HOUSES OF PARLIAMENT

Joint Committee on Human Rights

Oral evidence: Protecting human rights in care settings, HC 714

Wednesday 23 February 2022

3 pm

Watch the meeting

Members present: Ms Harriet Harman (Chair); Joanna Cherry MP; Lord Dubs; Florence Eshalomi MP; Lord Henley; Baroness Ludford; Baroness Massey of Darwen; Angela Richardson MP; David Simmonds MP; Lord Singh of Wimbledon.

Questions 25 - 29

Witnesses

II: Dr Lucy Series, Senior Research Fellow and Lecturer in Law, Cardiff University; Richard Charlton, Court of Protection solicitor and specialist in mental capacity and mental health; Judy Laing, Professor of Mental Health Law and Policy, University of Bristol's Human Rights Implementation Centre.

Examination of witnesses

Dr Lucy Series, Richard Charlton and Professor Judy Laing.

Q25 **Chair:** I now invite our second panel to join us. We have Dr Lucy Series, who is a senior research fellow and lecturer in law at the University of Cardiff and a leading expert on the Mental Capacity Act 2005, the deprivation of liberty safeguards and the UN Convention on the Rights of Persons with Disabilities. She has also been a member of the Care Quality Commission's advisory groups on the deprivation of liberty safeguards for the past 12 years. Thank you for joining us, Lucy.

We can welcome in person Richard Charlton, who is a practitioner in mental capacity and mental health law and, as such, has been president of the Mental Health Lawyers Association since 2014. He is a senior peer reviewer in mental health law for the Ministry of Justice. Welcome, Richard.

We have Professor Judy Laing, who is a professor of mental health law and policy at the University of Bristol Law School's Human Rights Implementation Centre. Thank you very much indeed, all of you.

Perhaps I can start with this question. We heard about restrictive practices before, and you could just remind us of what these restrictive practices are. When can restrictive practices amount to deprivation of liberty? What is the impact of deprivation of liberty measures on the human rights of those who are in care, looking not only at the right to liberty and security under Article 5 of the European Convention on Human Rights but also looking at other rights, such as the right to protection of private and family life under Article 8 of the European Convention on Human Rights?

Dr Lucy Series: Thank you for having me here today. Currently, for the purpose of people drawing on care services, the deprivation of liberty is defined by a 2014 Supreme Court ruling known as Cheshire West. This established a legal test of whether a person is deprived of their liberty known as the acid test, and it says that if a person is subject to continuous supervision and control and they are not free to leave, then they are deprived of their liberty. This acid test replaced earlier tests that looked at how normal a person's care was, what kind of setting they were in and whether they had somewhere else to go. The problem with these earlier tests is they could leave quite large numbers of people with disabilities or conditions like dementia subject to quite high levels of restriction and even restraint before they qualified for any kind of safeguards or an independent check.

As an aside, I know that people are quite worried that, in the Government's proposals to reform the Human Rights Act, they are suggesting they might look to reform this test. In my experience, when we talk about liberty safeguards, the conversation can become quite abstract and technical, but really the kinds of issues that fall within the safeguards are very concrete and very human. Often, they fall within that remit of Article 8 as well. For example, the safeguards might look at issues around whether a person should remain living in their own home, perhaps with their family, or move into a care setting where others believe they will be safer. This can include situations where the person or their family do not want this.

The safeguards can also be involved where there are restrictions on people’s contact with friends or family. This might be because of safeguarding concerns, perhaps about abuse, or it could be because the person imposing the restrictions is regarded as having too much influence over that person. Sometimes measures are involved to stop a person from having sex because it is believed they lack capacity or that they will be exploited. The safeguards can also potentially look to restrictive practices such as restraint or sedation, or locks or devices that restrict a person’s freedom of movement where they are living, or rules imposed by care settings that prevent a person from coming and going.

There is a bit of debate at the moment about whether deprivation of liberty relates only to measures that prevent a person from leaving permanently. The Government take a narrower view, and that has had quite significant implications for the use of the safeguards to secure the rights of care home residents during the pandemic because, in theory, they were always free to leave permanently. They just had to isolate in their rooms when they returned.

Richard Charlton: Lucy has really covered the background of what amounts to deprivation of liberty. As a practitioners on the ground, we know that the impact of DoLS measures on care users with regard to human rights is really far-reaching.

Chair: Deprivation of liberty. I do not think most people know what DoLS are, so sorry to pick you up on that.

Richard Charlton: Sorry. I promised at the beginning not to use abbreviations, so deprivation of liberty measures are really the measures as described by Lucy. Article 5, the right to liberty, is clearly a starting point. In our experience and my experience of going into a care home initially and talking to somebody who is not free to leave, their reactions are between anger, depression, confusion and talking about suicide, and extreme emotions are often expressed. As part of that, the immediate reaction often is, “Why am I here? Why am I locked up? I’ve done nothing wrong. I’ve worked honestly all my life”.

Talking about the role of the Court of Protection, quite often there is a fear of actually going before a court: “If I have done nothing wrong, is a judge going to find that I have done something wrong and I am going to be sentenced?” These are the kind of fears that some people feel—hopefully it is a minority—as a reaction to being deprived of their liberty in care homes.

Moving on from that, clearly Article 8 has been discussed in terms of right to private life and family. Particularly in the pandemic, we have found that there has been very little community and family access, and that has clearly had a major impact on many of our clients. They have become much more institutionalised. They have become more confused. The lack of family contact particularly has often led to a decline in their health and a rapid increase in their dementia.

What is disturbing is that we find that, as the pandemic has lifted, care homes are very reluctant, frequently, to reinstitute access to the community and support residents in doing that as part of making their life as least restrictive as possible. Maybe that is partly to do with shortage of staff—I do not know—but we are given safety reasons, even when the care home is by the seaside and it would be easy for the residents to go out and get some fresh air. That is very slow to recommence, and it has a major impact on the quality of life.

Staff training is also a part of that, because what we are told is, "Mrs Smith just does not want to go out. We've asked her", but, when you talk to Mrs Smith, you learn that what has actually happened is that somebody has come in at, say, 2.45 and said, "All right, Mrs Smith. We can take you out now". Mrs Smith is confused. She has not been prepared to go out. She says, "I'm not ready yet. Not right now", so in the notes it is recorded that she does not want to go out. It rolls forward and forward, and Mrs Smith probably walks less and her health declines.

Looking at other rights, Article 3 is a major issue, unfortunately, in care homes as well. We often find that people are effectively forced to wear incontinence pads, for example. Sometimes they spend the night in excrement when they are not incontinent, but, because of staff shortage, they are forced to wear incontinence outfits. I know the courts have been concerned about this in the past, but sometimes it is that the funding and staffing are not there. It is one thing for somebody who is incontinent to suffer in this way, but if somebody is aware that they are not incontinent and is forced to lie all night or a large part of the night in excrement, it is an appalling situation. Certainly, that would amount to breaches of Article 3.

We know about the Article 2 issues. Clearly the way that residents arrived often from hospital and carried the Covid virus with them has been rehearsed before, but in other cases we have known of clients have remained in care homes because there has not been care provision for them in the community. There has been some delay in arranging that. They should never have been there. Because of delays in the process, they have been there much longer than they should have been, they acquired the virus and they died. There are Article 2 issues as well that are involved in these situations. A host of human rights are engaged in the situation.

Professor Judy Laing: It is good to be able to join you today. I just wanted to add a few points to what has already been said by Lucy and Richard in relation to the human rights issues of deprivation of liberty in care homes. I will echo what Lucy said about the test for deprivation of liberty. The definition is very broad, both in international and domestic law. Lucy has referred to the Cheshire West case, and that did lower the threshold quite significantly. It led to quite a lot of concerns about the number of people who could potentially be deprived of their liberty in England and Wales without the right safeguards in place, which led to the new law being passed in the Mental Capacity Act.

That is reflected in European Court of Human Rights jurisprudence as well. The case of Guzzardi v Italy reinforced that approach to not being free to leave your place of residence, for example. The European Court of Human Rights has also stated that, in determining a deprivation of liberty, account should be taken of a whole range of factors, including the type, duration and effects, and how the measure is implemented.

The deprivation of liberty safeguards, which I think we are going to move on to a little bit later, are intended to apply in this situation, to comply with Article 5, and they are very much tied to Article 5. Quite how they work in practice, of course, to safeguard that right is open for considerable debate, and we are going to talk about that later. There is a range of restrictive practices that can amount to a deprivation of liberty. We have talked about those sorts of restrictive practices already. The examples that Dan gave, such as segregation, the use of seclusion, the use of physical restraints, stopping people leaving and the use of sedatives, which are chemical restraints, could potentially amount to a deprivation of liberty. There are also other restrictions that may be due to staffing restrictions, such as inability to leave the care home or the room, restrictions, perhaps, on daily rituals, and periods of time where you are left and unable to move could potentially amount to a deprivation of liberty.

I would echo what Richard has said about the engagement of other articles, potentially Article 3. Again, we are going to move on to this later on when we look at the potential for inhuman and degrading treatment. There is a higher threshold of severity for this right. It includes things like serious physical or psychological abuse or mental suffering, and the conditions of detention could very much impact, as well as the degrading treatment, so that also could arise in a deprivation of liberty situation. A number of Article 3 breaches in the European Court of Human Rights have in fact related to ill treatment where people are deprived of their liberty.

I would also point out Article 8, which is really important in this context. As Sam mentioned earlier in her evidence, this is not just about your right to see family; it goes beyond that to your right enjoy your private life. That means exercising autonomy, control and choice and the respecting of dignity. The sorts of things that could amount to a breach in a care home for a resident could be daily restrictions on contact with family and relatives, for example through visits and calls; oppressive environments; an inability to make personal choices, for example around your food and drink, what to watch on television, and when and how to take medication; and limits on movement around the care home.

Another important example that may often be overlooked occurred in a European Court of Human Rights case called Stanev v Bulgaria some years ago in relation to a breach of Article 3. There were some extreme conditions in that case of a person who was detained for a long period of time in a care home in Bulgaria, but one of the factors that influenced the decision of the court that impacted on the Article 3 right was communally washing residents' clothes and allocating them at random. Again, that may be something that happens in care homes routinely without the right staffing in place, et cetera. Those are the sorts of examples that could amount to some of those breaches of rights.

Just to add one more point, we do not really know enough about how much training staff have on human rights of residents in care homes and what the level of training and knowledge is. I know that the Mental Health Act, which is another piece of legislation that regulates compulsory treatment, is monitored by the Care Quality Commission every year, and it produces an annual report. Certainly in the context of mental health facilities, it found that more focus on human rights was needed by healthcare services when using the Mental Health Act. We do not have that same level of detail around care services, but I suspect that if its findings in relation to health services suggest that, there are probably similar concerns around the quality and content of human rights training for social care staff as well. Hopefully that is helpful.

Q26 **Chair:** The deprivation of liberty safeguards are supposed to be, as the name suggests, safeguards, and there are processes in the system around the deprivation of liberty safeguards, but we have heard a lot of concern about delays in applying these processes, which are supposed to put in place the safeguards. Why do you believe there are processing delays and problems with following other statutory requirements for the deprivation of liberty safeguards? What issues does this cause in practice? Is the system actually operating, notwithstanding these delays, in the way that it was intended?

Professor Judy Laing: Mention has already been made of the deprivation of liberty safeguards. Essentially, they are designed to provide legal protection for people who lack the mental capacity to consent to their care and treatment in a care home, a hospital or supported living. There are certain conditions that need to be attached for a deprivation of liberty and an approval process. Essentially, the deprivation of liberty is made if it is in a person's best interest and it is the least restrictive alternative. The care home or hospital is known as the managing authority, and they, essentially, must apply to the supervisory authority, usually the local authority, for the deprivation of liberty authorisation. If it does not do that, it is going to be an unlawful deprivation and a breach of Article 5, as we have just mentioned.

There are two different types. You can have an urgent or a standard eligibility. The supervisory authority must carry out an assessment of six criteria for the standard authorisation by two assessors within 21 days. The current process has a number of checks and balances and procedural safeguards in place. The deprivation of liberty safeguards have been really dogged with controversy from the moment they were implemented. We have already heard them being described as unfit for purpose by various people such as the House of Lords Select Committee that looked at them as well as the Law Commission. There is a range of factors that impact on their implementation.

Particularly because the threshold was lowered in Cheshire West, we saw an exponential increase in the number of DoLS applications, and that has led to a rising backlog, which has been exacerbated by the challenges facing local authorities during the pandemic. The CQC state of care report last year, in which there is a small section on the deprivation of liberty safeguards that the CQC has some limited oversight for, notes that the issues have been exacerbated by the pandemic and that there is a number of reasons why this might be so. The problems are due to variation in knowledge and quality of training, poor quality of best-interest decision-making and capacity assessments under the Mental Capacity Act, and then huge delays and backlogs in applications. It also noted that providers, the care homes, are not actually escalating the applications when needed.

We are seeing huge problems now. There have been online assessments for best-interest assessments that have hindered processes, and there has been a lack of visiting during the pandemic from family and other important people under the legislation such as the relevant person’s representative who is there to provide support and advice. That also impacts on the whole process.

I know that there are regional variations between settings and between professional groups. The problems with the falling budgets that local authorities are facing, as well as the cumbersome nature of the process and the fact that things have to be done within very short time limits, mean that it is problematic. I think there are also workforce shortages for assessors.

Another problem is the fact that a triage system is in place, which I think local authorities have been encouraged to put in place, and that has led to some applications being deemed to be a lower priority than others. In fact, the Local Government and Social Care Ombudsman published a public interest report in March 2019 into local authority failures to carry out these assessments and has decided to investigate it because it has had so many concerns about the complaints that it has received in relation to the delays. I hope that gives you a little bit of an overview. I am sure Lucy and Richard will be able to testify as well to some of the challenges.

Chair: To give us a scale of the problems and delays, has there been any quantification of it? For example, has any assessment been done of how many people who have been in residential care have died before their assessment has been made about whether it is appropriate for them to be deprived of their liberty, and how many incarceration years there are every year without the protection of these safeguards because the proper processes have yet to be put in place and yet that person has spent a year having been deprived of their liberty? What kind of quantification could help us understand the scale of these delays? I do not know which among the three of you would like to answer that, but perhaps we can go ahead and hear from Lucy next, and whoever wants to answer with the numbers can help us along the way.

Dr Lucy Series: As you asked that question, I just looked it up. At the end of the last year, there were an estimated 119,740 cases that had not been properly processed by DoLS teams.

Chair: By cases, you mean people who are in a deprived-of-their-liberty situation. What do you mean by "case"?

Dr Lucy Series: I mean that local authorities have received those applications to deprive a person of their liberty and they have not yet been able to get around to conducting the right assessments and securing the safeguards for them.

Chair: It does not hold up the applicant from depriving of their liberty, does it?

Dr Lucy Series: No.

Chair: Basically, these people are in a deprived-of-their-liberty situation. They are supposed to get it ratified, but it is not being ratified in the case of the number of people you said.

Dr Lucy Series: Yes, that is correct. What is happening is, since Cheshire West, which, as Judy Laing just explained, expanded the definition of deprivation of liberty, it is estimated that there are around 300,000 people drawing on care services who need these safeguards, most of whom are living in care homes or community settings. The current system of deprivation of liberty safeguards is quite resource-intensive, so the local authority is supposed to send out independent assessors to look for things like whether the person has mental capacity. It is not unheard of for DoLS assessors—in fact, it is relatively common—to conclude that the person does have capacity, contrary to what was submitted by the care provider.

They are also supposed to look at whether the restrictions are necessary or proportionate or whether there are less restrictive ways of caring for a person. They are supposed to meet the individual and speak to them and their family about their wishes. They are supposed to secure for the person representation and advocacy and even assist the person or their family in using the safeguards to challenge arrangements, if they are unhappy with them, in court. Each of these processes is quite resource-intensive, and often that is right, because these involve very fundamental human rights considerations, but supervisory bodies have never been resourced to do this on the scale required, particularly after Cheshire West. That is what has led to this backlog.

Local authorities cope by a kind of triage process. They look at the paperwork as it comes in, and they try to see which have the most serious issues, and they direct their resources there. The rest get put in a low-priority pile where they may not get seen to. The problem with this is that things can get missed. That might be because they were not properly recorded in the paperwork submitted by the care home or the hospital to the supervisory body, or it might just be that something was missed or there was a poor judgment in that triage process, which is desktop-based.

For example, the Local Government Ombudsman was worried about this backlog, and it visited a local authority and looked at a sample of supposedly low-priority cases where these checks were not being conducted. From memory, I think the sample size was only about 50, and it found one case that was so serious it ended up having to go to court. Of course, when other people are stuck in this backlog, they do not get safeguards like advocacy. Some local authorities judicially reviewed the Government to ask for more resource, but the court said they could allocate resources from other budgets. This often means that it is drawn from front-line care services as well, and this clearly is not acceptable from a human rights perspective.

This has led us to a situation where the Government recognise that the system needs redesigning, so that is why they will bring in the liberty protection safeguards at some point, but it also really needs adequate resourcing, or the problems will not go away.

Richard Charlton: We view this more from a front-line point of view. I would say that no case that we take on referred by the Official Solicitor or any other route does not include periods of unlawful detention, because that is what this is. Sometimes we see the paperwork and a person has been unlawfully detained for years, in the kind of backlog that Lucy has been describing. What is so tragic on a human level is you see in that time that the person concerned has been objecting but has not reached or engaged in the process at all and, in that time, they have become much more disabled in their approach. Perhaps their dementia has got a lot worse. Perhaps they have been diagnosed with depression partly because of their situation. They are receiving medication for that, and, of course, maybe that is subduing them. The human cost is extremely high.

We talk about these figures of 120,000. These are all people with lives. In the case of dementia, they have worked as citizens all their lives, and now they are basically left suffering in a situation of deprivation of liberty that they just do not understand. The answers have been given by the others. There is clearly a terrible lack of resources. If cases come to us and we are aware that somebody is unlawfully detained, suddenly, in triage terms, they come to the top of the pile and they are assessed quickly by a local authority. The case moves forward and is examined by the Court of Protection because that is mostly where our work is.

We are aware that, in taking that case, other people will also be losing out. That does not make us feel comfortable. As I say, we also feel extremely bad about the fact that a human life has been, often, wasted in that period of time. Quite frequently, when that case goes to court and is examined by the local authority afresh, as inevitably it is—it goes to the top of the pile, social workers look at it—and maybe there is quite an easy answer for the client to go back into the community; maybe more support is available. Of course, there are other issues about support in the community that I would like to talk about later, but the fact is that there is this huge army of people who are just detained unlawfully, and the figure is just appalling. As I say, it is clearly a lack of resources that drives that.

Chair: So some will be suffering in their unlawful detention. Others will die before the situation is resolved.

Richard Charlton: Yes.

Chair: Others will have got so much worse that, by the time the process reaches them; they are incapable of exercising that autonomy.

Richard Charlton: Yes, absolutely. Other life events may have taken place as well. For example, there may have been a family dispute and, as a result, perhaps the admission to the care home was for a respite period. Perhaps, with the right kind of support, the client could have gone back home, but, because of the time delay, the relative has sold the home and the options are reduced. Clearly, family support is extremely important for most residents in care homes, but sometimes there are disputes in the family and the care home resident is in a vulnerable situation that is not highlighted. Sometimes, by the time we are involved, it is too late. Sometimes clients are dying in the first two or three months of us being involved, which is a tragedy.

Q27 **Baroness Ludford:** That discussion sets the scene for my question, which is about challenging decisions. How adequate are existing mechanisms to challenge decisions and make complaints about deprivation of liberty, and do individuals in all care settings have equal access to such mechanisms? I see Judy is nodding vigorously, so I will start with her.

Professor Judy Laing: The short answer is they are not adequate and, no, people do not have equal access, but I will find it helpful to elaborate a little. Current complaints mechanisms are variable and inconsistent. The nature of a complaints system is that it is reactive, but, in order to be an effective complaints system, people who need to use it have to have access, so it has to be accessible and transparent. That is the biggest challenge at the moment.

It was mentioned earlier that there is an obligation on care home providers to investigate complaints, but, of course, the problem with that as a first port of call is that the providers are not independent and there is a huge fear of reprisals if you are bringing a complaint on behalf of a resident or if the resident is seeking to bring that complaint themselves. The next port of call for people in care homes at the moment, if they are not detained under the Mental Health Act, is to go to the Local Government and Social Care Ombudsman with an individual complaint. It has an online complaints system. Having had a mother in a care home who always struggled with access to her iPad, I know that being able to mobilise that as an effective complaints mechanism can be really challenging.

There are also current gaps in jurisdiction, such as the ability to investigate some parts of the care sector with the Local Government Ombudsman, and there is no legal duty currently, as I understand it, on providers to signpost to complaints services such as the ombudsman. There is a real issue about awareness-raising of those complaints mechanisms. Dan mentioned earlier that you can write to the CQC, but it does not have the power to investigate complaints at an individual level. It can simply take that information as intelligence that informs its overall monitoring and regulation of the particular service. The ability to exercise the rights is so important. If you do not have the awareness, knowledge and wherewithal to access them, I think it is always going to be problematic.

For people who are deprived of their liberty under the safeguards, there are supposed to be supports in place such as the relevant person’s representative. It is usually a family member or a friend who can help you to exercise rights. There is also the support of an advocate, but, again, there are concerns about the quality and the variability of the advocacy service. Also, having a friend or a family member to act on your behalf may not always be helpful if they might not act in your best interest. There is a need for more research about the effectiveness of advocacy and how some of these safeguards work to help people to exercise their rights. Hopefully that has helped to give you a little bit of information.

Baroness Ludford: Can we go next to you, Richard? My apologies, I should have introduced myself. I am Sarah Ludford, a Liberal Democrat Member of the House of Lords.

Richard Charlton: We have to look at this in the context of the army of people waiting to be assessed. My understanding—others might correct me—is that there are a little under 500,000 people in care homes at the moment. My firm and lawyers like me are particularly engaged in the process whereby somebody who is deprived of their liberty takes challenges to the Court of Protection to see whether it is right that they should be detained for a lack of capacity, whether the requirements of a deprivation of liberty scheme are too restrictive and whether they should return home.

The figures of the cases that we take are, once again, extraordinary. If you start with, say, 400,000 to 500,000, in figures that we have recently obtained from the Legal Aid Agency, around 2,000 cases are funded a year, so you can see it is a bit less than 0.5% that are actually going before the court. The Court of Protection has managed extremely well in the pandemic, from the court staff to the judiciary. It has managed a very difficult job moving towards electronic systems and so on, but these, in one sense, are the very lucky, very small minority of people who are in that situation.

We have seen a big backlog in terms of people going on the deputation of being actually authorised by the deprivation of liberty system. Following on from that, there is a chain whereby the relevant person's representative or a representative becomes involved, and they are supposed to support the care home resident, who is often frightened and confused. We find that those advocacy services operate in an extremely variable way. Regrettably, they sometimes operate as gatekeepers who take the view that it is in the person's best interests to stay where they are. They have been to the meetings. They have looked at the reports and so on, and, basically, the resident's case stops at that point.

Other advocates are quite outstanding, and they pursue that resident's case on, and it gets referred to the Official Solicitor and to us, but there are a whole series of hoops for, in a sense, the lucky few to make it through to the court, which is supposed to be the court that makes the UK compliant with Article 5, for that resident to challenge their detention in hospital. Once the case gets to court, there is really a very thorough review for these very few people who make that. There are often very positive outcomes that show that, if cases are examined properly and thoroughly, there is almost always a least restrictive option, be that more community access, a return to home or a move to a more suitable care home.

One of the other issues that we have not discussed to date is that, frequently, residents are placed in care homes miles away from their family or where they may have lived all their lives. That has been partly because of the pandemic or partly because there just was a vacancy around at the time. Once a court gets involved, issues about Article 5 and contact with family and access to family can be examined, and, in many cases, that resident is moved to a more suitable care placement. As I say, we really are talking about the few who make this stage.

I do not want to dominate this section too much, but there are other issues in relation to legal aid. Legal aid is means-free for people who are under the deprivation of liberty safeguards, but for those who are detained in supported living, legal aid is means tested. I am sure the others could help us, but there have been various figures about how many people are detained in supported living. The number is growing because housing benefit is obtainable in those situations, and it is much more difficult for those residents to bring challenges.

There are often no advocacy services that they are involved in, but if they manage to bring challenges then, as I say, they face a very severe means test such that if their savings are more than £3,000—as they may well be because they have not been spending in the pandemic, for example—then they have to start paying a substantial contribution. If the figure is more than £8,000, they will not get legal representation. It is very distressing to explain to somebody who wants to bring that case that they will have to provide their money in that kind of way if they want to get access to a court to challenge their deprivation of liberty. There are a lot of problems in the system. I know that we are coming on to talk about the liberty protection safeguards, the new system, later, but, as I say, the existing mechanisms are really failing the vast majority of people in care homes.

Baroness Ludford: Can I just ask you, Richard, two quick questions before I go to Lucy? You made it clear that you are talking about the small, 0.5% of cases that go to the Court of Protection. Would those cases have gone through other channels—for instance, the ombudsman—before they get to you, or do they go straight to court? Secondly, you talked about advocacy services. Are we talking about professional advocacy services or about amateurs such as members of the family? I did not quite understand who the advocates were.

Richard Charlton: I am sorry if I was not clear. The ombudsman would not be involved. The ombudsman might be involved if there were certain situations where there was a complaint and it had escalated through to an ombudsman, but that would take a while. This is the pathway through to challenge your deprivation of liberty, and this was the response of the Government following the Bournewood case.

These are professional advocates. What is slightly confusing is that there can be family members who take on this supportive role to help the resident bring a challenge, but, often, family members are confused. They do not really know what is right. As has already been said, in a care home, residents are often frightened of the care home manager, rightly or wrongly: "We do not want to upset her. She might do this, that and the other". Those fears are probably exaggerated, but they are there. Family members sometimes feel that, if they make moves to challenge detention, that will make life more difficult or perhaps the resident will be evicted. Then, of course, we also have an issue that private paying residents are not actually covered by the Human Rights Act in terms of the care home manager as well.

As far as the paid advocacy services are concerned, as I say, the standard is extraordinarily variable. It is also disturbing that, of course, the people who are paying the advocacy services are the supervisory authority, who are also nominally responsible for the detention. I am not saying that there is any interference there, but one wonders at times whether some of the advocates are concerned that if they make too much of a noise then, of course, the local authority gets involved and then the Court of Protection and that might be a difficulty. To counterbalance that, there are some absolutely outstanding advocates who really are a great voice for their clients and their residents and a great support, but it is a very patchy system indeed.

When we set up our firm in Folkestone in Kent, we looked at a business plan and thought, "There are around 250 care homes immediately around us. We will get some local business”. Although we are recognised across the south-east and by the Official Solicitor, we have not a single case in terms of deprivation of liberty from any of those care homes. I cannot believe that, among all those care homes, there are not a few residents who would like to challenge their deprivation of liberty. Certainly, if I sit there in a lounge waiting to see a client, I am very often approached by somebody who says, “Who are you?” and, frequently, if they know I am a solicitor, “Can you get me out of here?” That is just anecdotal, but, as I say, there is an army of people out there who are not getting their rights.

Dr Lucy Series: I can put some numbers on the picture that Richard has been painting, which I find very familiar. A few years ago, we did some research, funded by the Nuffield Foundation. We looked at accessibility and participation in the Court of Protection for welfare cases in general, but deprivation of liberty cases were a subset of that. We found that, for care and welfare matters generally, it was extremely rare for people who were alleged to lack capacity or their families to be able to challenge care and treatment decisions made by professionals in court, even though we know from other sources, such as ombudsman reports and the House of Lords report from a few years ago, that disputes under the Mental Capacity Act are quite common and they can be very serious in human rights terms. Part of that is for the reasons outlined by Richard and Judy: that going to court is very scary, stressful and expensive, and many people do not even know that they have this right.

When we looked at a sample of the court’s files, we also found that the process was slow, echoing what Richard was saying. In the sample of deprivation of liberty safeguards appeals we looked at, 8% of people died before they got a final decision from the court. I would say that, also, we found that, where the court was involved, finally, its involvement could be really transformative. That was because of the depth of scrutiny it offered and the broad scope of its powers. Just to reiterate, access to justice and the Court of Protection in general is a serious problem, and that includes under the deprivation of liberty safeguards.

We found, in fact, that people were slightly more able to go to court if they were subject to these safeguards, but the rate of appeal when we looked at it was around 1%, and that is still roughly what the Government estimate it to be. This 1% is 1% of people whose deprivation of liberty is authorised under the safeguards. This does not include appeals by people in the backlog or in services like supported living who do not have any safeguards, which is an estimated 58,000 people. Those people are very unlikely to be able to go to court if they want to challenge what is happening to them.

It is difficult to say how many people would want to go to court, because there have been no systematic studies looking at that, but the Law Commission, in its recent review of the deprivation of liberty safeguards, estimated that 30% of people subject to the safeguards at the moment were objecting to the care they were receiving. Some DoLS professionals will put this figure even higher still. This means that a really significant proportion of people who are unhappy with their restrictions are not able to exercise their rights of appeal in accordance with Article 5.

Often, that is because the route to appeal is stressful and challenging and people who are supporting them may not know how. Sometimes it is also because the people who are legally supposed to be assisting that person exercising rights of appeals—so the independent advocates that Richard was speaking about or the person's relatives acting as their representatives—think that it is not in the person's best interests to be given the help they need to challenge things in court, even though human rights law is actually very clear that these rights of appeal against deprivation of liberty are not discretionary and are not conditional on capacity or a person's best interests or what other people think.

Really worryingly, the Government estimate that this rate of appeal will fall to 0.5% when the liberty protection safeguards come into force. This is likely to be because the cost of Court of Protection litigation can be very high. We estimated it could cost around £10,000 for the local authority alone. You need to multiply that by the involvement of the solicitors for the person and the other parties, so this means that, from a governmental perspective, if you increase access to justice, it vastly increases the cost of the safeguards overall. We need to think much harder about the best way to facilitate and adjudicate these rights of appeal, and potentially even revisit primary legislation on this.

Q28 **David Simmonds:** I would like to ask about the use and collection of data. The evidence we received from Dr Series made reference to the relevance of this. Certainly we know that, in respect of children's social care particularly, the monitoring of data is very helpful in flagging up concerns, so I would like to ask whether you have a view about who should be responsible for collating data around this issue and what improvements you might like to see around it, if there are improvements specifically you could point us to.

Dr Lucy Series: I have some concerns about the data that we are gathering at the moment, but I want to caveat that by saying, when the deprivation of liberty safeguards came into force first in 2009, they were a completely new system, and we had little idea what we needed to be looking at, how they should be monitoring or what kind of systems data we needed to tell us if they are working properly. Over the past decade, we now have a much better idea of the pressure points that we need to be monitoring through data gathering and review.

The particular pressure points and issues that I would like better data to be collected on include understanding whether the safeguards actually change care outcomes for people. This is not data that is systematically gathered in the official statistics held by NHS Digital. It is also not something that the CQC routinely or reliably reports on. Sometimes we have to rely on anecdotal data, and what we really want is a systems-level picture of how often, when these safeguards are implemented, people's situations improve as a result.

We also know very little about how the people subject to the safeguards experience them and their families. Although the CQC is going into these settings and is undoubtedly speaking to people and observing their care, that information does not seem to be gathered in a way that can be used in relation to the deprivation of liberty safeguards to tell us about people’s experiences of the safeguards in particular as opposed to their care in general. It is therefore not coming through in the annual reporting that it is doing about the safeguards, so we know next to nothing about how the people who are directly subject to the safeguards, the person who is deprived of their liberty, feel about this process. We know slightly more but still relatively little about how their families experience it.

Another area where we need to collect better systems, statistical and qualitative data is looking at how key rights like advocacy and access to appeals are working. We would like to know things like who is being appointed as a representative—is it a family member or a paid advocate?—and how they are fulfilling that role. That requires better data to be gathered by bodies such as NHS Digital, and a slightly different approach from the Care Quality Commission.

Now, when the liberty protection safeguards come in, there will be new regulations that look at how these frameworks are monitored. This is a really great opportunity for us to reset what kinds of data we are gathering, what happens during inspections and how these safeguards are monitored. The Care Quality Commission could really look to how it monitors the Mental Health Act, which I know Professor Laing is a real expert on, and borrow from that when it comes to looking at how it monitors the DoLS and the liberty protection safeguards and how it reports on them.

David Simmonds: May I perhaps pursue a little further in terms of the collection of the data and whether you have a view about who would be the data holder that you think should be identified—forgive me if I slightly missed the point in your answer—so that it would be clear who was responsible for ensuring that the information that you have described the usefulness of was available and up to date at a given period?

Dr Lucy Series: That is an important question. At the moment, there are two data holders, and they are both really well placed to hold the kinds of data they do hold. The first is NHS Digital, which holds all kinds of data across the health and social care services. It does a very good job every year of presenting what data it holds and analysing it. The issue is that the data that it is given and that it is routinely collecting does not really tap into some of those systemic issues.

The other data holder is the Care Quality Commission. It holds data when care providers tell it that they have made a deprivation of liberty application or authorisation, which is called a notification. Now, at a systems level, that data is not terribly interesting to us because it is not telling us anything we do not already know from NHS Digital. What the Care Quality Commission can add is about the experiences of the individuals and how, in more qualitative terms, these safeguards are operating, so it can speak to the cared-for person and the family and go in and look at the paperwork in a way that NHS Digital is not going to. It can gather that data and it is very well placed to do that. It does it very well under the Mental Health Act, and it can learn from that in how it applies that to these safeguards.

Q29 **Lord Henley:** Dr Series mentioned the liberty protection safeguards, and, as you know, those were planned to be introduced in April of this year to replace the deprivation of liberty safeguards. That has now been delayed. What changes do you understand will be made by the new system, and how much do you think the changes will help? What further changes would you like to see? That is important.

Dr Lucy Series: The liberty protection safeguards have been delayed. I will not be popular for saying this, but it is probably wise to wait for a time when providers, local authorities and NHS bodies can put their minds to it properly. At the moment, they are very busy coping with the fallout from the pandemic. The safeguards were intended by the Government to be more proportionate and a more comprehensives system for protecting rights to liberty and care. This is because, partly, the existing system under the deprivation of liberty safeguards could not cope with the scale required after the Cheshire West ruling. It is also because the system did not apply in certain care settings where we now know that people are deprived of their liberty, such as supported living.

The way the new process will work is that the first tier of checks will be undertaken by the professionals who are already involved in planning a person’s care. They will not be independent, which is a weakness of a scheme, but the hope is that this will encourage these front-line professionals to properly assess capacity and think about human rights from the outset. This documentation will then be sent for desktop review at the responsible body by an independent person. That person will be independent, but they will have only the paperwork to look at. In the majority of cases, the authorisation will be issued on that basis.

However, if the person is identified as objecting in some way to their care arrangements, or if they are in an independent hospital, the independent reviewer will refer this to a specialist professional, called an approved mental capacity professional, who has much broader powers and discretion to look into things, speak to people, conduct assessments and perhaps try to negotiate changes and improvements. The Government also hope that these professionals are going to mediate disputes, avoiding the need to go to court.

On paper, this may potentially improve things, but there are worries about people falling between the gaps and not being identified as objecting, or there being some problem with their care when there needs to be that additional scrutiny by the right professionals. There are also concerns about potentially very long durations under this new scheme without the need for fresh assessments or reviews, amounting to years. There are concerns that access to advocacy, so that is independent specialist professional advocacy, is going to be much more limited than the Law Commission proposed. The Law Commission had wanted lots of access to independent advocacy to make up for the shortfall in independent scrutiny within the rest of the scheme.

Rights of appeal look set to be even weaker than under the deprivation of liberty safeguards, as I have already mentioned. This means that, if people are unhappy and they want to challenge, they might find it even harder to do so.

We need to help, at this stage, responsible bodies and care providers to make the new scheme work as best we can, supported by a really robust code of practice that could potentially address some of these concerns. There needs to be strong professional training and adequate resourcing, but we really need to keep our eye on this through better monitoring and data collection, so that we can revisit things in the future if it is not working properly. There is a case, potentially, for parliamentary post-legislative scrutiny in a few years' time, to see whether we need to go back and amend the primary legislation.

Richard Charlton: I would agree with what Lucy says. We have an awful lot of concerns about the lack of independence on the ground. I am still not entirely clear about the role of the care home manager. I know, initially, the care home manager used to play quite a role in arranging assessments. I am not entirely clear how the assessment for mental disorder would be arranged. As I say, the burden on the care home manager would be very difficult. I think that the Government have recognised that and have stepped back from requiring the care home manager to have this particular kind of a role. There is recognition of the idea that there should be, perhaps, somebody less involved directly making these initial assessments.

Anecdotally, we know that, going into care homes, we are frequently met by the care home manager, who says, "I don't know why you're here because Mrs Smith is fine here. She is happy. It's not a problem". You sit down with Mrs Smith on her own and she wants desperately to get out, but she is afraid of the care home manager and does not want to offend them: "They are kind and helpful, but I want to go home". Assessments starting at this kind of level is of great concern to us.

As Lucy said, if you have a good advocacy service going in and supporting the resident then, clearly, matters would be looking up. I am still very unclear. There is no code of practice yet. The regulations are not clear. The role of advocates still is not clear. I know at the moment the system takes a long time, but it has good assessments behind it. It has a psychiatrist. It has a good independent social worker, usually through a best-interests assessor.

The danger here is that we have a DoLS-lite and that we face the risk, given the extended periods that Lucy talked about, where we go up to three years before any of these reviews take place. We risk building new "back wards". When I was a social worker years ago, the big psychiatric hospitals used to have back wards where people with dementia particularly really just spent the rest of their lives without any very good effective review. I fear that, in this kind of system, we are going to have people who have no rights to advocates, whose voices just are not heard and who just fall off the system.

I find it difficult to follow all the LPS developments. It seems pleasing that it has been stopped, although the principle of its expansion to cover people in the community and supported living is a very good one. I am just sceptical at the present time about what it could really do in terms of human rights for the residents that we are talking about.

Professor Judy Laing: I have a few additional thoughts, but I would certainly echo what both Lucy and Richard have already said. The Bill had a very turbulent passage through Parliament, and there were a number of changes and compromises made along the way, so quite whether it is going to provide a stable basis for reform remains to be seen, particularly because the effectiveness of the law will obviously depend very much on how it is interpreted and applied, and we have no way of knowing what the code of practice is going to look like yet and all the accompanying regulations, which is going to be challenging.

I have a few positive comments and a few negative comments and concerns. On the positive side, it is obviously going to try to streamline the process, so, in theory, it should be easier and quicker. The fact that we have a wider range of responsible bodies, so not just local authorities but NHS trusts can authorise these liberty protection safeguards, should take the pressure off the local authority. Of course, the NHS is still facing considerable pressure in the wake of the pandemic, so there is still potential there for concerns around delays.

They are going to be expanded to a broader range of settings and age groups. Again, that also causes concerns in terms of numbers. I would query, in the impact assessment, whether the best guess around how many applications there will be is perhaps a little on the conservative side. If we take that in line with some of the proposed changes to the Mental Health Act in the White Paper—to limit the application of the Mental Health Act to certain groups and certainly to remove people with learning disabilities and autism out of the Mental Health Act where there is longer-term detention—I am a bit worried that we will simply move one issue with the Mental Health Act and it will end up becoming an issue for the way that the liberty protection safeguards are implemented.

Procedurally, it has potential to be better in terms of it being clearer, but it also needs to be accessible. Again, with all the code of practice delays and all the regulations, we are going to have to make sure that it is accessible to those people, both staff and service users, and that that process is clear. I have concerns that the delays might impact negatively on the engagement of the sector. There is a lot of cynicism and scepticism about the new process, and so it will be important to see what happens in the detail when it comes out.

I would echo the concerns about the review and the renewal provisions. There are no statutory time limits there. Again, I worry how that might impact on certain groups that might be deflected from other legislation that deprives them of their liberty. I am concerned as well about the role for care home managers. As Richard has pointed out, there is a little uncertainty about how that is going to play out. There was potentially, initially, a greater role for care home managers in the liberty protection safeguards to arrange assessments, so that was passed from the local authority to the care homes. That original proposal, we have been told, has been put on hold, although I understand that there is still a possibility that the local authority might allow that in individual cases. I am not quite sure how that is going to work; we will have to wait and see how that poses in the code of practice.

I would echo the concerns about the dilution in the role of the mental capacity advocate and the approved mental capacity professional. There is a dilution in the scrutiny and oversight role. Again, that worries me from a legal and human rights perspective.

The final point is that I would echo what Lucy and Richard have said about oversight and monitoring. That is going to be key to how effectively the safeguards are implemented, to make sure that people are not left in the same situation that they have been found in now. Perhaps looking at the role of the CQC and how it monitors the Mental Health Act, under which it has a statutory duty to interview patients in private and to lay a report before Parliament on the Mental Health Act, and mapping that on to the liberty protection safeguards might help a little with the monitoring and oversight of an independent body. It would help to collect some of the qualitative data that Lucy was talking to around patients' experiences.

I was trying to find information about independent mental capacity advocates to prepare for today, and I was really struggling to find lots of research around how they work, how often they are used, the quality and the quantity. We lack that really important data about experiences of how the DoLS are working, which we really need to make sure that the liberty protection safeguards are going to work more effectively for those who are subject to them, as well as the professionals who are working with them on a daily basis. I hope that is helpful.

Chair: Thank you very much indeed to our second panel this afternoon. Your evidence has been very striking. One of the things that will stand out for me is that over 100,000 people at any one time are deprived of their freedom but without the protection that they are intended to have. The evidence this afternoon could hardly be more serious and more worrying, so you have given a great impetus for us to proceed with our report.