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The Liberty Protection Safeguards

Neil Allen

Barrister and Senior Lecturer

39 Essex Chambers and University of Manchester

www.lpslaw.co.uk

ARTICLE 5 ECHR

1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law: …

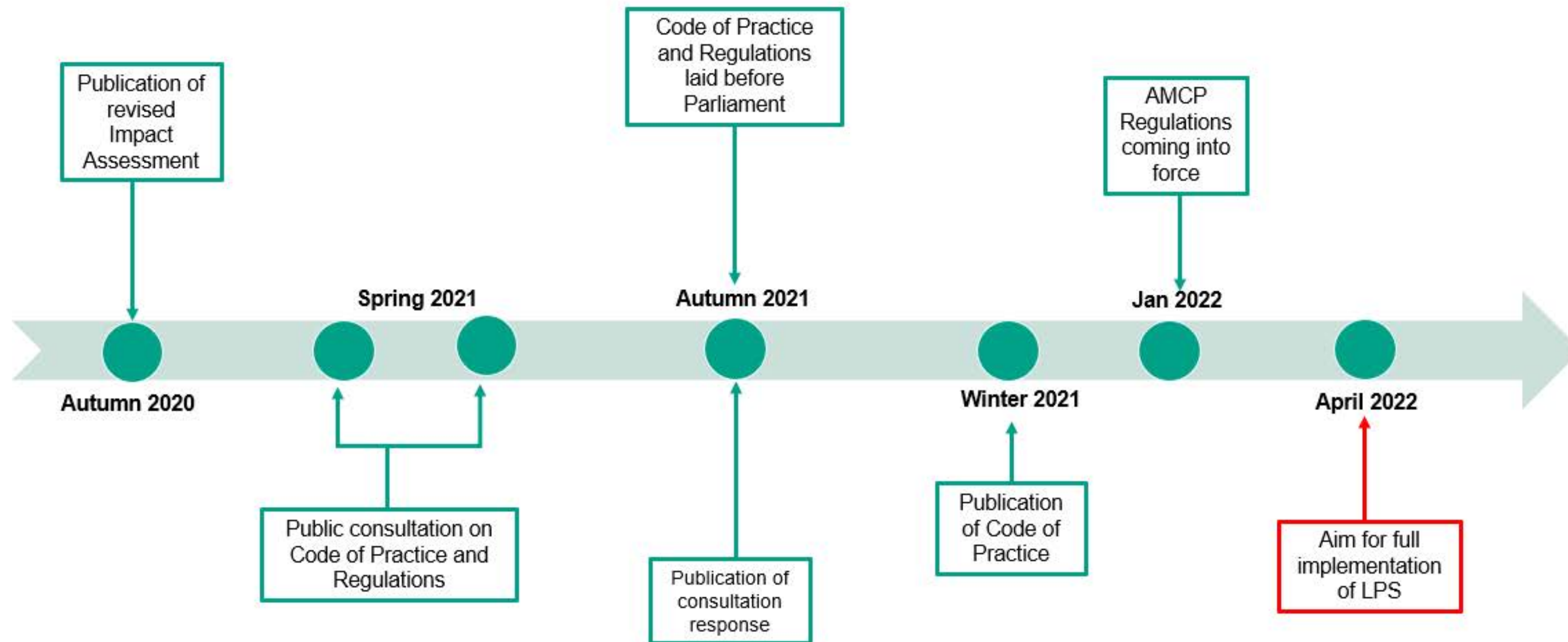
(e) the lawful detention … of persons of unsound mind…

4. Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.

Prescribed procedures for detaining those of 'unsound mind'

- Mental Health Act 1983: psychiatric detention in hospital (except ss135/6, 17) not community (*MM, PJ*).
- Mental Capacity Act 2005:
  - Court of Protection: (16+ year olds in any setting) – dispute or COPDOL11 if undisputed
  - DoLS: (18+ year olds in hospitals and care homes only)
- Inherent jurisdiction of the High Court in limited circumstances

LPS Timescales



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Mental Capacity (Amendment) Act 2019

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CHAPTER 18

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The Procedure Prescribed

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NHS hospitals: manager
NHS CHC: CCG
All other: LA

X identifies DOL in advance and contacts responsible body ('RB')

Responsible body takes steps to determine (1) conditions, (2) consultation, (3) AP/IMCA, (4) pre-authorisation review (by AMCP if independent hospital or against P's wishes), then (5) may/not authorise

(1) Conditions:

1. Incapacity: "lacks capacity to consent to the arrangements" – equivalents "if reasonable to rely on the assessment" (NB length of time, purpose, change in condition likely to affect it)
2. Medical: "has a mental disorder" – equivalents "if reasonable to rely on the assessment" (NB length of time, purpose, change in condition likely to affect it)
3. N+P: "the arrangements are necessary to prevent harm to the cared-for person and proportionate in relation to the likelihood and seriousness of harm to the cared-for person", having regard "(amongst other matters) to the cared-for person's wishes and feelings in relation to the arrangements" – **NO EQUIVALENTS**

(2) Consultation:

By RB: statutory consultee list "must" be consulted unless not practicable or appropriate.
Main purpose = ascertain P's wishes and feelings in relation to arrangements.

THE PROCEDURE PRESCRIBED

(3) Appoint **APPROPRIATE PERSON OR** "take all reasonable steps to appoint" **IMCA** "while arrangements are being authorised or are being proposed". IMCA can support AP.

(4) **PRE-AUTHORISATION REVIEW** by (a) someone not involved in P's day-to-day care or providing treatment, or (b) AMCP if (i) independent hospital or (ii) reasonable to believe P "does not wish to reside in that place" or "does not wish to receive care or treatment at that place", or (iii) case is referred by RB and ACMP accepts referral.

- Reasonable to conclude authorisation conditions are met (desktop)?
- AMCP (i) meet P if practicable or appropriate, (ii) statutory consultee list, and (iii) "take any other action, if it appears to the Approved Mental Capacity Professional to be appropriate and practicable to do so".

(5) May **AUTHORISE** if conditions (up to 28 days before arrangements): record with start/end date, programme for review (can be delegated to care homes), safeguards. Provide accessible info within 72 hours. Defence to liability for acts done pursuant to authorisation (not care/treatment itself). Can be varied after consultation and where reasonable.

CHALLENGING AUTHORISATIONS:
Those "with an interest in the arrangements" can make a "reasonable request" for a review (could trigger AMCP). MCA s21ZA with non-means tested legal aid. MCA s.16A repealed

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Getting Ready

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- New bodies have Article 5 safeguard responsibilities: implications?
- Develop staff confidence with MCA basics: capacity, best interests, necessity and proportionality, ROL or DOL (consider shortened COPDOL11 form as possible template).
- Scope potential numbers (independent hospitals (including most hospices), care homes (non-NHS CHC), community (including supported living, self-funders, children's homes (16+), residential schools, own home etc)
    - Enough AMCPs? Cannot be involved in day to day care/treatment of person
    - Enough IMCAs?
- Who will be the independent reviewers? How many?
- Need an updated (realistic!) impact assessment to fund LPS.

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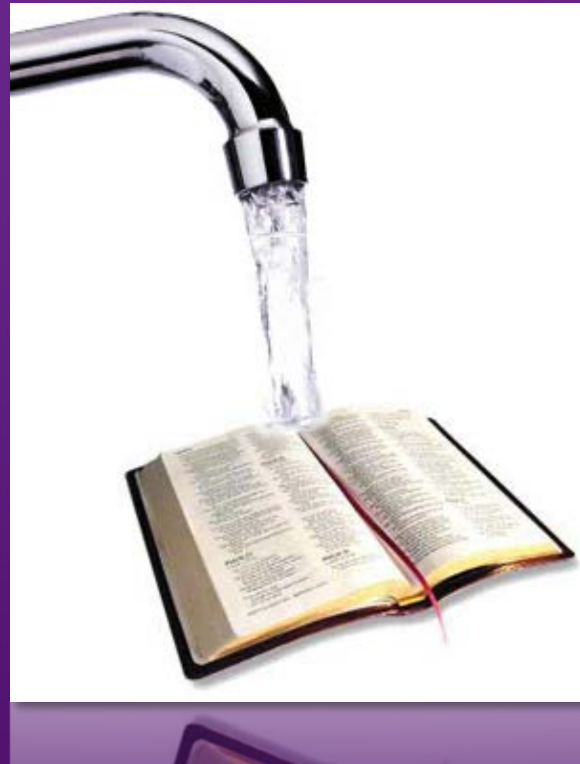
More People With Less Safeguards



	ROL	DoLS/COPDOL	LPS
Responsibility	MCA s.5 reliers	DoLS: LA (adults in hospitals/care homes) COP: (16+ elsewhere)	1. NHS managers for NHS hospitals. 2. CCG for NHS CHC. 3. LA for independent hospitals and everything else.
Scope	MCA ss5-6 care and treatment	DoLS: 263,940 applications in 2019-20 (243,300 completed) – no conveyance power COP: 5219 applications in 2019 (2795 orders) – can authorise conveyance	Under-estimate 257,984 p.a. Can authorise conveyance
Length	For care / treatment	1 year max	1 year, 1 year, 3 year max
Advocacy support	IMCA in certain circumstances	DoLS: RPR (paid/unpaid) COP: rule 1.2 representative	Appropriate person or IMCA **("all reasonable steps")**
Non-means tested legal aid	Not available – means tested	DoLS: available COP: means tested	**Available**
Assessments	Those involved. **Incapacity**, best interests, **necessity and proportionality**	DoLS: usually external assessors – 6 assessments. **Independent BIA in all cases.** COP: those involved (COPDOL11).	Those involved (or AMCP?). **Incapacity**, mental disorder, **N+P** (prior best interests assessment assumed).
Emergencies	MCA ss5-6	DoLS: 7/14 day urgent authorisation. COP: MCA s.4B	Extends MCA s.4B to LPS plus **legal cover if RB "carrying out functions" to determine whether to authorise.**
Requiring changes	Necessity and proportionality	DoLS: conditions and recommendations. COP: judge decides.	**AMCP taking "any other action" appropriate and practicable**
Reviews	Necessity and proportionality	DoLS: Part 8. COP: annual.	LPS: review programme in authorisation

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APPRAISING LPS

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CONCERNS:

1. Heavy reliance on Code of Practice to address legal concerns. Eg
   - No statutory deadlines for completing assessments and generous interim legal cover pending authorisation (NB Bournewood criticised "no limits in terms of time" of the common law).
   - No contact requirement for appropriate person / IMCA - only "represent and support".
   - Impact assessment: 5% (12,899) will have no AP/IMCA.
2. Meaning of "mainly" for the arrangements?!!
3. What will happen to best interests?
4. Cornerstone of DoLS protection gone except in independent hospitals and against the wishes cases.
5. Family reactions to family home authorisations? Impact of Article 5 on 8?

BENEFITS:

1. CCGs, hospitals (and local authorities) will have ownership of the safeguards (or *deja vue?*).
2. Emphasis on pre-authorisation (or *deja vue?*)
3. Better embed MCA core in practice?
4. More people will have (less) safeguards.

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