprivation of Liberty Safeguards applications in hospitals and care homes.

Figure 11: Increase in the number of applications made to the Court of Protection in 2014³⁴



In response to the current and predicted increase in applications, in November 2014 the Court of Protection introduced new measures to streamline its process for managing applications for a court-authorized deprivation of liberty.³⁵ In addition, a group of new judges has been put in place to deal with non-contentious requests for authorisation (including those where there is no disagreement on the facts, where the person appears happy in their living situation, and where restraint is light touch).

³⁴ Data source: Communication from the Court of Protection, 30 October 2014.

³⁵ HM Courts and Tribunals Service. Letter Re Implementation of the Re X Procedure. November 2014.

<https://courtofprotectionhandbook.files.wordpress.com/2014/11/letter-to-court-users-re-x-process.pdf>

03 MONITORING THE USE OF THE DEPRIVATION OF LIBERTY SAFEGUARDS IN CARE HOMES AND HOSPITALS

Key points

- Last year we committed to improving the knowledge of our inspectors and wider staff. Over the last year we have improved awareness through better training on the Mental Capacity Act (MCA), integrating the MCA into our new inspection methodology, and updating our resources for providers and inspectors.
- We have analysed the enforcement actions taken by CQC in 2013/14 associated with the MCA, including Deprivation of Liberty Safeguards.
- By August 2014, 61% of the providers who we took action against had made improvements. Our inspectors are continuing to monitor the remaining services and take further action if required.



Case study: Views from care homes



“[Staff] have an increased awareness of Deprivation of Liberty Safeguards and have involved families, and people who use the service where possible, because they do have a locked door and therefore they might be depriving people of their liberty because most residents do not have the key code. They have taken time to

explain this to families and families are reassured that the situation is being openly discussed and acknowledged.”

“We have been giving thought to what this means for our residents and using the Deprivation of Liberty Safeguards process to benefit our clients and improve their circumstances”.

Our frontline staff

In last year’s report we said that we would make sure that the Mental Capacity Act (MCA) is embedded in the way that we operate. We committed to improving the knowledge and confidence of our inspectors, and encouraged them to support all the services we regulate to use confident, human rights-based, MCA-compliant practice.

We also said we would update the materials for inspectors and for users of our website and integrate the MCA into our new approach to inspection across all sectors.

Over the past year we have:

- Integrated the MCA into our new inspection methodology across all sectors we regulate, including a specific key line of enquiry that is linked to consent.
- Given all new CQC staff awareness training on the MCA as part of the corporate induction programme.
- Given all new inspectors better training on the MCA, including the Deprivation of Liberty Safeguards, as part of their role specific induction training.
- Developed, and are delivering, a training programme for all existing inspectors.
- Provided advanced training to 100 inspectors across all regions and all sectors who will become MCA leads in their area to provide ongoing support and advice to other inspectors.
- Updated our MCA e-learning package for staff.
- Established an MCA policy team.
- Started updating and improving our website resources for providers and for our inspection staff.

Our inspectors' experience of monitoring the Deprivation of Liberty Safeguards

This information was collected by asking inspectors for examples of the use of the Deprivation of Liberty Safeguards from their practice. We also analysed a sample of published inspection reports and enforcement action taken.

As part of the planning process for the inspection of a care home or hospital, our inspectors check whether the provider has made any Deprivation of Liberty Safeguards notifications to CQC. This enables the inspector to specifically look at the care given to people subject to a Deprivation of Liberty Safeguards authorisation during an inspection and, where possible, listen to the person's experiences. Inspectors check that the service is acting in accordance with the authorisation and not restricting the person more than is authorised. Our inspectors also check that people using the service are not being deprived of their liberty without the proper authorisation.

Good practice

When providers are acting within the principles of the MCA they have clear policies and guidance in place, and staff are aware of these and apply them in practice. People's care records should show clearly what support they have been given to make their own decisions. Where people are not able to make their own decisions, and there is no one with legal authority to act on their behalf, care records should record how decisions have been made in the person's best interests.

Our inspectors found that staff working in some care homes and hospitals understood the MCA, including the Deprivation of Liberty Safeguards, and acted in a way that made sure the rights of people who lacked capacity were being protected.



Good practice examples

"An authorisation under the Deprivation of Liberty Safeguards had been issued because this patient had continually wanted to leave the hospital to return to their home, and they had been assessed as not having the capacity to make this decision. Staff said that when an application for an authorisation was made, the trust staff worked cooperatively with staff from adult social services who undertook the assessment. They felt that this process worked well."

"We saw that the home had procedures around the assessment and recording of people's mental capacity to ensure that decision making was in line with the Mental Capacity Act 2005. We also spoke with two social workers who were attending a meeting in regards to a person's Deprivation of Liberty Safeguards assessment. The Deprivation of Liberty Safeguards make sure that there are systems in place so that if a person lacks the capacity to consent to their care or treatment, their freedom is not restricted more than necessary, and any restriction is in their best interests."

Poor practice

When providers do not understand the MCA and the Safeguards, we find clear evidence of it through our inspection activity. Despite the Safeguards being in effect since 2009, we are still finding many examples of unacceptably poor practice.



Poor practice examples

“The manager had assessed a person as ‘lacking capacity to consent’ and had made the decision [that] the person’s family was to act on their behalf. There was no evidence that anyone in the person’s family had legal authority to act on their behalf and no consideration of the person’s best interests.”

“A condition had been attached to the authorisation for one person, requiring them to be given support to access the community at least once a week. This had not happened over a three-month period.”

“We spoke with staff who told us that staff had given a patient sedative medication as an injection because the patient had refused the medication. We spoke to this patient, who said: ‘I had an injection but didn’t want it.’ This patient’s medical notes stated: ‘Patient is at risk to [self] and at risk to other patients. Given IV [sedative medication] – best interests as patient has no capacity.’ There was no record of a capacity assessment of this patient regarding the decision to stay in hospital or the decision to take or refuse medication. There was no detail regarding how the patient was a risk to themselves.”

Review of our enforcement actions

Case study: Use of restraint



“We found that care workers were regularly using physical restraint with three people during the delivery of care, due to their behaviour. There was also evidence that one person was sedated before being given personal care. Our checks of the three people’s care files showed there were no records that capacity assessments were carried

out ... Nor did we find records that the decision to use restraint had been formally assessed and decided through a best interests process to show that this action was necessary, proportionate and the least restrictive practice.”

When we find that a service is not complying with the regulations we ask the provider to make improvements. There are a range of enforcement actions that our inspectors can take depending on the severity of the breach and the level of risk posed to people using the service.

We analysed what enforcement actions we had taken during 2013/14 with providers who were not complying with the regulations associated with the MCA and Deprivation of Liberty Safeguards. We found that:

- Over half (19 out of 34) of all enforcement action taken under Regulation 18 (Outcome 2 – consent) contained some evidence that the provider had not complied with the MCA, including the Deprivation of Liberty Safeguards.
- Almost a quarter (23 out of 94) of all enforcement action taken under Regulation 11 (Outcome 7 – safeguarding) contained some evidence that the provider had not complied specifically with the Deprivation of Liberty Safeguards.

We also found some common themes emerging:

- People's capacity to make a specific decision was not being assessed.
- Decisions were being made on behalf of people without following the best interests decision making process.
- Relatives were asked to give consent without legal authority.
- The person and other people concerned with the person's care were not always being consulted when making best interest decisions.
- There were examples of unlawful use of restraint and unauthorised deprivation of liberty.
- Lack of staff training in the MCA including the Deprivation of Liberty Safeguards.

We looked at whether our enforcement action had been effective in driving improvement in those services reviewed. By August 2014 we found that 61% of services against whom we took action had made improvements. Our inspectors are continuing to monitor the remaining services and taking further action where necessary

Through our analysis, we also identified that the way inspectors reported on the MCA, including the Deprivation of Liberty Safeguards, varied. In some areas we struggled to get accurate figures about the enforcement actions taken by CQC as there were issues with the reporting of actions taken. As a result, the above figures should not be taken as a complete account of our entire MCA and Deprivation of Liberty Safeguards enforcement activity.

Through our new regulatory approach, we will inspect and report against the MCA under the key question 'are services effective?'. This will help us to resolve reporting issues such as these in the future. Also, prompts for inspectors will encourage them to consider the MCA far more widely than just the Deprivation of Liberty Safeguards.

CONCLUSIONS

The Deprivation of Liberty Safeguards have been in effect since 2009 and up until March 2014 our monitoring showed that very little had changed in their use during the previous five years.

The changes we have seen since March 2014, following the House of Lords report on the implementation of the Mental Capacity Act (MCA) and the Supreme Court judgement, mean that we are now certain there will be significant developments in the use of the Safeguards and understanding of the wider MCA in the coming years.

We anticipate that these developments will be both interesting and challenging for all those working in health and social care. During this time we urge organisations and the professionals working within them not to lose sight of the person at the centre of the process for whom the Safeguards remain an important protection at times when their freedoms are being greatly restricted.

Next steps

What we will do:

- Listen to the experiences of people with personal involvement in the Deprivation of Liberty Safeguards, and consider how the MCA is being used in our inspections of providers that supply services to people aged 16 and above.
- Use our inspections and reports to encourage improvements in practice and, where necessary to protect people who use services, take enforcement action to drive improvement.
- Make sure that our inspectors have the confidence and competence to recognise and encourage good practice.
- Take enforcement action where we find that providers are failing to notify us of Deprivation of Liberty Safeguards authorisations.

What we expect others to do:

- We expect local authorities to do all they can to assess the backlog of requests for authorisation and prevent its recurrence, for example by using the triage tools created by the Association of Directors of Adult Social Services (ADASS).
- We expect providers of all adult health and social care to work within the framework of the MCA and, where relevant, the Supreme Court judgement, pending the Law Commission review and any changes that arise from it.
- We expect joint working, locally and nationally, to make sure that local authority and NHS commissioning, training and policies take into account the need to avoid deprivation of liberty wherever possible.

- We expect providers to examine care and treatment plans for individuals lacking capacity, to determine if there is a deprivation of liberty (following the revised test supplied by the Supreme Court). The test is clearer and easier to apply than previously and, where a potential deprivation of liberty is identified, alternative ways of providing the care and/or treatment should be fully explored, so that where possible less restrictive ways of providing that care can be identified.

We recommend that:

- Local authorities continue to consider using advocacy services for all those subject to the Deprivation of Liberty Safeguards.
- Local authority leads for the MCA and Deprivation of Liberty Safeguards create good working relationships with their local coroners. This is likely to be of great benefit to ensure that a consistent message is given to providers and that they can work together in dealing with the considerable extra activity as a result of the Supreme Court judgement.
- Local authorities and Independent Mental Capacity Advocacy (IMCA) providers work together to enable IMCAs to support the person or their unpaid relevant person's representative to challenge an authorisation to the Court of Protection when it is the person's wish, whatever the IMCA's views on the rightness of the authorisation.
- Hospitals and care homes continue to request authorisations when they think that people are being deprived of their liberty based on the new 'acid test'. However, they must also continue, within the provisions of the wider MCA, to seek less restrictive options to meet the needs of each person.

APPENDIX A

Recent developments in case law

Meaning of deprivation of liberty

P v Cheshire West and Chester Council and another and P and Q v Surrey County Council [2014] UKSC 19 and its implications

Our last report for 2012/13 was published shortly before the Supreme Court gave its judgement in the case of **P v Cheshire West and Chester Council and another and P and Q v Surrey County Council [2014] UKSC 19** on 19 March 2014. We anticipated last year that this case would have an impact on practice, and that has certainly proved to be the case. The case has been headline news for everybody involved in adult health and social care since March and, legally speaking, it dominates any analysis of the current position. The decision has had two important effects: it has clarified what it means to be deprived of liberty, and demonstrated that such a deprivation takes place much more frequently in the delivery of health and social care than previously thought.

The case involved appeals lodged by P, a man with cerebral palsy and Down's Syndrome who was living in a staffed bungalow where he was receiving 24-hour care provided by the local authority, and by P & Q, two sisters who, similarly, were living in placements arranged by the local authority which involved 24-hour care and direction. All were appealing against previous findings by the Court of Appeal that their living arrangements did not amount to a deprivation of their liberty, because the "relative normality" of their lives was an important factor to be taken into account. Essentially, the court had said that if a person with restricted ability was being assisted to live as "relatively normal" a life as possible, then those caring for them were not depriving them of their liberty.

Seven Supreme Court judges considered the appeals, with four judgements given, an indication of the importance of this matter. The final decision was not unanimous, and three judges disagreed with the leading judgement given by Lady Hale. The finding was, however, that a deprivation of liberty was taking place for P and P & Q, and the implications are that it will be taking place for many thousands of people like them. Lady Hale described the issue in the case as being the "criteria for judging whether the living arrangements made for a mentally incapacitated person amount to a deprivation of liberty", adding that where they do, they must be authorised either through the Deprivation of Liberty Safeguards or directly by a court, as otherwise "no independent check is made on whether those arrangements are in the best interests of the mentally incapacitated person".

The leading judgement examined recent case law in the UK and Europe, and provides an interesting history of the evolution of the Deprivation of Liberty Safeguards and of their use. It arrived at what is termed the 'acid test' of when authorisation is required, a

test that offers a much simpler and more practical legal decision than previously. The acid test has two elements; if a person is (a) under continuous supervision and control and (b) not free to leave, then they are being deprived of their liberty. In arriving at this view, the court dismissed the argument that a person cannot be deprived of their liberty if they lack the capacity to understand and object, with Lady Hale reiterating that “the whole point about human rights is their universal character”. The case makes it clear that the “comparative benevolence” of a person’s care arrangements does not affect a decision about whether or not those arrangements deprive them of their liberty.

The implications of this important judgement have been unfolding since March 2014. We have not covered this period in detail in the main body of this report, though we report on the findings of the first two quarters’ information collected by the Health and Social Care Information Centre (HSIC) and reflect some responses to the judgement. By next year’s annual report, we will have access to more complete statistical data and be able to present our own findings about the effect the case has had on people receiving care or those who deliver it. However, in looking at the current legal position it would be misleading not to refer to developments immediately following the judgement.

On 28 March 2014, the Department of Health issued guidance to local authorities, carers and policy makers about the implications of the case. On 16 April 2014, CQC issued guidance to health and care providers, reminding them of the importance of reading the case and recognising the change in the criteria for requiring a Deprivation of Liberty Safeguards authorisation or, for settings other than hospitals or care homes, authorisation from the Court of Protection. In August 2014, the Association of Directors of Adult Social Services (ADASS) produced detailed guidance for local authorities on interpreting the case. On 8 September 2014, the Department of Health issued further detailed advice to MCA and supervisory body leads in local authorities and the NHS, recognising the rise in work resulting from the case and outlining the Government’s own response. This includes widening the scope of the current Law Commission review of the Deprivation of Liberty Safeguards, and producing case law guidance about what constitutes a deprivation of liberty in both social care and health care settings. This should be available from February 2015.

Meanwhile, Sir James Munby, President of the Family Division and of the Court of Protection, heard representations from local authorities and NHS trusts about the likely effects of the judgement. On 8 May 2014 he addressed the Court of Protection about the large increase in volume of cases, adding that he would be working to produce guidelines for handling them. This was duly given in the case of **Re X and others (Deprivation of Liberty) [2014] EWCOP 25**, a case arising from a number of deprivation of liberty cases pending at the time of the Cheshire West case. Sir James used this case to outline how the Court of Protection would be dealing with deprivation of liberty cases coming before it. His judgement sets out 25 key questions and answers, and is intended as a standardised, and so far as possible ‘streamlined process’ for the proper handling of cases while further developments are awaited.

It is expected that the results of these judicial and governmental initiatives will become clearer over the year to come, and that we will be able to offer an assessment in next year’s report, when we will have statistics and other information to help us to understand the implications. In the meantime, the courts do continue to consider the

issue of when a deprivation of liberty has taken place, and it is worth mentioning that very recently – and again outside our normal timeframe – one case has demonstrated that there continues to be disagreement with the view of when a deprivation of liberty has occurred. Three Supreme Court judges disagreed with the main findings, and some of their arguments have recently been taken up by Mostyn J, whose judgement on 18 November 2014 in the case of **Rochdale MBC v KW [2014] EWCOP 45** demanded that the Supreme Court “reconsider” its position. We are ‘watching this space’ during 2014/15.

Cases where Deprivation of Liberty Safeguards authorisations should have been sought

A number of cases have come before the Court of Protection this year that follow on from the case of Steven Neary, referred to in summaries from last year and the year before. They involve challenges to the practice of local authorities in devising and approving care plans for incapacitated people in their care. They show that the Court of Protection does not tolerate any local authority that fails to recognise its duties towards people lacking capacity, and which delays in seeking proper authorisation for any care plan that involves deprivation of liberty. The cases also demonstrate the Court’s readiness to award damages to those affected. The facts of these cases, and some of the frank remarks made in the judgements, reveal a continuing lack of awareness, even within local authorities, of how the Deprivation of Liberty Safeguards should operate.

The case of the **Local Authority v Mrs D and Anor [2013] EWCOP B34** involved a woman with Huntingdon’s Disease, whose husband had placed her in a care home for two weeks of respite care. At the end of that period, the local authority did not allow her to return home, but it did not seek any authority for her continued placement in the care home for six months. The application was finally made, but by the time the matter was heard, Mrs D had been living away from home, against her will, for more than a year. The court had no hesitation in finding that Mrs D’s human rights had been violated as no valid authorisation for the deprivation of her liberty had been sought, and found compensation was due, with an agreed sum of £27,000 awarded.

The case of **Milton Keynes Council v RR and SS and TT Ors [2014] EWCOP B19** involved an 81-year-old woman, RR, with vascular dementia. In 2006, her son SS and companion TT moved into her home to care for her. The local authority removed her from her home as a result of safeguarding alerts about a physical injury in 2012, although they did not proceed to investigate those concerns. The local authority placed RR in a care home on 25 October, and applied for an authorisation on 29 October. The authorisation was not granted until 8 November. The Court of Protection later considered the matter and made a declaration that RR had been removed from her home unlawfully, and remained unlawfully detained until authorisation was given nearly two weeks later.

In **Somerset v MK [2014] EWCOP B25**, the Court of Protection considered the actions of a local authority caring for a 19-year-old woman P, with a learning disability and autistic spectrum disorder. The local authority applied to the court for authorisation for P’s placement at a specialist home six months after she was removed from her family, and prompted only by her mother’s request for her return. The court faced

opposing views about P's placement and proceeded to make a best interests decision. In doing so, the court examined the actions of the local authority, finding their failure to recognise that they were depriving P of her liberty to be unacceptable. Judge Marston gave a damning summary, "These findings illustrate a blatant disregard of the process of the MCA and a failure to respect the rights of both P and her family under the ECHR [European Convention on Human Rights]. In fact it seems to me that it is worse than that, because here the workers on the ground did not just disregard the process of the MCA, they did not know what the process was and no one higher up the structure seems to have advised them correctly about it." The judge did, however, ask that the local authority should now proceed to co-operate with P and her family to avoid further abuses.

Best interests

A number of cases have been decided in the Court of Protection and the higher appeal courts giving more detail about what it means to take a decision in somebody's best interests; not all are about deprivation of liberty, but the remarks are informative about what is and is not relevant when considering what course of action is in any incapacitated person's best interests.

The case of **Aintree University Hospitals NHS Foundation Trust v James [2013] UKSC 67** involved a seriously ill 68-year-old man who was in a minimally conscious state and in intensive care, where his condition was deteriorating. The man's family did not agree with the intention of specialists caring for him, to withhold further invasive treatment "in the event of a clinical deterioration". This led the Official Solicitor to seek declarations from the Court of Protection about his treatment. The Court of Protection did not make the declarations, prompting the trust responsible for his care to appeal to the Court of Appeal. Despite the hearing being expedited, the man died shortly after the Court decided to allow the appeal; it also gave leave for further appeal. The Supreme Court thought it appropriate to consider the matter notwithstanding the death, as the case involved points of principle regarding the extent to which the MCA can 'dictate' any course of treatment, and in the light of the very different approaches of the two lower courts.

Lady Hale gave the leading judgement, establishing first of all that the MCA can only enable any incapacitated patient to do what they could do for themselves if they had capacity, and cannot go further. The MCA does not allow patients to demand treatment that might be in their best interests if it is not available or appropriate, and cannot endorse any treatment that is not lawful. The case also established that a patient's own wishes are of central importance, and that, to determine what those wishes might be, it is essential to see things from their point of view. This involves not only making an assessment of which treatment might sustain life for the longest period, but also considering the patient's welfare in the widest sense, not just medical but social and psychological. A best interests decision is one where the decision-maker puts themselves in the place of the individual patient and takes account of what their view might be.

Re M (rev 1) [2013] EWHC 3456 (CoP) involved a woman, M, who had been resident in a care home, but wished to return home where she (mistakenly) believed she could manage her own physical illnesses, which included diabetes. M appealed to

the Court of Protection against a Deprivation of Liberty Safeguards authorisation which required her to remain in the care home. In allowing her appeal, the court identified the central issue as being what weight should be given to the risks inherent in the two clear options, and indicated that considerable weight should be given to the person's own wishes. Significantly, the court said that M was entitled to ask why she had to remain where she was, and that if the only answer was that it prolonged her life, this was not sufficient. "In M's case there is little to be said for a solution that attempts, without any guarantee of success, to preserve for her a daily life without meaning or happiness and which she, with some justification, regards as insupportable."

In a similar scenario, in **Westminster City Council v Sykes [2014] EWHC B9 (CoP)** the local authority applied to the Court of Protection for a Deprivation of Liberty Safeguards authorisation to require Ms Sykes to live in a care home in the face of her determination to live at home, where there would be risks to her physical wellbeing. In this case, the authorisation was given, but on the basis that the local authority would also prepare for Ms Sykes to return home on a trial basis. Ms Sykes objected in the strongest terms to remaining at the care home, and to the fact she was being prevented from returning home. The court in this case met Ms Sykes at the care home, and learned about her health and financial status. In approving a course of action which would allow her to go home, the judge again emphasised the importance of a person's own wishes in determining their best interests, indicating that the risks inherent in any proposed course should be weighed with this in mind. On a philosophical note, District Judge Eldergill added that, "the desire to determine one's own interests is common to almost all human beings ... most individuals wish to determine and develop their own interests and course in life, and their happiness often depends on this".

This series of cases establishes that someone's best interests may sometimes be met by an option that leaves the person open to certain evident risks. The cases also highlight that any person making decisions about the care and treatment of a person lacking capacity must pay due regard to that person's wishes and feelings, however they may be manifested, and also recognise the importance of respecting their self-determination when assessing the risks and benefits of what is available.

Deprivation of Liberty Safeguards and children

A young person does not become an adult until they are 18, whereas the MCA applies to anyone over 16. In addition, the Deprivation of Liberty Safeguards apply only in establishments defined as a "care home" or a "hospital", and not in a children's home. This has caused some confusion about the treatment of young people aged 16 to 18, whose care is being arranged by the state. In February 2014, the Court of Protection in conjunction with Ofsted issued guidance in which it stated, among other things, that no application should ever be made to the Court of Protection regarding a child aged under 16, and that applications under the Deprivation of Liberty Safeguards could not be made in respect of any person resident in a children's home, as the Safeguards did not extend there.

In a case later in 2014, **Liverpool City Council v SG [2014] EWCOP 10**, Holman J held that it was appropriate for the Court of Protection to consider directly an application to deprive a young person aged 19 of her liberty where she was placed in a children's home. Although the Deprivation of Liberty Safeguards had no application

there, the woman's case did come within the remit of the MCA, such that the Court of Protection does have power to make an order which authorises that a person who is not a child (that is, who has attained the age of 18) may be deprived of their liberty in premises which are a children's home as defined in section 1(2) of the Care Standards Act 2000.

Publicity

On 16 January 2014, the Court of Protection issued guidance about when the judgments of Family Courts and the Court of Protection should be published. This guidance was given in response to the acknowledged need for greater transparency generally about the way courts operate, but in particular, for more transparency about proceedings in the Family Courts and Court of Protection. Here, the need to preserve the anonymity of parties has traditionally taken precedence over the need for public understanding of decision making, leading to public concern about secrecy and lack of accountability.

The Practice Guidance, given by President Sir James Munby, indicates that in considering whether particular cases should be published or not, "The starting point is that permission should be given for the judgement to be published unless there are compelling reasons why the judgement should not be published". It includes a Schedule of the types of cases to which this principle applies, and that Schedule incorporates "any application for a declaration or order involving a deprivation or possible deprivation of liberty", and "any application for an order that an incapacitated adult should be moved into or out of a residential establishment or other institution".

The effect of this will be to make the decisions of the Court of Protection and the higher appeal courts regarding Deprivation of Liberty Safeguards more readily available. Courts considering such cases will have to consider how best to make sure that their decision and decision making is publicised, which should in turn contribute to wider professional and public understanding of what a deprivation of liberty is, and how best interests are weighed.

The Court of Protection giving guidance for day-to-day decision making under the MCA

Following on perhaps from the above point, there have been some cases recently where the Court of Protection has offered very detailed guidance for practitioners on certain aspects of the MCA.

In **A Primary Care Trust v LDV, CC and B Healthcare Group [2013] EWHC 272 (Fam)** the Court of Protection considered the case of a woman detained in a private hospital, and whether she was in a position to give consent to her continued treatment. Baker J offered the following list of criteria for determining whether the patient was able to give such consent:

"I consider that on the facts of this case, the clinicians and the court should ask whether L has the capacity to understand, retain, use and weigh the following information:

- (1) that she is in hospital to receive care and treatment for a mental disorder;

- (2) that the care and treatment will include varying levels of supervision (including supervision in the community), use of physical restraint and the prescription and administration of medication to control her mood;
- (3) that staff at the hospital will be entitled to carry out property and personal searches;
- (4) that she must seek permission of the nursing staff to leave the hospital, and, until the staff at the hospital decide otherwise, will only be allowed to leave under supervision;
- (5) that if she left the hospital without permission and without supervision, the staff would take steps to find and return her, including contacting the police.”

In **LBX v K, L & M [2013] EWHC 3230 (Fam)**, the Court of Protection considered the placement of a 29-year-old man with a learning disability, whose care had been the subject of litigation over some years. In the latest case, Theis J was charged with finding whether or not the man could ever achieve capacity to make decisions regarding residence and contact, and some specific care related decisions. In doing so, she offered guidance about how a test for capacity should be undertaken, warning against adopting too high a threshold, and giving a similar list of criteria that are relevant to a decision about whether a person has the capacity to decide where to live, who to have contact with, and what sort of care they wish to receive.

Although these cases are not directly relevant to the application or interpretation of the Deprivation of Liberty Safeguards, they do offer an insight into the way courts expect day-to-day decision making to be undertaken under the MCA, and so do contribute to our understanding of how the Deprivation of Liberty Safeguards should be used.

Deprivation of liberty during obstetric procedures

A number of cases involving the treatment of women during childbirth and labour have required the Court to consider how the MCA should be used to protect the rights of women for whom the state has made plans regarding delivery of their babies.

The most significant is **NHS Trust (1), NHS Trust (2) and FG [2014] EWCOP 30**, in which Keehan J was required to consider whether the care FG received in the course of childbirth was appropriate. FG lacked the capacity to take legal action or to make decisions about her treatment in her own and in her baby’s best interests, so the NHS trusts caring for her applied to the Court of Protection for authorisation of their care plan. The Court decided that wherever an application was made to the Court of Protection to permit the trusts to undertake various steps and measures in respect of labour, it was appropriate to regard it as a potential deprivation of the patient’s liberty, and it proceeded to set out a detailed procedure for how the application should be prepared, and what evidence should be cited. This includes a detailed statement from a consultant obstetrician giving details of the planned treatment and including a risk analysis and a list of the treatment options available.

This case involved a situation where the woman’s lack of capacity to agree to a proposed care plan was known in advance, and in which detailed consideration had been given to likely eventualities. It should not be taken to apply to situations in which a woman’s capacity is temporarily reduced through the childbirth itself, or treatment given during the course of it.

APPENDIX B

Resources on the Mental Capacity Act, including Deprivation of Liberty Safeguards

Document(s)	Brief/provider	Website link
Resources on the implications of the Supreme Court judgement	Mental Capacity Law and Policy	www.mentalcapacitylawandpolicy.org.uk/resources-2/cheshire-west-resources/
Guidance to coroners on the Supreme Court judgement	Chief Coroner	www.judiciary.gov.uk/wp-content/uploads/2013/10/guidance-no16-dols.pdf
Practical solutions and assistance for local authorities	Association of Directors of Adult Social Services	www.adass.org.uk/uploadedFiles/adass_content/policy_networks/mental_health/key_documents/DoLS%20Guidance%20note%20November%202014.pdf
Mental Capacity Act 2005: Code of Practice	Government: statutory guidance for professionals	www.direct.gov.uk/prod_consum_dg/groups/dg_digitalassets/@dg/@en/@disabled/documents/digitalasset/dg_186484.pdf
Mental Capacity Act 2005: Deprivation of Liberty Safeguards Code of Practice	Government: statutory guidance to supplement the main Mental capacity Act 2005 Code of Practice	http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476
Information on lasting power of attorney (LPAs) and deputyships	Office of the Public Guardian: forms and guidance	www.gov.uk/government/organisations/office-of-the-public-guardian
Consent to treatment	NHS online resource: assessing capacity, consenting to treatment	www.nhs.uk/conditions/consent-to-treatment/Pages/Introduction.aspx
Reference guide to consent for evaluation or treatment, second edition 2009	Guide to the legal framework that all health professionals need to take into account when getting consent for treatment	www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103643
Application for a search of the Public Guardian registers	Office of the Public Guardian: form to search to see if someone has a LPA or deputy acting on their behalf	www.gov.uk/find-someones-attorney-or-deputy

Document(s)	Brief/provider	Website link
Mental capacity toolkit online	British Medical Association: online resource with downloadable sections about assessing capacity, basic principles of Mental Capacity Act (MCA), LPAs	http://bma.org.uk/practical-support-at-work/ethics/mental-capacity-tool-kit
Range of resources on MCA including Deprivation of Liberty Safeguards and audit tools	Social Care Institute of Excellence	www.scie.org.uk/key-topics/mental-capacity
Range of MCA resources	Alzheimer's Society	www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=354
Help with managing money if you or someone you care for lacks mental capacity	Money Advice Service: guide for people with a learning disability or mental health issues.	www.moneyadviceservice.org.uk/en/articles/help-manage-the-money-of-someone-youre-caring-for
Mental Capacity Act resource pack	Mencap: guide for families of people with learning disabilities	www.mencap.org.uk/sites/default/files/documents/mental%20capacity%20act%20resource%20pack.pdf

APPENDIX C

External advisory group

An advisory group of people with expertise in the Mental Capacity Act and the Deprivation of Liberty Safeguards advised us on the production of this report. The group helped to test ideas, share information on the operation of the Safeguards in practice, and develop more collaborative approaches to our monitoring role.

We are grateful to the group for the time, support, advice and expertise they have generously given.

The members of the group were:

Name	Organisations
Neil Allen	University of Manchester
Jamie Balbes	Care England
James Batey	Court of Protection
Elmari Bishop	South Essex Partnership Trust
Julie Chalmers	Royal College of Psychiatrists /Oxford Health Trust
Alison Cobb	Mental Health Alliance
Sam Cox	Alzheimer's Society
Lorraine Currie	Association of Directors of Adult Social Services (ADASS) / Shropshire County Council
Beverley Dawkins	Mencap
Niall Fry	Department of Health
Roger Hargreaves	Mental Health Alliance
Lucy Series	Cardiff Law School
Paula Scully	Law Society / Derbyshire County Council
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