

## Written evidence from Dr Lucy Series (HCS0055)

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My research focuses on legal capacity, social care and human rights. My particular expertise is in the Mental Capacity Act 2005 (MCA),<sup>1</sup> and my research recently focused on deprivation of liberty in care settings. My forthcoming book concerns social care detention (the regulation of social care living arrangements as a deprivation of liberty) and the challenges tackling restrictive and institutional practices through care regulation.<sup>2</sup> I also have published analyses of how the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and the Liberty Protection Safeguards (LPS) comply (or not) with the requirements of article 5 of the European Convention on Human Rights (ECHR)<sup>3</sup>, the right to liberty and security of the person. I have analysed the Supreme Court's ruling on the meaning of deprivation of liberty for people using care services, known as the *Cheshire West* 'acid test' (*P v Cheshire West and Chester Council and another; P and Q v Surrey County Council* [2014] UKSC 19).<sup>4</sup>

I previously gave evidence to the Joint Committee on Human Rights' inquiry into *The Right to Freedom and Safety*<sup>5</sup>, and fed into later JCHR work on pre-legislative scrutiny of the Mental Capacity (Amendment) Act 2019<sup>6</sup> and the detention of young people with learning disabilities and/or autism.<sup>7</sup> I gave expert testimony and oral evidence to the National Institute for Health and Care excellence, for their guidance on *Decision-Making and Mental Capacity*.<sup>8</sup> I was a member of the Human Rights and Equality Working Group of the recent Independent Review of the Mental Health Act 1983.<sup>9</sup> I have been a member of the CQC's advisory group on the deprivation of liberty safeguards since 2010. I was previously a member of the Law Society's Mental Health and Disability Group (2015 - 2020). I am a co-founder of the UK and Ireland Mental Diversity Law Network, which brings together academics, practitioners and people with lived experience of mental disability, illness and diverse experiences to discuss developments in the law; I am currently running workshops with them around the potential impact on liberty safeguards of possible changes to the

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<sup>1</sup> For a full list of publications see: <https://www.cardiff.ac.uk/people/view/478911-series-lucy>

<sup>2</sup> Series L, *Deprivation of Liberty in the Shadows of the Institution* (Bristol University Press 2022). Forthcoming in March 2022.

<sup>3</sup> Series L, 'On detaining 300,000 people: The Liberty Protection Safeguards', (2019) 25 *International Journal of Mental Health and Capacity Law* 2, <https://www.northumbriajournals.co.uk/index.php/ijmhcl/article/view/952>

<sup>4</sup> Series L, 'Making sense of *Cheshire West*' in Spivakovsky C, Steele L and Weller P (eds), *The Legacies of Institutionalisation: Disability, Law and Policy in the 'Deinstitutionalised' Community* (Hart 2020).

<sup>5</sup> Joint Committee on Human Rights, *The Right to Freedom and Safety: Reform of the Deprivation of Liberty Safeguards* (HC 890, HL paper 161, 2018).

<sup>6</sup> Joint Committee on Human Rights, *Legislative Scrutiny: Mental Capacity (Amendment) Bill* (Twelfth Report of Session 2017–19, HC 1662 HL PAPER 208, 2018)

<sup>7</sup> Joint Committee on Human Rights, *The detention of young people with learning disabilities and/or autism* (HC 121 HL Paper 10, 2019).

<sup>8</sup> National Institute for Health and Care Excellence, *Decision-making and mental capacity* (NICE guideline, Published: 3 October 2018, 2018) <https://www.nice.org.uk/guidance/NG108>

<sup>9</sup> Wessely S and others, *Modernising the Mental Health Act: Increasing choice, reducing compulsion* (Final report of the Independent Review of the Mental Health Act 1983, 2018) <https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review>

Human Rights Act 1998. I have previously worked with the World Health Organisation and UN human rights bodies on matters concerning legal capacity and deprivation of liberty.

### **The importance of rights to home**

There is a danger in an inquiry of this nature that our focus becomes on ‘wrongs’ in care settings, and not on what we want to get right. Human rights law can be a powerful tool for formulating positive goals as well as redressing wrongs. I would like to start by emphasising one of the most important human rights goals that social care can enable: ensuring people are well supported to enjoy meaningful homes in real communities, alongside the people they care about. As inclusive research by Social Care Future puts it:

We all want to live in the place we call home with the people and things that we love, in communities where we look out for one another, doing things that matter to us.<sup>10</sup>

But what is a home? Inserting the word ‘home’ into a living arrangement – for example, calling it a ‘care home’ - does not make it a home. Moving somebody into a setting and calling it their home, does not mean they will experience it as a home. A good deal of research – which I explore in my book – finds that many people living in care homes and other care settings do not experience these spaces as ‘homes’ in the ordinary sense, and many resemble ‘institutions’ in their internal workings and power dynamics. Historically, social care developed to move us away from the ‘institutional’ legacies of the past, but this is a work in progress as we continue to rely on smaller scale institutions in ‘community’ settings.

My recent research explored research on what ‘home’ means to different people, and particularly to older people, people with learning disabilities and mental health problems, and others who draw on care and support.<sup>11</sup> Homes are places where people expect to enjoy a locus of control over their environment, embodied by the saying derived from the English common law ‘an Englishman’s home is his castle’.<sup>12</sup> Most people expect to enjoy a fair degree of choice and control over where they live and who they live with, as well as a considerable degree of privacy and control over who enters their home (‘control of the threshold’). Most home-dwellers enjoy considerable control over everyday activities and decisions, daily rhythms and routines. People expect to be able to move freely within their homes, and not be confined to, or prohibited from, particular parts of it.

Homes offer safety, security, a ‘haven’ from the intrusion of others. Homes are places where we can express our identities, for example through our decorative choices. Homes are an important locus for relationships with family and friends, where we can receive guests and offer hospitality (the ‘social home’). Homes also offer the privacy and freedoms necessary for establishing intimate personal relationships – including sexual relationships – and founding a family. Over time, homes become places of rootedness and belonging. Researchers argue that homes are vital ‘scaffolding for the self’,<sup>13</sup> particularly for people with cognitive

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<sup>10</sup> Crowther N, ‘Talking about a brighter social care future’ (*Social Care Future* 2019) <https://socialcarefuture.blog/2019/10/31/talking-about-a-brighter-social-care-future/>

<sup>11</sup> I synthesize this research in *Deprivation of Liberty in the Shadows of the Institution* (n 2). For a summary of this, see my blog post: <https://thesmallplaces.wordpress.com/2021/11/20/places-like-home/>

<sup>12</sup> Semayne’s Case (1 January 1604) 5 Coke Rep. 9.

<sup>13</sup> E.g. Lindemann H, ‘Holding One Another (Well, Wrongly, Clumsily) in a Time of Dementia’, (2009) 40 *Metaphilosophy* 3, 416.

impairments whose environment becomes critical in maintaining a sense of self. Living in depersonalising environments can exacerbate conditions like dementia or autism.<sup>14</sup> Meaningful homes are important for recovery from physical and mental illness.<sup>15</sup>

Yet many people who draw on care and support do not experience ‘home’ in the ordinary way that most other people expect. Many do not exercise real or meaningful choices over where and with whom they live.<sup>16</sup> In congregate settings, like care homes, people will have very limited opportunities to choose who they live with, who supports them, who enters their private spaces, and they often experience depleted opportunities to exercise meaningful choices in their everyday lives. Many social scientists describe these settings as ‘institutional’ or as having ‘institutional’ aspects, and this has harmful effects on individual wellbeing.<sup>17</sup>

The recent covid pandemic sharpens our awareness of how readily human rights and human needs can be curtailed in more institutional care settings. Government guidance for care homes imposed (without any clear legal basis) significant restrictions on residents’ rights and freedoms, including rights to freely come and go from the setting, to receive visitors, or even sometimes to move outside of a person’s own room where they were required to isolate. Care home residents experienced some of the most severe restrictions imaginable in our society, often tantamount to segregation or solitary confinement. Yet similar guidance issued for people living in settings like supported living acknowledged that such restrictions could not be imposed without the person’s own agreement, because these were legally the person’s own home.<sup>18</sup> Entering a care environment fundamentally weakens a person’s human rights, conferring authority upon the care provider and those commissioning or securing the care over many matters of basic importance to the person.

Our society is heavily dependent on congregate care settings, and we have normalised the care of older people in institutions like care homes. Yet these are not environments where most people would choose to live, and they entail intrinsic losses to the ordinary rights to home that most people expect to enjoy. It is not inevitable that because a person draws on care and support, or has difficulties with ‘mental capacity’, that they should enter living arrangements where their rights to home can be so depleted. Our goal should be to advance our knowledge, services (public and private) and practices enabling us to secure homes for all.

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<sup>14</sup> E.g. Sabat SR, ‘Subjectivity, the brain, life narratives and the ethical treatment of persons with Alzheimer’s disease’, (2009) 9 *American Journal of Bioethics* 9, 23; Kitwood T and Booker D (eds), *Dementia reconsidered: The person still comes first* (Open University Press 2019).

<sup>15</sup> Borg M and others, ‘What Makes a House a Home: The Role of Material Resources in Recovery from Severe Mental Illness’, (2005) 8 *American Journal of Psychiatric Rehabilitation* 3, 243.

<sup>16</sup> A violation of the ‘right to live independently and be included in the community’ under article 19 of the United Nations Convention on the Rights of Persons with Disabilities

<sup>17</sup> For a landmark paper on the importance of control over one’s living environment see: Langer EJ and Rodin J, ‘The effects of choice and enhanced personal responsibility for the aged: A field experiment in an institutional setting’, (1976) 34 *Journal of personality and social psychology* 2, 191. For a review of the research in this tradition see: Mallery MH, Claver M and Lares LA, ‘Perceived Control in the Lives of Older Adults: The Influence of Langer and Rodin’s Work on Gerontological Theory, Policy, and Practice’, (2014) 54 *The Gerontologist* 1, 67.

<sup>18</sup> Department of Health and Social Care, ‘Guidance: COVID-19: guidance for supported living (Updated 17 August 2021)’ (2021) <https://www.gov.uk/government/publications/supported-living-services-during-coronavirus-covid-19/covid-19-guidance-for-supported-living>

However, without fundamental reforms to existing models of housing and social care provision, without the political will to treat social care as a visionary project not a national burden to be managed, we will remain heavily reliant on quasi-institutional settings. Without a radical change to social care's political vision and political settlement, we become reliant on human rights and other forms of law to address the worst problems in care settings, we do not *fulfil* rights to home and community. There is only so much that regulation – including liberty safeguards and regulation by bodies like the Care Quality Commission (CQC) – can achieve without fundamental changes to the political settlements for care. At best, we can temper the most institutional features of these environments and carve out slightly more home-like spaces.

### **Liberty safeguards**

Until quite recently nobody really thought about rights to liberty for people in community care settings. Deprivation of liberty was associated with hospital environments and even then, only certain kinds of patient - people with 'mental illnesses', not those living with dementia, learning disabilities or autism, whose confinement was mainly 'informal'. Yet England and Wales, and a growing number of other countries around the world,<sup>19</sup> do now recognise that even 'community' care settings can restrict people's rights, and that this can amount to a deprivation of liberty.

In 2014 in *Cheshire West* the Supreme Court ruled that a person was deprived of their liberty if they were subject to 'continuous supervision and control' and 'not free to leave'.<sup>20</sup> This 'acid test' of deprivation of liberty affects an estimated 300,000 people who draw on care and support, including people in hospitals, care homes, supported living and even 'ordinary' domestic settings.<sup>21</sup> The majority are older adults, around half are people living with dementia, but there are substantial numbers of people with learning disabilities, autism, brain injury and neurological conditions. These situations are currently regulated via the Mental Capacity Act 2005 deprivation of liberty safeguards (DoLS) and authorisations issued by the Court of Protection, and in future will be regulated via the Liberty Protection Safeguards (LPS).<sup>22</sup>

Some people find it surprising that people living in care homes and 'domestic' settings could be categorised as deprived of their liberty. Some query the need for this, and view it as human rights taken to excess (including, apparently, this government<sup>23</sup>). In fact, this is not an unprecedented departure for English law – before the Mental Health Act 1959 almost all settings where a person was restricted in some way by people paid to care for them were regulated as 'lunacy institutions'. People so confined were entitled to 'safeguards' for their liberty even if they lived in private homes, so long as the care provided was 'for profit'. This would have been the case at the time the ECHR was drafted and signed. It is a myth that

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<sup>19</sup> See *Deprivation of Liberty in the Shadows of the Institution* (n 22)

<sup>20</sup> *P v Cheshire West and Chester Council and another; P and Q v Surrey County Council* [2014] UKSC 19.

<sup>21</sup> Department of Health and Social Care, *Impact Assessment: Mental Capacity (Amendment) Bill* (Revised IA, dated 31/01/2019, 2019).

<sup>22</sup> Previously considered by the JCHR in: Joint Committee on Human Rights, *The Right to Freedom and Safety: Reform of the Deprivation of Liberty Safeguards* (HC 890, HL paper 161, 2018); Joint Committee on Human Rights, *Legislative Scrutiny: Mental Capacity (Amendment) Bill* (Twelfth Report of Session 2017–19, HC 1662 HL PAPER 208, 2018).

<sup>23</sup> Ministry of Justice, *Human Rights Act Reform: A Modern Bill Of Rights* (CP 588, 2021) [159]-[160].

‘institutions’ and detention has always been synonymous with hospital confinement.<sup>24</sup> It was only from the 1960s onwards that the care of people with ‘incapacity’ was deregulated and de-formalised in the way we now view as natural and inevitable.

### ‘Liberty’ safeguards protect more than just ‘liberty’

There are now more people considered to be deprived of their liberty in Britain’s care homes than its prisons.<sup>25</sup> Why are we regulating so many care arrangements as a deprivation of liberty? In my book I argue that this is because we are increasingly aware of the potential for human rights violations in care settings, which have no obvious alternative and accessible form of redress. Concerns include:

- Placing people in settings where they (or their families) do not wish them to live, including moving people out of their existing homes or preventing a return home after a hospital admission;
- Subjecting people to excessive restrictions, including physical restraint, chemical restraint, ‘blanket rules’ and institutional regimes;
- Imposing specific restrictions on people’s ordinary rights to privacy – for example restrictions on contact with friends or family, restrictions on access to social media, regimes imposed to prevent sexual activity;
- Concerns about generally poor quality care, neglect, lack of meaningful activities, lack of access to communities, loneliness and isolation.

The CQC has detailed how ‘services where people are unable to leave of their own accord’ and where people may have one-to-one care (that is, they are under ‘continuous supervision and control’) are ‘inherent risk factors’ that a ‘closed culture’ might develop there, placing residents at heightened risk of abuse. This stemmed from work looking at serious institutional abuses

‘Liberty’ has therefore become something of a catch-all for a wide range of human rights violations and concerns about what happens to some people in formal care settings.

Why are we then regulating these matters as a ‘deprivation of liberty’ and not under article 8 ECHR or some other mechanism? Why do we need checks and safeguards for people when the MCA already requires that their care should be arranged in their ‘best interests’ and ‘least restrictive’?

### Preventive safeguards

The answer is that people living in these situations are generally unable to call attention to their predicament when things go wrong. In the *Bournemouth* case, *HL v UK*<sup>27</sup>, procedural safeguards of the kind required by article 5 were described as protecting people against ‘misjudgments and professional lapses’. If things have gone seriously wrong then those responsible for their care are likely either to have not noticed this, to be complicit with this, or to be unable to fix this (or they would have put it right). To have a system that responds

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<sup>24</sup> This history is detailed in: *Deprivation of Liberty in the Shadows of the Institution* (n 22).

<sup>25</sup> Series L, ‘On detaining 300,000 people: The Liberty Protection Safeguards’, (2019) 25 *International Journal of Mental Health and Capacity Law* 2, <https://www.northumbriajournals.co.uk/index.php/ijmhcl/article/view/952>

<sup>27</sup> [2004] ECHR 720.

only when there is a problem with somebody's care would not work – how would the system know about it if the person cannot alert it and the professionals believe they are doing the right thing?<sup>28</sup> The safeguards are *preventive*.

The *Cheshire West* acid test is a red flag for situations that require more than usual scrutiny in care settings. The Supreme Court's policy intention was to secure an 'independent check' on the care arrangements of people whom Lady Hale characterised as extremely 'vulnerable'.<sup>29</sup> Whilst the content of article 8 might sometimes fit the issues better, it does not entail the bundle of rights and procedural safeguards required by article 5 ECHR. These include requirements for formal assessments with an independent element, rights to information, rights to representation and advocacy and – where the person or others object to their situation – rights to appeal to a court. Without these kinds of safeguards, people whose care has gone wrong will find it almost impossible to secure the attention and redress they require. In our research on the Court of Protection we found that people who are alleged to lack capacity and their families almost never bring proceedings to challenge decisions made by professionals under the MCA *unless* they are subject to DoLS, because DoLS facilitates 'rights of appeal' via access to information, advocacy and non-means tested legal aid.<sup>30</sup> There is ample evidence that people who are considered to 'lack capacity', and their families, can find it extremely difficult to challenge professional decisions made around care under the MCA.<sup>31</sup>

#### Deprivation of liberty in 'supported living'

At present the DoLS only regulate care homes and hospitals; the LPS will extent safeguards to other 'community' and domestic settings. This is people are not only restricted in care homes, and things do not only go wrong in care homes. Supported living is not an 'ordinary' domestic setting. It is a care setting that has a lot of parallels with regulated care homes, including that these tend to be 'segregated' environments outside of ordinary housing stock. The reality is that people may have limited control over where they live, who they live with, who supports them and how they are supported, especially if they 'lack capacity' in the meaning of the Mental Capacity Act 2005 (MCA) and their care is funded and arranged by public bodies. Research has found that supported living services can operate in very

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<sup>28</sup> A point made by the Court of Appeal in *SSJ v Staffordshire CC & Ors* [2016] EWCA Civ 1317.

<sup>29</sup> See paragraphs 1 and 57 of Lady Hale's judgment in *Cheshire West*.

<sup>30</sup> Series L, Fennell P and Doughty J, *Welfare cases in the Court of Protection: A statistical overview* (Cardiff University, Report for the Nuffield Foundation, 2017) <http://orca.cf.ac.uk/id/eprint/118054>

<sup>31</sup> House of Lords Select Committee on the Mental Capacity Act 2005, *Mental Capacity Act 2005: post-legislative scrutiny* (HL Paper 139, 2014); Local Government Ombudsman, *The Right to Decide: Towards a greater understanding of mental capacity and deprivation of liberty* (2017).

institutional ways.<sup>32</sup> There are examples of the use of restraint in supported living,<sup>33</sup> restrictions on contact with others,<sup>34</sup> and even institutional abuse.<sup>35</sup>

### Problems with liberty safeguards

As mechanisms to respect, protect and fulfil human rights the DoLS are imperfect, and so too are the LPS. They can only choose between the ‘actually existing options’ and cannot secure more resources or better options than public bodies and/or the care market provides. The DoLS and LPS are also complex and have significant weaknesses in terms of independence, advocacy and rights of appeal.<sup>36</sup> In practice, resources are stretched very thin, meaning applications are ‘triaged’ and many people never get safeguards.

Another current problem is that in *obiter* remarks the Court of Appeal interpreted the *Cheshire West* ‘acid test’ narrowly to only relate to restrictions whereby a person is not ‘free to leave’ on a permanent basis.<sup>37</sup> This is unlikely to be what Lady Hale meant in her *ratio*, since she explicitly included in her analysis the more everyday restrictions – for example over contact and activities – that the appellants were subject to.<sup>38</sup> However the government endorsed this narrow analysis in its guidance on deprivation of liberty during the covid pandemic.<sup>39</sup>

This has had the surprising and alarming outcome that the government apparently considers the very extreme restrictions that care home residents have been subject to when required to self-isolate for weeks during the pandemic as not amounting to a deprivation of liberty because they are – in theory – free to leave the care home and live elsewhere. Government lawyers apparently expressed this view to the families of people living with dementia who argued their relatives in care homes were being falsely imprisoned during the pandemic.<sup>40</sup> Of course the reality is that nobody could leave – where would they go? If they could live at home safely they surely would be there and not in a care home, and during the pandemic all

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<sup>32</sup> E.g. Fyson R, Tarleton B and War L, *Support for living? The impact of the Supporting People programme on housing and support for adults with learning disabilities* (Joseph Rowntree Foundation, York, 2007).

<sup>33</sup> In the *Cheshire West* case a man with Down syndrome was frequently physically restrained to prevent him from ingesting his incontinence pads.

<sup>34</sup> For example, in one Court of Protection case a man – G – was removed from his foster carer – E – because of (unfounded) allegations of abuse by her. He was moved to supported living. Contact with her was restricted. This was said to be a violation of both their article 8 ECHR rights *G v E, A Local Authority & F* [2010] EWHC 621 (Fam). Several people with learning disabilities have been removed from their families, their contact restricted and supervised, on the basis that their family carers exercised ‘undue influence’ over them and were hampering their ‘independence’. In some of these cases the individuals concerned still wished to live with their families: *A Local Authority v WMA & Ors* [2013] EWHC 2580 (COP); *A Primary Care Trust v AH* [2008] EWHC 1403 (Fam).

<sup>35</sup> Commission for Social Care Inspection and Healthcare Commission, *Joint Investigation into the Provision of Services for People with Learning Disabilities at Cornwall Partnership NHS Trust* (2006).

<sup>36</sup> Series (2019; 2022) n 2 and n 3.

<sup>37</sup> *D (A Child)* [2017] EWCA Civ 1695 [22].

<sup>38</sup> *Cheshire West*, UKSC, [51], [52], [53].

<sup>39</sup> See: Department of Health and Social Care, *The Mental Capacity Act (2005) (MCA) and deprivation of liberty safeguards (DoLS) during the coronavirus (COVID-19) pandemic: additional guidance* (Version of 15 October 2020, 2021) <https://www.gov.uk/government/publications/coronavirus-covid-19-looking-after-people-who-lack-mental-capacity/the-mental-capacity-act-2005-mca-and-deprivation-of-liberty-safeguards-dols-during-the-coronavirus-covid-19-pandemic-additional-guidance>.

<sup>40</sup> John’s Campaign, *The Holding Pen: 14 Days Enforced Isolation for People Living in Care Homes* (Golden Duck 2021). ‘The Government lawyers assure our lawyers that what is happening is not false imprisonment, as adults with mental capacity are always free to leave – they just can’t come back unless they are prepared to quarantine for 14 days.’ P 38.

care homes operated these self-isolation rules. It is striking that during the pandemic the number of DoLS applications fell for the first time since *Cheshire West*, despite care home residents living under some of the most extreme restrictions.<sup>41</sup> This issue extends beyond the pandemic. If ‘deprivation of liberty’ (and therefore deprivation of liberty safeguards) only go to the question of whether a person can leave *permanently*, then they cannot address the wide range of issues around restrictions, restraint, interferences with private and family life and so on that practitioners and the Court of Protection currently use the safeguards to address.

Beyond what is reported by the Court of Protection and official statistics,<sup>42</sup> we know surprisingly little about how the DoLS operate in practice because of weaknesses in official data protection and monitoring of the system by CQC. Further empirical research, better data collection and better regulatory oversight are much needed. The two critical questions that we cannot currently answer are:

1. how often are care arrangements improved by the interventions of assessors, advocates or others involved in the DoLS/LPS? and
2. how do those directly subject to the DoLS/LPS experience these processes and outcomes?

### **Regulatory protection of rights?**

Critics of the DoLS (and LPS) often ask why this independent preventive role cannot be undertaken by the Care Quality Commission (CQC)? Here are some reasons why CQC in its current form cannot undertake the kind of individualised, preventive and responsive action necessary to safeguard people’s rights in care in the way that the DoLS are intended to:

- The CQC regulates services not individual people’s care. It does not (currently) investigate individual situations or respond to individual complaints. Where it hears of concerns CQC will usually look to see whether the service has a process in place to deal with concerns (e.g. safeguarding processes, complaints processes, MCA assessments). CQC may in some instances make a local authority safeguarding referral (although the evidence it gave to the JCHR’s earlier inquiry implies this step is rarely taken)<sup>43</sup>.
- CQC inspectors can check to ensure mental capacity assessments and best interests meetings have been documented and conduct surface checks as to their quality. CQC inspectors do not undertake such assessments themselves nor make substantive

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<sup>41</sup> NHS Digital, *Mental Capacity Act 2005, Deprivation of Liberty Safeguards - 2020-21* (2021) <https://digital.nhs.uk/data-and-information/publications/statistical/mental-capacity-act-2005-deprivation-of-liberty-safeguards-assessments/2020-21>

<sup>42</sup> NHS Digital, *Mental Capacity Act 2005, Deprivation of Liberty Safeguards - 2020-21* (2021) <https://digital.nhs.uk/data-and-information/publications/statistical/mental-capacity-act-2005-deprivation-of-liberty-safeguards-assessments/2020-21>

<sup>43</sup> Hatton C, *Analysis of information provided to the Joint Parliamentary Committee on Human Rights in support of the Inquiry into the detention of children and young people with learning disabilities and/or autism* (2019) <https://publications.parliament.uk/pa/jt201919/jtselect/jtrights/121/Analysis-of-data-from-CQC-and-NHS-Digital-JCHR.pdf>; Hatton C, *Summary of information available to the CQC and CQC inspections January 2014 – June 2019* (2019) <https://publications.parliament.uk/pa/jt201919/jtselect/jtrights/121/Hatton-analysis-inpatient-units.pdf>

determinations about what care is right for specific individuals. They cannot review the substantive outcome of these assessments and decisions. DoLS assessors – and the Court of Protection – do precisely this.

- Where CQC has concerns about a specific individual it would be rare for it to continue to follow up and advocate for that person to ensure their situation is resolved, instead seeking reassurances that the service provider and/or commissioning body are taking action. In contrast, DoLS inserts roles for advocates, representatives and reviews by the supervisory body to continue to maintain contact with the person and monitor their situation over the longer term.
- CQC does not presently have the resources to even visit care homes annually, let alone individually assess and monitor everyone subject to the DoLS/LPS. Figure 1 shows how care home inspection frequencies have fallen since the first social care inspectorate was created. Since the pandemic began, this has fallen even further.

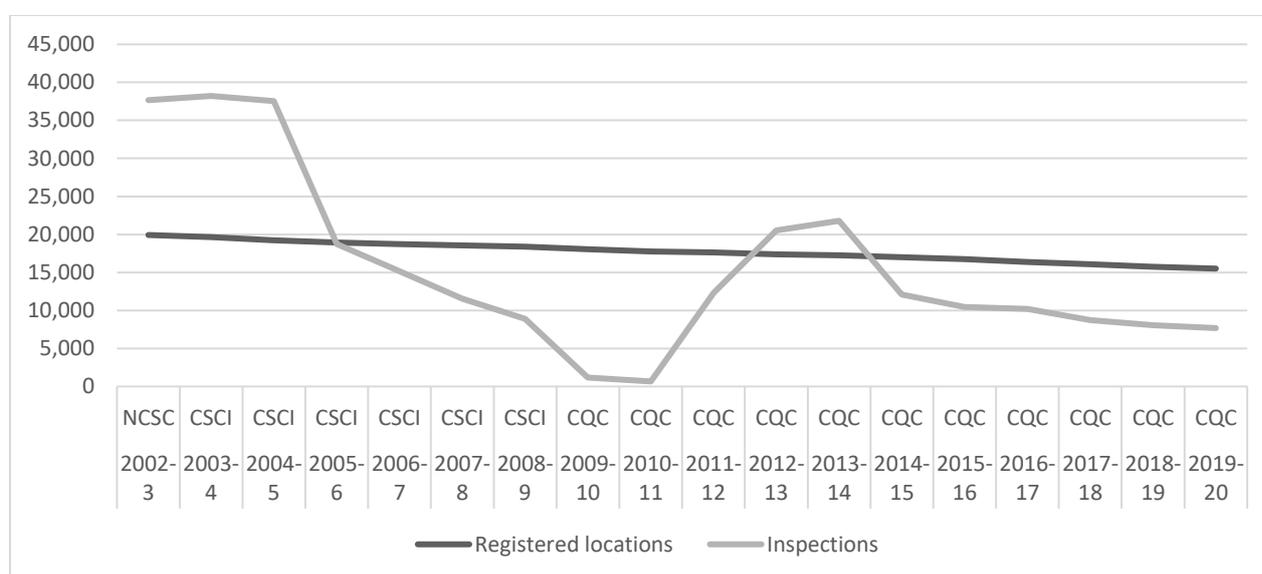


Figure 1 Registered locations and inspections of care homes 2002-2020

- CQC regulates services, but not the public bodies (local authorities or CCGs) that may commission those services. Often when something goes wrong with a persons’ care, the underlying issue is connected with how the person came to be in a particular service in the first place, and the care plan as it was commissioned and funded. CQC has no powers to investigate or address this.
- CQC has no powers to require changes to a particular individual’s care, let alone to ‘discharge’ an individual from a deprivation of liberty authorisation, enabling them to return home. It inspects and enforces against a set of national standards for services. Regulatory compliance is not a lever like a mental health tribunal or a court – it cannot enquire what plans would be put in place if a person were discharged and then force them to be released.

### CQC’s role in preventive detention monitoring

CQC does perform a preventive monitoring function as National Preventive Mechanism under the UN Optional Protocol of the Convention Against Torture (OPCAT). This means it is tasked with visiting places where a person is deprived of their liberty to ensure they are not being tortured or subjected to cruel, inhuman or degrading treatment. As the JCHR have

previously considered in their work around autism and learning disability hospitals, the CQC's actual ability to detect abuse and its preventive monitoring function is limited.<sup>44</sup> For this reason, CQC is undertaking a review of how it monitors these kinds of closed settings.<sup>45</sup> However, abuse is not limited to hospitals and it is not limited to people with learning disabilities and autism – it can happen across all kinds of care setting, and all populations who draw upon care.

One significant limitation for CQC's preventive monitoring role is that it currently has no powers to inspect 'supported living' style services. This is because these are not 'regulated premises'; CQC only regulates the care. The law enshrines a belief that these are ordinary domestic homes where people are receiving 'homecare'. Yet as outlined above the reality is that supported living services can function very similarly to congregate and segregated settings. There are even examples of providers building 'supported living' style services on old hospital campuses, where CQC would have no powers to refuse registration because it does not regulate the 'premises' only the support.<sup>46</sup> If a provider decided to develop a large 'supported living' block of housing, and extend the reach of its existing registered support provision, there is no reason why CQC would even know where it was providing care and support or who to. It is estimated that as many as 58,000 people may be deprived of their liberty in services like this.<sup>47</sup> From a preventive detention monitoring perspective, this is a significant blind spot. For this reason some Nordic countries are including (or considering including) supported housing within their OPCAT monitoring remit.<sup>48</sup>

One option is to categorise these services as 'regulated premises', enabling powers of entry and tighter regulatory controls on the premises themselves. The problem is that this would affect a wide range of ancillary matters, including people's entitlements to welfare benefits and funding for supported housing. It also runs the risk of further embedding 'institutional' mindsets instead of tackling these and ensuring providers understand and treat these 'private dwellings' as a person's home. A better tactic would be to find an alternative way for CQC to engage with people living in these services who are at heightened risk of excessive restrictive or even abuse care, in ways that does not undermine the ethos underpinning supported living – that these *should be* run as private homes with support (even if in practice they often are not). CQC could also use its enforcement powers to ensure that supported living services were being run in the way they were originally intended – as services that are provided in people's own homes, giving them meaningful choice and control over who supports them and how.

An alternative possibility is to give CQC similar powers to visit people who are subject to deprivation of liberty authorisations under the LPS, to interview them in private, to receive

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<sup>44</sup> Joint Committee on Human Rights, *The detention of young people with learning disabilities and/or autism* (HC 121 HL Paper 10, 2019) <https://publications.parliament.uk/pa/jt201920/jtselect/jtrights/121/121.pdf>

<sup>45</sup> Care Quality Commission, *Out of sight – who cares? A review of restraint, seclusion and segregation for autistic people, and people with a learning disability and/or mental health condition* (2020) <https://www.cqc.org.uk/publications/themed-work/rssreview>; Care Quality Commission, 'How CQC identifies and responds to closed cultures' (2021) <https://www.cqc.org.uk/guidance-providers/all-services/how-cqc-identifies-responds-closed-cultures>.

<sup>46</sup> Discussed in chapter 7 of *Deprivation of liberty in the Shadows of the Institution* (n 2).

<sup>47</sup> See Law Commission, *Impact Assessment: Mental Capacity and Detention* (LAWCOM0055, 2017) <http://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/>

<sup>48</sup> Discussed in chapter 5 of *Deprivation of liberty in the Shadows of the Institution* (n 2).

their complaints, as those CQC already possess for people who are detained under the Mental Health Act 1983. This is the approach taken by the Mental Welfare Commission for Scotland in connection with both its capacity and mental health legislation.

Visiting powers and duties for people subject to the LPS could be effective via regulations. The government is currently preparing regulations for the LPS which it will lay before Parliament. These should address how CQC monitors the safeguards. The issue is not about ‘powers of entry’ so much as powers to undertake *visits to people* and to interview them in private. CQC should also be empowered to speak to the person’s representatives (the ‘appropriate person’ and any advocate), anyone involved in caring for the person or with an interest in their welfare, and to look at the key documentation around capacity, care planning and the LPS. Ideally the regulations should require that such visits be undertaken by a person with the appropriate expertise and communication ability, and good knowledge of the MCA and the LPS.

#### CQC’s potential role in monitoring the Liberty Protection Safeguards

Ideally new regulations for how CQC monitor the LPS would also seek to close the gaps in our knowledge, by explicitly requiring the regulator to document and report upon the operation of all aspects of the safeguards including:

- Rights to information
- The quality of assessments and reviews
- How care home managers fulfil their new role under the LPS
- How Approved Mental Capacity Professionals fulfil their role under the LPS
- Representation and independent advocacy
- Rights of appeal
- Outcomes for cared-for persons
- The experiences of cared-for persons and families whose care is authorised under the LPS.

At present CQC’s monitoring of the DoLS does not provide us with satisfactory information of this nature. Their DoLS monitoring has tended to focus on procedural matters like whether care homes are making DoLS applications when inspectors believe they should be, and whether providers notify CQC they have made applications. There have been few efforts over recent years to gather information over how the *safeguards* themselves operate – that is, how the assessments and decisions are made, how they impact upon care, how representation and advocacy is secured and operating, whether people are being given appropriate accessible information about their rights and able to exercise rights of appeal. Most fundamentally, in over a decade of monitoring the DoLS, the CQC has not yet reported on how those subject to applications and authorisations experience the safeguards; at best there are anecdotal accounts of the experiences of relatives. The annual DoLS monitoring report became a slim chapter in the ‘State of Care’ report (in contrast with their annual report on the Mental Health Act 1983).

The new LPS regulations offer an opportunity to start again, and ensure that there is appropriate monitoring of this framework, closing gaps in our knowledge and securing systemic improvements in human rights protection.

**Are there better ways to protect human rights in care settings than liberty safeguards?**

Undoubtedly yes. Article 5 ECHR provides only one way of conceptualising and responding to what is going on, and it has its limitations and problems.

Safeguards are certainly needed, but ideally these would be anchored in positively promoting rights to home and independent living, as outlined at the start. Ideally these would address the multifaceted and complex issues around care planning, care commissioning and the different ways that care can promote or interfere with fundamental rights to home, family and private life. We are, however, a long way short of policy proposals to do this, and the Law Commission was only recently discouraged from adopting a broader human rights remit that focused on article 8 rights and rights to supported decision making, instead of a narrower focus on article 5.<sup>49</sup>

01/02/2022

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<sup>49</sup> Law Commission, *Mental Capacity and Deprivation of Liberty* (Law Com No 372, 2017) [www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/](http://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/)