

# PARLIAMENTARY DEBATES

HOUSE OF COMMONS  
OFFICIAL REPORT  
GENERAL COMMITTEES

## Public Bill Committee

### MENTAL CAPACITY (AMENDMENT) BILL [*LORDS*]

*Fifth Sitting*

*Tuesday 22 January 2019*

*(Morning)*

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SCHEDULE 1 agreed to, with amendments.

CLAUSE 2 under consideration when the Committee adjourned till this day at Two o'clock.

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**not later than**

**Saturday 26 January 2019**

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**The Committee consisted of the following Members:***Chairs:* MARK PRITCHARD, † IAN AUSTIN

- |   |  |
|---|--|
| † Afolami, Bim ( <i>Hitchin and Harpenden</i> ) (Con)       | † Morton, Wendy ( <i>Aldridge-Brownhills</i> ) (Con)     |
| † Chalk, Alex ( <i>Cheltenham</i> ) (Con)                   | † Norris, Alex ( <i>Nottingham North</i> ) (Lab/Co-op)   |
| † Cunningham, Alex ( <i>Stockton North</i> ) (Lab)          | † O'Brien, Neil ( <i>Harborough</i> ) (Con)              |
| † Debbonaire, Thangam ( <i>Bristol West</i> ) (Lab)         | † Sherriff, Paula ( <i>Dewsbury</i> ) (Lab)              |
| † Dhesi, Mr Tanmanjeet Singh ( <i>Slough</i> ) (Lab)        | † Syms, Sir Robert ( <i>Poole</i> ) (Con)                |
| † Dinenage, Caroline ( <i>Minister for Care</i> )           | † Whately, Helen ( <i>Faversham and Mid Kent</i> ) (Con) |
| † Keeley, Barbara ( <i>Worsley and Eccles South</i> ) (Lab) | † Williams, Dr Paul ( <i>Stockton South</i> ) (Lab)      |
| † McCabe, Steve ( <i>Birmingham, Selly Oak</i> ) (Lab)      | Adam Mellows-Facer, <i>Committee Clerk</i>               |
| † Moore, Damien ( <i>Southport</i> ) (Con)                  | † <b>attended the Committee</b>                          |
| † Morris, James ( <i>Halesowen and Rowley Regis</i> ) (Con) |  |

## Public Bill Committee

Tuesday 22 January 2019

(Morning)

[IAN AUSTIN *in the Chair*]

### Mental Capacity (Amendment) Bill [Lords]

9.25 am

**The Chair:** Welcome back, everyone. Can we all make sure our phones are on silent?

#### Schedule 1

SCHEDULE TO BE INSERTED AS SCHEDULE AA1 TO THE  
MENTAL CAPACITY ACT 2005

*Amendment proposed:* 27, in schedule 1, page 18, line 31, leave out paragraph 30(b).—(*Barbara Keeley.*)

*This amendment makes provision for the responsible body to take on all functions relating to renewal of deprivation of liberty in cases relating to care homes.*

*Question put,* That the amendment be made.

*The Committee divided:* Ayes 6, Noes 9.

#### Division No. 17]

##### AYES

Cunningham, Alex  
Debonnaire, Thangam  
Keeley, Barbara

Norris, Alex  
Sherriff, Paula  
Williams, Dr Paul

##### NOES

Afolami, Bim  
Chalk, Alex  
Dinenage, Caroline  
Moore, Damien  
Morris, James

Morton, Wendy  
O'Brien, Neil  
Syms, Sir Robert  
Whately, Helen

*Question accordingly negatived.*

**Barbara Keeley** (Worsley and Eccles South) (Lab): I beg to move amendment 45, in schedule 1, page 19, line 34, at end insert—

“(2) In varying an authorisation, the responsible body may also consider—

- (a) whether the cared-for person’s capacity is likely to fluctuate, and
- (b) whether any restrictions imposed are necessary to prevent harm to the cared-for person and proportionate to the likelihood of that harm, and are likely to continue to be necessary for the duration of the authorisation.”

*This amendment enhances safeguards around the variation of conditions by the responsible body. It indicates that the responsible body should consider whether the person’s capacity may fluctuate, and whether the restrictions which are proposed should be in place for the duration of the authorisation.*

It is a pleasure to speak under your chairmanship again, Mr Austin. At least we do not have a boiling hot room to contend with.

The amendment deals with the way fluctuating conditions are addressed under the liberty protection safeguards system. The concept of fluctuating capacity is not expressly addressed or provided for in the Mental Capacity Act 2005, including the deprivation of liberty safeguards. The Mental Capacity Act code of practice recognises the steps that should be taken to support a person with fluctuating capacity to take their own decisions—choosing the time of day at which they are most alert, for instance. However, it does not indicate what should happen where an assessment is required of a person’s ability to make decisions on an ongoing basis about a particular matter. As such, the Law Commission did not consult on fluctuating capacity. However, when it launched its consultation, it received a large number of submissions on the topic.

It is clear that individuals with fluctuating capacity represent a major challenge under the current system. That is unsurprising, as capacity to consent is not a black and white issue. Everyone has varying capacity from day to day and from issue to issue. It is not reasonable to categorise people as entirely having or lacking capacity in all cases. My hon. Friend the Member for Dewsbury gave an example of how that can go wrong in practice.

Our amendment 32 would have required an assessment to be made of whether a cared-for person’s capacity was likely to fluctuate. That would have laid the ground for our amendment 45, which would allow the responsible body to take account of fluctuating conditions in varying an authorisation.

Under the current system, a deprivation of liberty safeguard must be terminated if a person regains the capacity to consent; the Mental Capacity Act makes no mention of what should happen if a person is likely to regain capacity only for a short period. That is not changed in the Bill. Under paragraph 26 of new schedule AA1, the authorisation will end if

“the responsible body believes or ought reasonably to suspect that any of the authorisation conditions are not met.”

That includes the person regaining capacity for any length of time.

There are two ways the issue can be dealt with. The first is that a new authorisation will have to be sought every time someone regains and then loses capacity, but that would dramatically increase the number of applications made. It would place more pressure on approved mental capacity professionals and on the cared-for person, who would be undergoing regular identical assessments. I understand that one aim of the Bill, as we have discussed, is to reduce the backlog of applications for deprivation of liberty. Requiring regular repeated applications for the same individual would not help to achieve that.

The second outcome is that the liberty protection safeguards will not be used properly. For example, in the case of older people with dementia whose condition fluctuates, such assessment might need to be hourly. It would simply not be practical to reapply for an authorisation every time they lost the capacity to consent. A person cannot give advance consent to be deprived of their liberty, so either they will be inappropriately deprived of their liberty through a blanket application or they will not receive the safeguards in the system because no application will ever be made. I reiterate that it does not matter, under the current system, whether a person is

perfectly happy with arrangements when they have capacity. The moment that they no longer have capacity to consent, that consent is invalid. They cannot consent to any future arrangements.

Both outcomes leave responsible bodies potentially liable for breaching people's rights under article 5 of the European convention on human rights. The Law Commission report states:

"it is not acceptable for the legislative framework simply to ignore fluctuating capacity. That exposes health and social care professionals and those authorising a deprivation of liberty to significant legal risk. It is therefore vital that the Liberty Protection Safeguards provide for fluctuating capacity expressly."

However, the Bill the Government have brought forward makes no provision for fluctuating capacity. Our amendment is aimed at addressing that.

Amendment 45 would allow the responsible body to consider whether the arrangements it is authorising need to be in place for the entire duration of the authorisation it is granting. That would allow authorisations to be granted with specific provision for the arrangements to be suspended while a person has regained capacity. We will return later to what deprivation of liberty means, but that is relevant here. It may be that while someone has capacity, they are free to come and go as they please, with no supervision. But when they do not have capacity, they must be accompanied at all times for their own safety. There is no need for arrangements to require that they be accompanied at all times, regardless of their capacity. Instead, it should depend on their condition on a given day.

This comes back to the amendment moved by my hon. Friend the Member for Birmingham, Selly Oak. In it, he called for arrangements to be authorised only if there were no less restrictive alternatives available. If care providers treat capacity as something that, once lost, remains lost, people will inevitably be subject to unnecessarily restrictive arrangements—not all the time, but for the periods when they have regained capacity. That approach also fails to recognise that people's capacity can vary without crossing the legal line in the sand. There will be days when someone with dementia can, with a certain amount of support, make the decision that they want to go out for coffee with an old friend, but it may be that, because they cannot make such a decision normally, there is no provision in the arrangements for them to go out. I am sure that the Minister would agree that we do not want over-zealous care managers, concerned about the danger of litigation, to end up unduly restricting a person's liberty purely because they are treating capacity as a constant. Instead, we must establish a system that recognises the way capacity changes and what that can mean for the cared-for person, and that system should be described in the Bill.

The current system deals with fluctuating capacity through the code of practice. I will be concerned if the Minister says in her response that the Government mean that to continue to be the case. The Law Commission was clear, in its assessment of this legislation, that the code of practice was simply not an appropriate place to deal with this issue. I remind the Minister of the Law Commission's comment that

"it is not acceptable for the legislative framework simply to ignore fluctuating capacity."

Bringing individuals with fluctuating conditions within the scope of the Bill would not require them to be deprived of their liberty when that was not appropriate.

An authorisation is not an order or injunction to detain the person, and professional discretion should of course be exercised—for example, as to when to take or not take steps to ensure that the person is not allowed to leave, or to bring about their return if they do leave.

Will the Minister cast her mind back to 14 March 2018, the day she published the Government's response to the Law Commission review of the Mental Capacity Act 2005? On page 6 of the response, she accepted the Law Commission's recommendations about fluctuating capacity. I should like her to clarify why she accepted them if she had no intention of taking on board the commission's advice that they be contained in the statutory framework.

The amendment would require a consultation to be carried out before arrangements can be varied to account for fluctuating conditions. In some cases, where capacity fluctuates for short periods, that would be an onerous requirement, but it would also mean arrangements could not be made more restrictive when that might not be appropriate. The amendment does not go as far as the Law Commission wanted to on this topic, so it could be seen as a compromise.

In its draft Bill, the Law Commission set out provision for people to consent in advance of being deprived of their liberty. That would have meant that a cohort of people with degenerative conditions, who foresaw the requirement to deprive them of their liberty, would be removed from the system altogether. The Law Commission also said that

"the giving of consent should generally be regarded as an ongoing state of mind which is required in order for a confinement not to amount to a deprivation of liberty. There will be some who will lack capacity to give such consent for such a substantial proportion of the period covered by the proposed authorisation, and regain it for such brief periods, that it is right to regard them as, overall, lacking capacity to give or withhold consent to the arrangements."

That is in line with the provisions in the current code of practice. It would codify them in statute, ensuring that the group in question would be adequately covered by the liberty protection safeguards. I do not understand why the Government have not yet taken those suggestions on board. They would ensure that people whose conditions fluctuate are properly dealt with by the new liberty protection safeguards, and close up one of the most glaring holes in the current Act. It seems clear that detaining someone while they have capacity would, at the moment, be a breach of the Act. We need real amendments to the Bill to make sense of the system, rather than yet more promises about a code of practice that we have not yet seen. I acknowledge that the Minister has sent us a list of its contents—but that is not the code of practice.

**The Minister for Care (Caroline Dinéage):** It is a great pleasure, once again, to serve under your chairmanship, Mr Austin.

I thank hon. Members for raising an important point. We agree that the likelihood of fluctuating capacity should be addressed by the mental capacity assessment. We also expect fluctuating capacity to be considered when the responsible body is deciding to give an authorisation and setting the length of authorisation and frequency of reviews.

I think I set out in my comments on amendment 32 that I am tempted by some of the hon. Lady's suggestions. However, they do not quite encapsulate the "What then?" of the issue: fluctuating capacity should be

[Caroline Dinenage]

considered, but what then? That is why I have concerns. Fluctuating capacity is a complex, fact-specific matter that deserves in-depth, detailed guidance. That is why we will include details of it in the code of practice. We consider that a much better way, allowing examples and real guidance to be set out. That will include the issue of where a person with fluctuating capacity meets or does not meet the authorisation condition of lacking capacity to consent to the arrangements, and whether the authorisation continues in force or ceases to have effect.

The backdrop to the matter is the fact that courts have been considering whether decision makers can take a long-term view in some cases of fluctuating capacity. We expect a judgment from the Court of Appeal soon, in the case of *Royal Borough of Greenwich v. CDM*. Hopefully, that will give legal guidance on how decision makers should deal with fluctuating capacity. That, of course, will be reflected in the code.

With those assurances in mind, I hope the hon. Lady will feel able to withdraw the amendment.

**Barbara Keeley:** The Minister says she is tempted by the amendment. It is about time, because she accepted the recommendations when she accepted the Law Commission's report, and I have even read out the date when she did that. The Law Commission was clear in saying that fluctuating capacity is not something that can be dealt with adequately in the code of practice.

Despite the Minister's having said that she would accept the recommendations, the Government have made no attempt to deal with fluctuating conditions on the face of the Bill. There is a real danger that breaches of the Act will be encouraged because responsible bodies and care practitioners have no proper avenue to pursue if a cared-for person has a fluctuating condition. It is open to the Minister to move an amendment on Report, but we will be putting our amendment to a vote this morning.

*Question put, That the amendment be made.*

*The Committee divided: Ayes 8, Noes 9.*

#### Division No. 18]

##### AYES

Cunningham, Alex	McCabe, Steve
Debonnaire, Thangam	Norris, Alex
Dhesi, Mr Tanmanjeet Singh	Sherriff, Paula
Keeley, Barbara	Williams, Dr Paul

##### NOES

Afolami, Bim	Morton, Wendy
Chalk, Alex	O'Brien, Neil
Dinenage, Caroline	Syms, Sir Robert
Moore, Damien	Whately, Helen
Morris, James	

*Question accordingly negated.*

*Amendment proposed: 43, in schedule 1, page 20, line 34, leave out*

*“if it appears to the Approved Mental Capacity Professional to be appropriate and practicable to do so”.*—(*Barbara Keeley.*)

*This amendment varies the role of the AMCP so that they must meet with the cared-for person in making their determination.*

*Question put, That the amendment be made.*

*The Committee divided: Ayes 8, Noes 9.*

#### Division No. 19]

##### AYES

Cunningham, Alex	McCabe, Steve
Debonnaire, Thangam	Norris, Alex
Dhesi, Mr Tanmanjeet Singh	Sherriff, Paula
Keeley, Barbara	Williams, Dr Paul

##### NOES

Afolami, Bim	Morton, Wendy
Chalk, Alex	O'Brien, Neil
Dinenage, Caroline	Syms, Sir Robert
Moore, Damien	Whately, Helen
Morris, James	

*Question accordingly negated.*

*Amendment proposed: 41, in schedule 1, page 20, line 40, at end insert—*

*“(d) determine whether an application to the Court of Protection is required; and*

*(e) notify the responsible body, cared-for person, the appropriate person and any IMCA of that decision.”*—(*Barbara Keeley.*)

*This amendment requires an AMCP to determine whether an application to the Court of Protection is required, and notify the responsible body, cared-for person and others of this decision.*

*Question put, That the amendment be made.*

*The Committee divided: Ayes 8, Noes 9.*

#### Division No. 20]

##### AYES

Cunningham, Alex	McCabe, Steve
Debonnaire, Thangam	Norris, Alex
Dhesi, Mr Tanmanjeet Singh	Sherriff, Paula
Keeley, Barbara	Williams, Dr Paul

##### NOES

Afolami, Bim	Morton, Wendy
Chalk, Alex	O'Brien, Neil
Dinenage, Caroline	Syms, Sir Robert
Moore, Damien	Whately, Helen
Morris, James	

*Question accordingly negated.*

**Barbara Keeley:** I beg to move amendment 46, in schedule 1, page 21, line 42, leave out sub-paragraphs (1) and (2), and insert—

*“39 (1) The responsible body must take all reasonable steps to appoint an IMCA to represent and support the cared-for person if—*

*(a) sub-paragraph (2) provides that an IMCA should be appointed, and*

*(b) sub-paragraph (6) does not apply.*

*(2) An IMCA should be appointed if—*

*(a) the cared-for person makes a request to the supervisory body to instruct an IMCA;*

*(b) there is no appropriate person to represent and support the cared-for person;*

*(c) the cared-for person is 16 or 17 years old;*

*(d) there is an appropriate person to support and represent the cared-for person in relation to this Schedule and they make a request to the supervisory body to instruct an IMCA; or*



- (e) there is reason to believe that the appropriate person would be unwilling or unable to assist the person in understanding or exercising the relevant rights under this Schedule without the support of an IMCA.

(3) A person is not an appropriate person to represent and support the cared-for person unless the responsible body is satisfied that the person—

- (a) is a suitable person to represent and support the cared-for person;
- (b) consents to representing and supporting the cared-for person;
- (c) will maintain contact with the cared-for person;
- (d) will represent and support the cared-for person in matters relating to or connected with this Schedule; and
- (e) is not engaged in providing care or treatment for the cared for person in a professional capacity.

(4) A person is not an appropriate person if there is reason to believe that the cared-for person does not wish, or would not wish, to be supported and represented by the proposed appropriate person.

(5) The ‘relevant rights’ under this Schedule include—

- (a) rights to request a review by an Approved Mental Capacity Professional;
- (b) rights to request a review under paragraph 35;
- (c) rights to information about the authorisation, assessments and its effects;
- (d) rights to apply to the Court of Protection under s21ZA.

(6) An IMCA should not be appointed if—

- (a) there is reason to believe that the cared-for person does not wish to be supported by an IMCA; and
- (b) there is reason to believe that the cared-for person does not wish to exercise rights to apply to the Court of Protection under s21ZA.

(7) The responsible body must keep under review whether an appropriate person is undertaking their functions. If the responsible body finds that the appropriate person no longer fulfils the required functions, the responsible body must appoint another appropriate person or IMCA.”

*This amendment would amend the requirements for an IMCA to be appointed, so that advocacy is the default position. It also makes provision for appropriate persons to be appointed subject to certain conditions relating to how they discharge their role.*

Throughout the proceedings on the Bill, we have talked about the rights of the cared-for person and the protection that must be put in place to prevent inappropriate deprivation of liberty. In reality, many people who have suffered under the Mental Capacity Act will not be able to act on those rights. Instead, they require support and assistance from somebody else. Without that support, there is a real chance their rights are or how to enact them.

Before we discuss the amendment in depth, I will give the Committee some examples of why advocacy is so important to a person subject to the Act. The first is the case of Mrs L, a 67-year-old woman with Korsakoff syndrome who was placed in a care home on a temporary basis following a hospital stay as this was the only place she could receive appropriate support in the short term. A decision was needed as to whether Mrs L was to remain at the current care home long term or whether efforts would be made to return her home. There was a possibility that Mrs L could return to her own home if her legs improved sufficiently. She seemed happy to be

at the current care home, but she kept asking when she could go home. Professionals were inclined to recommend that Mrs L was kept in the care home in the long term.

Mrs L was given the support of an independent mental capacity advocate at this point. The IMCA worked to understand what was the least restrictive option available to support Mrs L. As part of that, the IMCA requested an reassessment of Mrs L’s capacity to make decisions on the matter, as she was clearly expressing a preference to return home. Without the intervention of an IMCA before a deprivation of liberty authorisation was applied for, Mrs L may have been kept in the care home against her wishes.

9.45 am

Let me give another example of the intrinsic value of advocacy. VoiceAbility provides advocacy services to countless vulnerable people across the country. Sam was referred to VoiceAbility’s advocacy service in 2017. Sam is 57 years old and has a diagnosis of Korsakoff disease. Sam was discharged from hospital in 2005 and placed in a long-stay specialist residential unit. Sam was known to have made several attempts to abscond and return home. Sam was described as unco-operative with care providers, and would choose to stay in bed sleeping for the best part of the day. Sam was known to express negative feelings about living in the unit and not being free to leave.

Sam’s mother and extended family struggled to maintain contact with Sam due to the location of the unit and the time involved in travelling. When the relevant person’s paid representative—the advocate—met Sam in 2017, it was evident that Sam had been objecting for some time and had felt isolated and unsupported. When the RPPR explained to Sam the right to challenge the ruling in the Court of Protection, Sam requested that the RPPR initiate such a challenge as soon as possible. During the process the RPPR represented Sam and maintained regular contact with the legal team managing the case. Although Sam’s family were supportive, they expressed concern to the RPPR and other professionals that if Sam were to leave the unit, a return to past negative lifestyles would be inevitable, placing Sam at risk. The family therefore felt unable to support the challenge in the courts.

In 2018, the Court of Protection decided that Sam could move from the residential unit. Sam was placed in supported accommodation and was reported to have settled in well. Sam now enjoys community activities, and is rekindling previous hobbies and interests. In addition, Sam no longer sleeps for long periods and engages well with the new care providers. The location of Sam’s new accommodation has meant that Sam’s mother and family can have more regular contact. The family told Sam’s advocate and legal representative how pleased they were with the outcome for Sam, stating that they did not think it possible. Such cases show that advocacy can deliver the kind of outcomes that we all want for cared-for people, and help them to regain confidence, independence and quality of life.

The Bill proposes a rather convoluted system for deciding whether an advocate should be appointed. I hope that colleagues have had time to read the evidence submitted to the Committee by Lucy Series. Lucy is a lecturer in law at Cardiff University and is widely held to be an expert on the Mental Capacity Act 2005.

Page 15 of her evidence includes a helpful guide to the system that the Bill proposes for assigning advocates, and the flowchart shows that the proposed system is complex and difficult to navigate. A number of different caveats must be worked towards, with the potential for applying a best interest test to be used at various stages. If Members have not had the chance to see the flowchart—I know we are not supposed to use visual aids in Committee—it makes it easy to see that the proposed system is complicated, and I suggest that they take a look.

The best interest test has been particularly opposed by stakeholders. At a recent stakeholder roundtable on the Bill, almost every organisation that attended expressed deep concerns about the provision. A best interest test should play no part in access to those essential safeguards, as that would interfere with a person's right of appeal and compromise that crucial safeguard against the powers given to health and social care professionals under the Mental Capacity Act 2005.

Our amendment proposes significant changes to the system and seeks to remove some of the issues with the Bill, while maintaining the parts that work. It is important to discuss some of those important provisions. The version of paragraph 39(2) proposed in the amendment lays out the different circumstances in which an independent mental capacity advocate should be appointed, and only one of those conditions needs to be met for such an appointment. The cumulative impact of those conditions means that advocacy should be the default position. It simplifies the system proposed in the Bill, and ensures that people are not denied advocacy based on a best interest test.

Proposed new sub-paragraph (2)(a) provides an unqualified right to request an advocate. Regardless of all other considerations, if the cared-for person wants an advocate, they will get one. Unlike in the Bill, that would be true regardless of a person's capacity. It is a move back towards the safeguards contained in the Mental Capacity Act. Under the deprivation of liberty safeguards, cared-for people have an unrestricted right to request that they be supported by an advocate. I cannot understand why the Government have not simply reapplied the current provision to the Bill, as we seek to do.

Proposed sub-paragraph (2)(b) would ensure that an IMCA is appointed in all cases where there is not an appropriate person to support the cared-for person. In the Bill, that provision is conditional on a best interest test. The Opposition feel that that is far too broad. When read in conjunction with sub-paragraph (6), this would ensure that the only cases where a cared-for person had neither an appropriate person nor an advocate to represent them were where they did not want such representation. We cannot see why it should ever be in somebody's best interest not to have advocacy available. We recognise, as the Minister in the Lords has said, that there may be cases where a person does not want advocacy, but it should not be in the power of the responsible body to decide whether an advocate is appropriate. That should be a decision for the cared-for person or those who are supporting them.

Proposed sub-paragraph (2)(c) would require an advocate to be appointed in all cases where the cared-for person is 16 or 17 years old. Earlier in the Committee's deliberations, I spoke about the need for greater protections

to be put in place where 16 and 17-year-olds are deprived of their liberty under the Mental Capacity Act. The reason for requiring an IMCA is bound up with that: 16 or 17-year-olds may have an appropriate person or persons to support them in the form of their parents. We have also discussed how parents can find it hard to stand up to authority, even when it is what their child wants and needs. We should not assume that they will all be able to carry out that role robustly enough. As we heard in the case of S, which I mentioned in a previous sitting of the Committee, parents do not always agree with their children what the best course of action should be. In the Government's Bill, it seems likely that almost no 16 or 17-year-olds would have access to an IMCA unless their parents requested it. That is clearly unacceptable.

Proposed sub-paragraph (2)(d) simply seeks to replicate the provision in the Bill that an appropriate person can request the support of an IMCA. As I said earlier, that would be particularly important in cases where the right to appeal to the courts may be engaged. An appropriate person is unlikely to be an expert in mental capacity law or have the expertise to take a case to court without an IMCA's involvement.

Proposed sub-paragraph (2)(e) relates to what happens when there is an appropriate person, but they are either unable or unwilling to assist the cared-for person in understanding and exercising their rights. We should not allow a cared-for person to be deprived of their rights because an appropriate person cannot assist them properly. In such cases, it seems the best course of action is to appoint an IMCA to support them in addition to the appropriate person.

Proposed sub-paragraph (7) sets out an obligation on the responsible body to monitor how an appropriate person carries out their role and to appoint an IMCA to support them if needed. That means an appropriate person will not be left alone if they do not have the time or expertise to advocate for the cared-for person to the best of their abilities. An example of where that might be useful is in maintaining contact with the cared-for person—a crucial but possibly time-consuming task. This is an important provision, as is demonstrated by a case study that was supplied to me by POhWER, an organisation that provides advocates to people who have no one else to support them.

**James Morris** (Halesowen and Rowley Regis) (Con): The hon. Lady is laying out an interesting case. I wanted to ask a quick question about the amendment. Proposed sub-paragraph (2)(e) states that “there is reason to believe that the appropriate person would be unwilling” and proposed sub-paragraph (7) states:

“The responsible body must keep under review”.

I wonder how she envisages that process working in practice. What would the review process be that the responsible body would undertake to determine whether they thought an appropriate person was capable of undertaking their functions? It sounds a bit like a procedure where somebody has power of attorney, which then has to be frequently reviewed. How does she envisage that process working?

**Barbara Keeley:** Obviously, it is an extensive amendment. There are two issues, and I will go on in a moment to talk about how important it is to keep in contact with the cared-for person. It is clear to anybody who knows



anything about care homes, or independent hospitals in particular, that some people end up without visitors and without having contact with anybody. The Bill allows renewal periods of three years. We can envisage a situation, given the examples I have given, where a cared-for person is hundreds of miles away from their family. In the example I gave of Sam, the family were not in contact due to the distance of travel.

With regard to review, a responsible body would keep an eye on the situation of a person who never receives any visits or contact. In those situations, it really is up to the care home, the independent hospital or the hospital. Those are the most vulnerable people. The amendment says that it should be a person's right and the default to have an advocate. It is a matter of how to get the mechanism working towards that. The idea of a review is that the responsible body should be looking out for people who have had no contact with anybody else.

My next example is a powerful one. It was supplied by POhWER, an organisation that provides advocates to people who do not have anyone else to support them. POhWER's advocate had been visiting an older lady in her care home for a few months. He described his work with her as follows:

"This was supposed to be a two-monthly visit but I felt monthly visits were more appropriate. I carried out mainly unannounced visits due to some of my concerns...

She had been living within the home for over a year. When speaking to the client, she wasn't really aware where she was living and either referred to it as a temporary placement or a hospital. She didn't state any unhappiness within the placement, but visually there appeared to be some neglect. There was inconsistency in the way she was described by staff and her documentation was also unclear...

After a few visits I noted her clothes were not appropriate for her skin condition. I was significantly alarmed by her swollen weeping legs and tight trousers that were wet from the fluid. I raised this with the managers immediately. She was then dressed in appropriate clothes. They spoke about the client having choice about what she wants to wear. I explained issues with her statement and the difference between choice and best interests for someone who lacks capacity and for someone who is not aware of the risk.

I asked them to identify this in various care plans, but there was nothing suitable in place...

My following visit saw some changes and this was now reflected in paperwork, but when speaking to the nurse in charge she wasn't aware of the protocol in place. The client was in a better condition than in my previous visits which was comforting to see. Again I fed back to management about the communication in the team being unclear and was assured by the care home management this would be addressed.

I carried out another unannounced visit and saw my client in a nightie with blood stains. I had seen her legs which looked in extremely poor condition. I asked staff and management how her skin on her legs was and was informed there were no issues and they were following the protocols in place.

My client's legs were weeping and covered in blood stains. I reported this to the managers of the home. This was also highlighted in my email and reported to the supervisory body and I was advised to contact the safeguarding team.

All my details and findings were reported to the safeguarding team and to the quality standards team. Since the involvement of the safeguarding team my client no longer resides at the home, has changed accommodation and is enjoying living there."

The only reason the advocate was able to pick up on the poor treatment being received by the cared-for person in that case was because they visited her several times over the course of several months. Had they been involved solely with the authorisation process but then

not visited until a scheduled review or renewal, which, as I mentioned earlier, might be three years later, it seems unlikely that the multitude of errors documented would have been seen. Ultimately, that would have led to the cared-for person receiving a much lower standard of care. That is why we want to see an appropriate person or advocate who will keep in touch with the cared-for person, and support to do that should be provided if it is needed.

Paragraph 39(5), which is proposed by the amendment, outlines some of the rights that the IMCA or the appropriate person should support the cared-for person to understand and exercise. I hope that the code of practice sets out in more detail the way in which IMCAs or appropriate persons should carry out their role, but we feel that the rights outlined in proposed sub-paragraph (5) are the most important for the cared-for person to understand. They include the ability to trigger an independent review of the application or authorisation, and I believe that they should be in the Bill. We have not seen the code—we have seen a list of what is going to be in the code—and we have not seen the guidance that will be issued to IMCAs. In the absence of those, we want to ensure that certain key rights are protected in the legislation.

10 am

Proposed sub-paragraph (6) is about the very specific circumstances in which an IMCA should not be appointed. If this sub-paragraph is met, the provisions of sub-paragraph (2) are overruled. Both conditions must be met for an IMCA not to be appointed. The first condition is that

"the cared-for person does not wish to be represented by an IMCA",

and the second is that the cared-for person does not wish to exercise their right of appeal to the Court of Protection.

This proposal would mean that the cared-for person's objection to an IMCA could be overruled if—and only if—they wanted to appeal to the Court of Protection. This is not without precedent. There have already been cases of the mental health tribunal appointing a lawyer to a case, despite the person's objection, because the case would not be effective without the appointment of a lawyer. When I proposed amendments 40 and 41 on access to the Court of Protection, I talked at length about the challenges that an appropriate person can face when trying to take a case through the court system. It can be an overwhelming amount of work for a layperson. It is crucial that an IMCA be appointed in such cases to ensure that the cared-for person is fully able to realise their right to appeal.

I hope that I have given hon. Members an idea of what we aim to achieve with the amendment. It would ensure that an appropriate person truly is appropriate to support the cared-for person. If they are not, either a different appropriate person or an IMCA would be appointed. Most importantly, it would make the provision of an advocate the default position. That should not be dependent on best interest tests or the capacity of the cared-for person.

I would like to give one final example of how important advocacy can be. This is the case of Ethel, an 85-year-old woman with a diagnosis of dementia that she refuses to

accept. She is unable to mobilise due to problems with her hip, and was admitted to a nursing home following a lengthy stay in hospital. Neither the local authority nor the care home additionally identified the need for a deprivation of liberty safeguard. It was only after Ethel had been in a nursing home for a year that an application to authorise deprivation of liberty was made. This is concerning, since Ethel had continued to request a return to her own flat throughout that year.

As part of the authorisation of deprivation of liberty, Ethel was appointed an advocate. This advocate reread the best interest assessment, and found that the best interest assessor had recommended that certain conditions be placed on the authorisation. This had not happened. When this was raised with the care home and the local authority, they disclosed the fact that they did not read the reports at all during their first visit. The advocate discussed this with Ethel and determined that an application was to be made in the Court of Protection. This was done, and the conditions were attached to the authorisation.

Without the involvement of the advocate, Ethel would not have been able to enact her right of appeal to the courts, and would not have had her care adjusted to meet her needs. That had been the original intention. Conditions that had been attached originally had not been enacted. That small example demonstrates the importance of advocacy. Our amendment seeks to ensure that nobody is denied this vital service, and I hope that in the spirit of consensus and to improve the Bill, the Minister will accept it.

**Mr Tanmanjeet Singh Dhesi** (Slough) (Lab): It is a pleasure to serve under your chairmanship, Mr Austin.

I rise to support my hon. Friend the Member for Worsley and Eccles South and to state that advocates are extremely important. They should be provided by default, with cared-for persons having the right to decline such representation if they wish. To illustrate my point, I will refer to a case study from POhWER, an organisation that provides advocacy support. Its advocate supported a cared-for person to go to court and stopped the local authority's attempts to sell his home. Thankfully, the client then returned home.

The disconcerting scenario is as follows. The POhWER advocate, or the relevant person's paid representative, visited a client in a care home where he was able to state that he did not want to be there, and wanted to go back to his own home. A discussion took place about requesting a review, accessing the court or liaising with a social worker. There were no conditions attached to the DoLS, but there was a lot of evidence and many statements confirming that the client did not want to be in the care home.

The cared-for person asked his advocate to have a chat with the social worker initially. The advocate contacted them to discover that although the client had not been in the placement for a long period, the local authority had placed his home on the market with the intention of funding his placement with the proceeds. That is an absolutely ridiculous scenario. It could happen to anyone here: unbeknown to us, the local authority could, without advocacy support, place our house on the market to fund a care placement with the proceeds of its sale. The client had no knowledge of this and there was no evidence at all that he had been consulted. He was very upset and wished to access court.

The court process determined that the cared-for person had substantial personal funds and a home that could easily be adapted for any mobility issues, with numerous bedrooms for live-in staff, whom he could afford to pay for himself. Thankfully, the judge ruled that he was to return home, in line with his wishes, given that he would have chosen that for himself if he had had full capacity to do so. Before the client moved back home, the new social worker who was appointed involved him in selecting the carers, who would live with him on rotation, and he had trial visits including some overnights. The return home was successful and the DoLS ended.

I hope that that example illustrates to the Minister and to Committee members that, without advocate intervention, the cared-for person's home would have been sold without his knowledge, and his wishes and feelings would have been completely discarded and ignored. That is why it is very important that advocacy should be there by default.

**Dr Paul Williams** (Stockton South) (Lab): It is a pleasure to serve under your chairmanship again, Mr Austin.

Like other hon. Members, I would like to share some cases to do with the issue of appropriate advocacy. Briefly, I will describe a simple intervention by an advocate who challenged assumptions made by care home staff and improved the quality of life of a person living with dementia. A relevant person's paid representative was appointed for a woman who, it was reported, had been financially abused by her child following her diagnosis of dementia. She had been placed in a care home by the local authority because of safeguarding concerns.

Visits from the RPPR identified that the woman appeared to be happier now that she was not subject to the conduct and behaviour of her child. However, she had none of her own clothes, photographs or personal artefacts with her. When she was asked about that, she said that that made her feel sad. The RPPR made representations and said that if she had those possessions, she might be happier. Contact was made with her child. The intervention resulted in her child bringing items of clothing and photographs to the care home and also having some supervised contact with her mother. The woman told the representative that she was happy for that to continue.

The care home staff had initially provided information that the woman was content and did not need anything further, but the difference in her demeanour when she was wearing her own clothing and surrounded by personal artefacts was remarkable. She even wrote a note to her advocate, thanking her for supporting her and helping to get her child back in her life. Later on, her child wished to take her out of the care home, but the RPPR listened to the woman, who said she wanted to stay where she was, and supported her to make the decision to remain where she felt safe and comfortable.

That case illustrates why appropriate advocacy must be available to all who need it. The new legislation must ensure the right of the person to object to and challenge arrangements if they wish and to have the support and representation to do so. Support from an IMCA should not depend on a person's best interests, as defined by other people. It should be a right that everyone is able to access an advocate, and people can then choose to opt

out. That would improve the Bill by offering clarity to the cared-for person and the responsible body. I am happy to support the amendment.

**Steve McCabe** (Birmingham, Selly Oak) (Lab): I, too, want to support amendment 46. I would like to draw on a case study that has been provided by the organisation POHWER, which concerns an arranged marriage. I wish to draw the Committee's attention to it because this occurs in the Birmingham area with remarkable frequency.

The case concerns a young woman who, for the purposes of the debate, I will call Layla. The authorities were contacted by her sister and advised that she was about to be taken to the airport and flown overseas for an arranged marriage. Her sister was extremely concerned that Layla did not understand what was happening and did not have the capacity to consent to sexual relations—many similar cases have been reported in the press. Having been alerted, the authorities decided on this occasion to step in, and Layla was given an emergency placement with a deprivation of liberty order while the matter was properly investigated. Following that, POHWER arranged for an advocate to be made available.

As the shadow Minister said, this is about the level of contact, because details are sometimes revealed during subsequent visits or after some time. During the advocate's initial visit things seemed fairly straightforward, and the young woman did not express anxiety about being detained at the care home. She did not say she was unhappy, and there was no reason to suppose there was any great problem. During subsequent visits, however, it became clear that she was very bored and isolated, largely because most of the other residents were elderly, and although she was safe, she was in quite an inappropriate place.

The other day I spoke to a friend in Birmingham who works at a care home, and she told me a remarkably similar story. Because of the pressure on places and funding, it is not always possible for people—particularly if placed as a result of an emergency situation—to be given an ideal placement. It is therefore common for people to find themselves in a place that is safe, but that most of us might regard as not that appropriate in terms of its potential to allow them to improve or develop.

On this occasion, the advocate made representations to social services about the young woman's ability to access a college place. Again, that request was initially ignored—throughout the Bill, we have spoken about the pressure on various authorities and the danger that if someone subject to a detention order is regarded as being in a safe place, attention will switch to the next emergency or crisis. By pursuing advocacy, we will ensure that we do not stop at that point and that we continue thinking about what is best for the person involved and what will improve their chances.

The advocate continued to make representations, and eventually the conditions of the DoL order were changed to require the young woman to be able to access a college place. As a consequence, she made phenomenally rapid progress and learned to read and write. She became better able to comment on what had happened with her family and to understand the nature of the arrangements under the DoL order. The end point of this was that, at a subsequent assessment and review, she was judged to

have sufficient capacity to live independently by herself with minimal support, and she went on to gain paid employment.

10.15 am

We started with a situation where she could have ended up in an arranged marriage overseas. She could then have ended up, essentially, being warehoused, vegetating in a care home where her physical needs might have been adequately dealt with and she might have been safe, to the extent that she was not in danger of immediate harm, but where the quality of her life had virtually disappeared. The intervention of the advocate resulted in that young woman having a quality of life that could not previously have been imagined.

That seems the perfect argument for the case my hon. Friend the Member for Worsley and Eccles South seeks to make. I ask the Minister to think about the variety of people we are asked to look after when applying this legislation. They may not all be elderly people; some may be quite young people, such as Layla, and may have a very long life ahead of them. Our duty is not just to offer them immediate protection, but to ensure that we do everything in our power to maximise their potential for the years ahead.

**Alex Cunningham** (Stockton North) (Lab): It is a pleasure to see you in the Chair again, Mr Austin.

As I reflect on what my hon. Friend the Member for Birmingham, Selly Oak was saying, I recollect that we were getting stories some years ago about people—possibly like that young person—who were suffering the fate that could have befallen her. In some cases, their only crime—the only thing they had ever done wrong—was to get pregnant; they were locked away in what, in those days, were called “mental institutions” because they got pregnant. We heard story after story, not so many years ago, of people coming out of those places having lived 30 or 40 years there, when there had been no mental capacity issues or anything like that at all—just something way back in their past. If people in that situation had had an advocate, we might never have had that situation or heard those stories of people being deprived of their liberty, particularly unlawfully, for decades.

To illustrate the case for this amendment—if my hon. Friend's story does not do so—I want to use real-life examples provided by the advocacy provider POHWER, to which I am grateful. Imagine someone is in a care home; their same-sex partner of more than 30 years has passed away, but the care home staff have denied them the right to look at photographs of their partner, because the relationship they enjoyed over all those years went against God's will. The staff are depriving that person of their liberty, unauthorised. The person is experiencing homophobia, and they are distressed, as they are not allowed to look at photographs of the person they spent their life loving. In time, however, they get an advocate; their distress is clear to the advocate, yet they smile and laugh when, at last, they are handed a photograph of their late partner. Situations such as that have happened, and are still happening.

Another case in the same care home centred on a cared-for person being prevented from attending the local mosque, because the care home manager, for some bizarre reason, felt the weekly visit from a Christian



[Alex Cunningham]

priest was sufficient to meet everyone's religious needs. Having seen them operate in hospitals and all manner of places, I know that good priests, rabbis, imams or other religious leaders visiting care homes or hospitals do not discriminate; they will speak to anyone and spend time with them. They do that because their faith is driven by compassion and care, and they have a genuine desire to minister to people regardless of their faith, or even if they do not have a faith at all. However, that is no reason for a person to be denied the right to attend the building that serves them in their faith, but that, too, happened in this care home.

A one-size-fits-all arrangement across the wide range of services provided in a care home is not sufficient, and it certainly does not work with faith and sexuality. The people in those examples were helped in their respective plights, thanks to an advocate—someone who could help to put matters right, who ensured those people had what they needed and who, perhaps more importantly, had the capacity, skills and knowledge to point out the rights of the person in care and to make the point that the actions I described are discriminatory and could be unlawful.

Last week, the Minister rightly spoke in praise of care home managers, and I have made it clear that I believe the vast majority do a good job and are genuine carers. But they too are ingrained; they are stuck in the day-to-day running of their care home, and we cannot expect them to function as an assessor, an advocate or anybody independent whom a cared-for person needs. Even if they did have that responsibility, that would have failed to protect the two people in the two examples I gave.

The default position in the Bill should be that every person gets an advocate unless they actively refuse one after they have been given one. As I and others said earlier, it should be an opt-out rather than an opt-in—my hon. Friends have covered that in some detail. It is much better for a person to decide that they do not want an advocate than for them to be unfairly treated because they did not have anybody to speak up for them.

I agree with Mencap, which argued:

“The new scheme must ensure the right of the person to object to and challenge arrangements if they wish, and have the support and representation to do so”.

If the person in the case I spoke about at the start of this speech had had the support and representation to challenge arrangements, she may not have been so distressed because she was denied access to photographs of her partner. She may have had a better emotional quality of life and, leading from that, probably a healthier physical life as well. Instead, she was let down by care home staff, and her rights to express her sexuality were denied. She was denied her liberty.

Age UK has also backed this amendment, saying:

“Support from Independent Mental Capacity Advocates should not depend on a person's ‘best interests’ as it is currently drafted in the Bill. Instead everyone should be able to access an advocate and a person who chooses not be represented can then opt out.”

**James Morris:** Obviously, everyone would agree that having advocates is a good idea, but I want to press the hon. Gentleman on the point about the circumstances

where there might be a need for a best interest test before an advocate is appointed. Does he accept that the number may be limited, but there may be circumstances in which the particular condition of an individual—the nature of their condition—might mean that there having an advocate might not be appropriate?

**Alex Cunningham:** I understand the hon. Gentleman's point. Unfortunately, we have to cover everybody with an amendment such as this, otherwise we end up with exclusions left, right and centre. We cannot afford to have exclusions. If an advocate is in place, there is no additional problem associated with that. At least the person has some chance of representation.

**Steve McCabe:** I think the Minister covered the point made by the hon. Member for Halesowen and Rowley Regis when she cited the small number of situations she thought could be distressing or problematic—I presume that is what the hon. Gentleman was thinking about. That is exactly the sort of thing that the code of practice is supposed to cover. Is that not exactly what we would expect? On the one hand, the Bill clearly legislates in broad terms for what is and is not acceptable, and on the other hand, the code of practice gives the back-up information for professionals, so that they can recognise the sort of situation to which the hon. Gentleman refers.

**Alex Cunningham:** That is most certainly the case. I go back to my Second Reading speech. This is about the individual. This is about one of the most serious things we can do as a nation to somebody—take away their liberty. We should do anything and everything we can do to ensure that they have every single piece of support before that decision is taken, effectively, to lock them up. I agree with my hon. Friend.

I was quoting Age UK, which believes that everybody should have access to an advocate and that a person who chooses not be represented can then opt out. The quote continues:

“This will greatly improve the Bill and give clarity to the cared for person and the responsible body.”

Mencap believes, as I do, that independent advocacy is vital to help vulnerable people to understand and exercise their rights under the law. We have had several examples of that this morning.

Rethink Mental Illness is also on board with the amendment. I appeal to the Minister to provide an opt-out approach, which would greatly improve this Bill, as others have said, and give clarity to service users and providers.

I mentioned care home managers, but the risk of independent hospitals being responsible for assessments is another concern about the Bill, and as we said the other day, we hope the Minister will ramp up the assurances in this area. I have another real-life example for her. A man was held in hospital for almost a year—with no advocate for 10 months. He was angry because he wanted to go back to his two-bedroom home, but the local authority wanted him to move into accommodation with 24-hour support and to not return home. The reason given was that the brother had moved into the spare room at the cared-for person's home and there had to be a spare room for any overnight carer, should the man return home.

What did the advocate find out by talking to the cared-for person? They found that, when he had been living at home, he had been sleeping in a chair in the lounge while his brother had his room and his carer had the spare bed. Then he had fallen and not been found for two days, as a succession of carers had failed to attend. The cared-for person's statements were not taken into account by the social worker involved. If they had been, the process might have been very different. The man needed an advocate from day one.

The case eventually went to court, and the judge accepted evidence from the advocate and ordered the cared-for person to be returned home—[*Interruption.*] Bless you!

**Alex Chalk** (Cheltenham) (Con): I wonder how *Hansard* records a sneeze.

**Mr Dhesi**: That is now a matter of record.

**Alex Cunningham**: The Committee is going to get this example whether it wants it or not. The case went to court, and the judge accepted the evidence and ordered that the cared-for person be returned home and that the sibling be evicted so that the live-in or an overnight carer could be accommodated. The gentleman in question returned home successfully and was later assessed as having regained capacity.

That is the power of an advocate, and it proves the necessity of an advocate in all cases, so I hope that the Minister takes these comments on board and ensures that she helps to enhance the quality of life for vulnerable people by including this amendment in the Bill. It would probably also ensure that she plays an important role in getting people who can be supported in the community the right result for their lives, rather than their being effectively locked up in a place where they do not want to be.

**Alex Norris** (Nottingham North) (Lab/Co-op): It is a pleasure to follow so many colleagues making so many eloquent points about just how important advocacy is. I think that all of us in this room recognise that. An individual up against powerful organisations, across all sectors, is in a very uneven power relationship. If we then add in perhaps a lack of knowledge of how systems and services work, they might need support. Certainly, when they do not have capacity either, there is a clear need for some sort of support.

Sometimes we might read, whether in our postbags or online, that we in this place do not get it on an issue. On this issue, we definitely get it, because every day all of us at some point are battling the local council, the health service or the Home Office—that feels like a regular one—in advocating, as Members of Parliament, for people who do not know the system the way we do. They might look at something and think, in a natural justice way, “Hey, this isn’t right” or “I’m not happy about this,” and we provide extra support and learned knowledge to try to help them through that.

We do get it, and I hope that we can layer that into this very important legislation. We know the sensitivities of the individuals we are talking about. The whole purpose of the Bill, of our being here for the third day and of the time in the Chamber as well, is to take a system that, at the moment, does not work in terms of

system capacity and has in the past created outcomes for people that we would not wish for ourselves, our loved ones or anybody, and to try to get something that does work and is robust. Fundamentally, we would always want to know that, as a result of what is decided by Parliament in this legislation, people living in Nottingham, Bristol or Birmingham, with relatively similar circumstances, would have similar outcomes, irrespective of the fact that the person in Nottingham had an adult child who was very active or even a DoLS specialist and the person in Bristol had no one. We would want, irrespective of those circumstances, that those people got consistent outcomes, because that is what a fair system means.

If we take away advocacy as a default, we get into the fundamental question of whether families, including active families, would even know to know that they could have an advocate. If the quality of the engagement with the responsible authorities is not good, for whatever reason—that has sometimes happened in the past—would the family know that they could ask for an advocate, or that there might have been a best interest assessment and a judgment that, given that the family were around, advocacy was not necessary?

10.30 am

To follow that idea for one more step, we have heard from the Government on previous amendments that it is not enough just to rely on the family. Sometimes the heart can rule the head in families. They might make the judgments that they would want to be best for their loved ones, but those judgments might not actually be best for them. Again, some independence and experience in the system would seem to be an improvement.

I will illustrate my point with an example, kindly provided by VoiceAbility, the advocacy service. An individual, Jo, was referred to VoiceAbility in 2016. She was 56 and a lone parent, and had a diagnosis of alcohol-related dementia. She had been in hospital for detoxification and was discharged in 2015 into a nursing care unit. At the time of that admission, she was extremely agitated and anxious, and reluctant to engage. She spent long periods sleeping, was lethargic and had little motivation. It was obvious to the advocate who then became involved that Jo objected to living in the setting. Her case was of course subject to DoLS.

Jo was at that time the youngest resident of the nursing home, and did not have the same complex needs as her fellow residents. She informed the advocate that living in the home had led to decreased contact with her family. She felt that that was because of the environment that she was living in, and she wanted that to be taken into consideration. The advocate informed Jo about her right to make a challenge in relation to DoLS, which she was keen to do, and supported the process, helping Jo to understand what was going on, initiating the section 21A challenge, and continuing to engage with Jo and help her engage with her legal representative to make the best case.

In 2017, the case was heard at the Court of Protection and a decision was made for Jo to move from nursing care to supported accommodation. She was able to see her potential new home before moving, and was supported by the advocate and by family and friends. On getting a back payment of benefits, she was able to purchase new items for the accommodation to make a home there.



The advocate visited her after the move and learned that she was happy. Family were coming, Jo was getting more access to the community, and staff were supporting her to cook meals and go to the shops. She was also being supported to take up hobbies and increase her fitness.

That is one person's case and it was transformative in her life. The impact of the advocate was extraordinary. The circumstances may be specific to the individual, but we can understand how that story could happen. We have been talking about how people with diminished capacity, caused by things that have happened in their life, can present as agitated, awkward, passive or lethargic in a way that would make someone say, in the moment, "This person is not very engaged or interested." The purpose of the amendment is to ensure that in such cases—where at the time of the best interest judgment someone appears too awkward to deal with, or not interested, or as wanting only to stay in bed all day—a judgment is not made that then means the person is forgotten about for the rest of their life.

That is the root and substance of the measure. We need some extra independence in the system—someone who has the responsibility to go in to help, to talk and to try to engage the person, even if they are a bit lethargic. The advocate did that for Jo, and numerous Members have given accounts of that happening. There is a compelling case for switching the default from a best interest judgment to an "everybody" judgment, unless there is a strong reason why the person in question would not want one.

**Caroline Dinéage:** We are, largely, starting on the same page. We all agree that advocacy is of the utmost importance for the cared-for person. The Bill is clear that everyone has a right to an advocate, whether an appropriate person, an IMCA or, in some cases, both. The Bill sets out clearly that, if no appropriate person is available or able to represent and support a person, the responsible body must take all reasonable steps to appoint an IMCA, if the person has capacity and requests an IMCA and wherever a person lacks capacity, unless in very rare cases it is not in their best interest, as my hon. Friend the Member for Halesowen and Rowley Regis mentioned.

I thank hon. Members for recognising in the amendment the wishes of the cared-for person as a condition for appointment, as we would not wish to force advocacy on anyone. The Bill already allows an appropriate person to request the support of an IMCA. However, I am concerned about the way in which that best interest has been discussed today. Best interest is the standard that governs decision making under the MCA. I am concerned that the Opposition are disregarding that in relation to IMCAs. I apologise if I have misinterpreted what hon. Members have said. The core aspect of best interest is the person's wishes and feelings. That has to be the primary consideration when it comes to rights and IMCAs.

**Barbara Keeley:** Given that the Minister has just expressed her view on how we are presenting our views on best interest, I hope I can summarise the examples that we have given and the view that we are putting forward that it is a subjective judgment. There is a difference with a cared-for person being allowed to have

an advocate, as a default arrangement, unless they do not want that, as in some of the cases we have mentioned. The best interest test is at best a subjective judgment. There are many examples where somebody's best interests have been ignored. That is why we have given many cases; those cases illustrate how incorrectly this test can be applied and how wrong it can go.

**Caroline Dinéage:** I thank the hon. Lady for that clarification. I am really grateful for all the interesting case studies and examples set out today. They show the incredible variety of cases, experiences and issues that the Bill needs to encompass, and the challenges of getting it 100% right. That is why we have to be incredibly careful with *carte blanche*.

We think it would only be in very rare cases that it would not be in the person's best interest to have an IMCA or appropriate person representing them. Of course, the default is that they would. If the appropriate person is not fulfilling their duties, there should be an alternative appropriate person in place, or an IMCA should be appointed by the responsible body.

There is a presumption in a case where a person lacks capacity. They have the right to request an advocate, if they have capacity, and that best interest test is to avoid overriding their wishes and feelings in cases where they do not. Families of those who lack capacity have told us that they often feel left out of the process. Allowing them to act as appropriate persons enables them to be involved and provide support. I am sure hon. Members agree that that is a good thing.

The role of appropriate person is an important way of involving those who are close to a person, but is not necessarily a matter of either/or. An appropriate person can request support from an IMCA if they wish, and that will include access to challenge in court. We are expanding rights to IMCAs. Currently they are available only to people in hospitals and care homes. The liberty protection safeguard would expand that to those in the community and supported living.

We have set out the fundamental requirements of who can act as an appropriate person and the code of practice will give further detail. I know there were concerns that an IMCA would make a one-off visit and, once everything was settled, they would never be seen again, but it is clear that an IMCA must keep up ongoing contact outside of review times to ensure that the person's rights continue to be protected and respected.

**Barbara Keeley:** The Minister said that that is clear. How is it clear? It is not clear anywhere in the Bill that there have to be constant visits. Where is that provision in the Bill?

**Caroline Dinéage:** It is clear in our minds, and it will be clear in the code of practice that hon. Members can approve.

**Alex Cunningham:** Will the Minister indicate what the code of practice will say in that respect?

**Caroline Dinéage:** I cannot give the exact wording because, as I have said, we are engaging with stakeholders and we wish to get the provision exactly right. If I were to provide the wording it would be just the opinion of a

politician, and we will all agree that we need the voices of experts, and that the views of those with lived experience of having to support people should be taken into consideration.

**Alex Cunningham:** Will the Minister give way?

**Caroline Dinéage:** I will in a moment, but I also wish to consider those parts of the amendment with which I fundamentally disagree, as that is important. The amendment would require all 16 and 17-year-olds to have an IMCA as well as an appropriate person. I feel strongly that automatically appointing an IMCA for a 16 or 17-year-old would risk freezing out parents from providing representation and support, and parents are often best placed to take such a role.

The hon. Member for Worsley and Eccles South often talks about the desperately distressing case of Bethany and countless others, where parents' wishes and concerns are not listened to or heeded. We have been clear about giving families a strong role in this model, and we do not want to risk that. As with an appropriate person, a parent or family can request the support of an IMCA, or for their role to be performed by an IMCA.

**Barbara Keeley:** I am surprised that the Minister seems to be referring to an advocate as someone who will get in the way of the parents. When I have met parents—I have met Bethany's father—a great deal of advocacy is going on. Stakeholders in the Bill help with the provision of advocates—indeed, they themselves provide advocacy and legal support. I know for a fact that Bethany's father would not have got very far because, as the Minister knows, an injunction against him by his local council tried to prevent him from even speaking about his daughter's case. People need professional support—parents need it, as do other carers—and I hope the Minister will not categorise the support of an advocate as somehow “getting in the way”. The professionals who make decisions have to be challenged, not advocates who are there to support people and their parents.

**Caroline Dinéage:** The hon. Lady slightly misrepresents what I am trying to say. Of course we have seen numerous examples of how important advocacy can be—it can literally make the difference between people living a happy life that suits their needs, or being kept in a place where they feel unhappy and that does not fulfil those needs. I agree that people should be able to access advocacy, that advocates should be able to work alongside parents, and that if parents feel that they cannot take on such a role, advocates should do that work instead of parents. I also feel, however, that if parents feel that they want to do this on their own and not take on additional advice they should not be forced to, and that is probably the fundamental difference between the Government and Opposition positions. People should be allowed to make decisions for themselves if they wish, and they should not continually be forced to take advice if they do not want to.

We want to make this model person-centric—that is key—and base it on the needs of individuals. By mandating the conditions for IMCA appointments in primary legislation we would once again be prescribing a one-size-fits-all approach that does not consider someone's

individual circumstances, or the wishes and feelings of those involved and their family and loved ones. I hope hon. Members agree and will withdraw the amendment.

10.45 am

**Barbara Keeley:** The Minister seemed to imply—I think she used similar words—that appointing an IMCA will be the default, but that is not the case in the Bill. The Bill states that an IMCA should be appointed if the responsible body is satisfied that being represented and supported by an IMCA is in the cared-for person's best interests. There is a best interest test there, which will potentially get in the way. With the wrong sort of process going through in independent hospitals, it will be subject to that best interest test. That is how people can end up ignored, festering in situations where they do not want to be.

**Caroline Dinéage:** I am struggling with this, because the hon. Lady is giving the impression that best interest should not be taken into consideration. “Best interest” is basically code for the wishes and feelings of the individual. Is she honestly saying that because a person may be lacking capacity their wishes and feelings should be totally ignored, and they should be given what everyone else thinks is best for them?

**Barbara Keeley:** The Minister knows that that is not an accurate interpretation of what I am saying. We spent a fair amount of time talking about independent hospitals, which are still a massive worry and concern. There is still great concern about the potential role of care home managers, because of the conflict of interest in the case of both independent hospitals and care home managers. There are too many actors in this process who could get in the way and be the people deciding whether a best interest test is met.

Were the best interest assessors the people who are used to this and have been doing this job in local authorities, I would be more comfortable. The Government are trying to give power over the process to care home managers and independent hospitals as responsible bodies, and we disagree with that profoundly, because of the cases that I have brought to the Minister's attention. I think she and the Government are wrong to put faith into bodies where there is a conflict of interest. That is why I feel so strongly about this.

**Steve McCabe:** I was going to put a similar point to my hon. Friend. The danger in the Minister's assertion is that she puts all her faith in the official position, in the position of the responsible authorities. As we have already discussed in the Committee, because of the pressures on those people, they may have other interests and other demands on their attention. If we want to represent properly the best interest of the person and make sure that they are at the centre of the process, we need a balancing mechanism, to ensure that all the issues that the authorities will take into account will be balanced against the best wishes of the person. That is why there is an argument for independent advocacy being set aside from the interest of the responsible organisations.

**Barbara Keeley:** That is very much the case. To summarise the debate, on the Labour Benches we have given some very powerful examples of the value of advocacy. I have been very impressed by the selection of cases and I thank my hon. Friends for their speeches.

[Barbara Keeley]

Advocacy is one of the most important safeguards in a mental capacity Bill. It is—perhaps we do not like to use the word these days—a final backstop against improper deprivation of liberty. Our amendment makes it clear that the provision of advocacy must be the default position and I do not resile from that being the right thing to do. There are a few limited exceptions, but the provision of an advocate should go ahead, so that cared-for people are able fully to enact their rights. Without that support they will not be able fully to enact their rights.

We have heard powerful examples about getting people out of inappropriate settings and preventing someone's home being sold when they did not want it to be sold, so that they could return to it. We should not underestimate—Labour Members do not underestimate—how vital advocates are. I know it is a wide-ranging amendment, but it seeks to improve the Bill in a number of ways, primarily guaranteeing an advocate for anybody who wants one.

*Question put, That the amendment be made.*

*The Committee divided: Ayes 8, Noes 9.*

#### Division No. 21]

#### AYES

Cunningham, Alex	McCabe, Steve
Debonnaire, Thangam	Norris, Alex
Dhesi, Mr Tanmanjeet Singh	Sherriff, Paula
Keeley, Barbara	Williams, Dr Paul

#### NOES

Afolami, Bim	Morton, Wendy
Chalk, Alex	O'Brien, Neil
Dinenage, Caroline	Syms, Sir Robert
Moore, Damien	Whately, Helen
Morris, James	

*Question accordingly negatived.*

**Caroline Dinenage:** I beg to move amendment 11, in schedule 1, page 24, line 3, at end insert “in a hospital”.

*This is to provide that only arrangements to enable medical treatment for mental disorder in a hospital (as opposed to medical treatment for mental disorder in any other setting) are excluded from being authorised under the new Schedule AAI.*

**The Chair:** With this it will be convenient to discuss Government amendments 12 and 13.

**Caroline Dinenage:** Amendments 11 and 12 are technical and tidy up the provisions in part 7 of new schedule AAI to the Mental Health Act 1983 that set out the interface with that Act. They provide that liberty protection safeguards cannot be used to recall to a hospital a person who is subject to the Mental Health Act and is residing outside a hospital. If someone is subject to a community power under the Mental Health Act and needs to be recalled to a hospital, that should be done through the Mental Health Act. That is already the case under the current DoLS system, and the amendments ensure that the Bill replicates that. The Bill is already clear that an order made under the liberty protection safeguards cannot conflict with an order made under

the community provisions of the Mental Health Act, so if someone is required to reside at a place under a community treatment order, they cannot be required to live somewhere else under the liberty protection safeguards.

Amendment 13 ensures that that principle also applies to other legislation with a similar effect to the community powers of the Mental Health Act. That means that if someone is required to reside in a particular place under equivalent enactments that extend to England and Wales, they cannot be required to be placed somewhere else under liberty protection safeguards. The amendments effectively ensure that liberty protection safeguards are not used inappropriately to complete functions that should be completed using the Mental Health Act, and clarify what we all know: that a person cannot be required to be in two places at once. I hope the Committee supports the amendments.

**Barbara Keeley:** I understand that the amendments are designed to address the interface between the Mental Capacity Act and the Mental Health Act, and to keep that interface exactly the same as it is now. I think this is the point to say that this is not the course we wanted the Bill to take. Amendment 52, tabled in my name and to be discussed later, would delay the implementation of the Bill until the Government have given proper thought to how that interface ought to work. We will not oppose amendments 11 to 13, because I can see that they are intended as technical, drafting amendments and we will treat them as such, but I think this is a missed opportunity.

There is a considerable grey area between the Mental Capacity Act and the Mental Health Act, and in his recent review, Sir Simon Wessely made some valuable recommendations on how that divide could be clarified. At this stage, the Government have not tabled amendments to enact those recommendations, but through these amendments they will instead maintain a deficient set of arrangements. I fall back on what I have said before: I call on the Government to pause the Bill until they have given proper consideration to the interface between the two Acts and can produce a Bill that will not require near-immediate amendment and generate a lot of court cases, as we think this Bill will do.

*Amendment 11 agreed to.*

**Amendments made:** 12, in schedule 1, page 24, line 10, at end insert “in a hospital.”

*This is to provide that only arrangements to enable medical treatment for mental disorder in a hospital (as opposed to medical treatment for mental disorder in any other setting) are excluded from being authorised under the new Schedule AAI.*

**Amendment 13,** in schedule 1, page 27, line 16, at end insert—

“(g) anything which has the same effect as something within any of paragraphs (a) to (f), under another England and Wales enactment.”—(*Caroline Dinenage.*)

*If arrangements conflict with requirements, conditions or directions imposed or given under certain provisions of the Mental Health Act 1983 those arrangements cannot be authorised under the new Schedule AAI of the Mental Capacity Act 2005. This amendment provides that arrangements which conflict with requirements, conditions or directions arising from an England and Wales enactment having the same effect as the provisions of the Mental Health Act listed in paragraph 54 also cannot be authorised under the new Schedule AAI.*

*Schedule 1, as amended, agreed to.*



**Clause 2**DEPRIVATION OF LIBERTY: AUTHORISATION OF STEPS  
NECESSARY FOR LIFE-SUSTAINING TREATMENT OR  
VITAL ACT

**Barbara Keeley:** I beg to move amendment 16, in clause 2, page 2, line 12, at end insert—

“for a maximum period of 14 days”.

*This amendment will limit the duration of an emergency authorisation to 14 days.*

This amendment and the next to be debated deal with the proposed system for emergency authorisations of deprivation of liberty. In most cases, emergency authorisations should not be needed. An authorisation can be made up to 28 days before the arrangements are due to come into force, and with proper care planning that should mean that liberty protection safeguards are applied for and enacted before someone is deprived of their liberty. That is also the case under the current system, in which applications can be made 28 days in advance—indeed, it is expected that applications will be made before arrangements need to come into force, if at all possible. None the less, data from NHS Digital shows that last year more applications were made for urgent authorisations than for standard ones, which suggests that care homes and hospitals are either unable or unwilling to apply for a deprivation of liberty safeguard until the point at which such deprivation must occur immediately.

I know that the Minister will want all applications to be made and decided in advance, to ensure that people receive the proper protection but, as one DoLS lead said to me recently, simply wanting it will not make it happen. Under the new liberty protection safeguards, there will be no system for urgent applications. Either a standard application will have to be made or the person will be held under an emergency authorisation. That is worrying, given that emergency authorisations come with far fewer safeguards than full authorisations. Amendments 16 and 17, therefore, aim to strengthen the safeguards applied to emergency authorisations, to prevent their misuse.

Amendment 16 would limit the time during which an emergency authorisation can be in place. I do not think that anyone on the Committee would be sad to see the end of urgent authorisations, and I am sure that the Minister agrees that it was unacceptable that care providers were able to self-certify that deprivation of liberty was both acceptable and required. We must do everything in our power to prevent a repetition of that, so I am glad that urgent authorisations have been taken out of the Bill. However, as in all our work on the Bill, we must ensure that we do not implement a flawed process purely because what came before was worse. We should strive to create a genuinely better system.

The Law Commission shares the view that the system of urgent safeguards no longer works, which is why it proposed the change to emergency authorisations. Although that still allows a degree of self-certification, it requires a far higher bar to be cleared. No longer will an organisation be able to self-certify a deprivation of liberty purely because it believes it is urgently needed; instead, the power will be available only when doing otherwise would have a fatal impact on the cared-for person. There will of course be occasions when that is

necessary—scenarios that could not have been foreseen—and in such cases it is important that people are not denied treatment because of the legal requirements, but it does not mean that we should ignore the vital safeguards that people must be entitled to.

The principle is clear: deprivation of liberty should normally be authorised through the proper processes, as set out in schedule 1. The only exception is where there is no way to get the relevant permission in time to deliver life-saving treatment. To ensure that the power is used for only the shortest possible periods, the amendment would put a time limit on it. Under the current deprivation of liberty safeguards, an urgent authorisation can last for seven days and can be renewed for a further seven; at the end of that 14-day period, the only way to continue to deprive someone of their liberty is to apply for, and be granted, a standard authorisation. That provides an important check. It means that a care provider can deprive someone of their liberty for a maximum of 14 days without the involvement of external assessors.

Under the Government’s proposals in the Bill, there is no such check. Instead, an emergency authorisation can run indefinitely, subject to two checks. The first check is that the arrangements are still needed to provide life-sustaining treatment. In the case of someone who requires a respirator or drip-fed medication, that could easily carry on beyond a few days—it could last for years. The second check is that a further decision is being sought from either the courts or the responsible body. However, a recent study by Cardiff University found that appeals under section 21A of the Mental Capacity Act 2005 took a median of five months to be heard. Even if cases relating to emergency authorisations are heard quickly, we are still likely to be talking about months, rather than days, before a case is decided.

One of the Law Commission’s reservations about imposing a time limit on emergency authorisations was the concern that responsible bodies might not always be able to arrange assessments quickly enough. There is a simple solution to that, which does not water down people’s rights. If we want responsible bodies to be able to deliver the scheme, or indeed any other scheme, we need to resource them properly. If they have the resources and staff they need, there is no reason why we cannot ask them to complete assessments in a timely manner.

11 am

The Law Commission also said that it was concerned that a maximum authorisation period for emergency authorisations would become the target for assessing the cared-for person, and we have a similar concern. Without an end date to the authorisation, what incentive would the responsible body have to expedite the assessment process? With no hard deadline by which to complete it, there is a danger that other cases would take priority. Given that anyone subject to an emergency authorisation has few, if any, safeguards, we cannot allow this to happen. Through this amendment, we are seeking to ensure that nobody is deprived of their liberty for long periods of time while waiting on a court or other assessment. I hope that the Committee accepts the amendment.

**Alex Cunningham:** I find it incomprehensible that any emergency authorisation would need to last longer than 14 days. An emergency is just that: it is a serious,

[Alex Cunningham]

unexpected and often dangerous situation requiring immediate attention. That is my online dictionary definition. Once that emergency has been dealt with and the dangerous situation averted, the normal approach should then be adopted. Why on earth would the authorities need to detain a person for many weeks on end without carrying out that full assessment under the law? I suspect the Minister agrees that emergency authorisations would not need to be in place for very long, so everything would be fine and there would be no risk to the person involved. Sadly, nothing in this Bill nails that down. I hope she will have no problem providing us with a guarantee, or supporting this amendment—the real guarantee—to limit that duration of emergency authorisation to 14 days.

We must always take every opportunity to make sure that every precaution is there to ensure that those under emergency authorisations have safeguards and protections. We have been talking about it for days on end. Those authorisations are to be in place so that a person cannot face an indefinite order against them. Not just those of us on the Opposition Benches think that. No fewer than 200 people from my constituency have either commented on this Bill or have signed a petition through 38 Degrees calling for the kind of safeguards in the Bill for which we have been arguing. They are worried about the further erosion of an individual's rights by the clause if it is not amended.

At every point in this Bill I have posed myself this same question: what does it mean to younger people—the 16 and 17-year-olds—who are captured by it? As I read it, a young person could be detained under these emergency powers. We have talked about insufficient safeguards for young people and parents under the Bill. Who knows how long it could be before they are fully assessed, even when the views of their parents or others were taken into consideration?

According to the Law Society, the Bill

“gives wide-ranging powers for depriving a person's liberty through emergency authorisations for unlimited periods of time where a “vital act” is deemed necessary. We believe this is unlawful.”

What action will the Minister take to ensure that such actions are not unlawful, as suggested by the Law Society? Although she said that the risks being taken in the care of vulnerable people are simply not there, she needs to convince us or support the amendment. The Law Society goes on to support the amendment in its evidence submission, saying that a

“time limit of 14 days is essential to prevent abuse in accordance with case law”.

Members have spoken at length and given full examples of how the Bill and proposed amendments could play out or have played out in the real world. It is also vital that we take note and address the issues that may arise outside this place in regards to any legislation introduced by us. Imagine the danger we could be unwillingly putting vulnerable people in if we do not pass the 14-day authorisation limit. A person under such an authorisation could be left for months and denied their freedom with no one having carried out a full assessment, perhaps because it is in the best interests of the person that has assessed them or not assessed them—a care home manager or an independent hospital director. Whatever it is, we have a duty of care over those

deprived of their liberty under the measures. The Bill falls short of ensuring that we properly protect and safeguard them.

We have debated authorisation renewals. This measure falls into a similar category in that we should provide adequate checks to ensure that people are not needlessly deprived of their liberty for any unnecessary time. I am not convinced we are there yet. Within those 14 days there is an expectation that an adequate, comprehensive assessment will be carried out to determine whether the cared-for person meets the authorisation conditions. If it is more than 14 days, who is going to tell us when it will happen?

**Steve McCabe:** I do not know whether I am being a bit paranoid about this, but is there a danger that this could become the easy get-out clause? It will be a bit complicated to get all the parties together and carry out a proper assessment, but it will not be as difficult to get someone to say, “Ah—there's an emergency.” That way, they have dealt with the paperwork in one fell swoop and they have the person where they want them. If there are no safeguards, it will become the clause that will bypass the rest of the legislation, because this is where people will go when they do not want to put in the work or they feel too hard pressed to do it.

**Alex Cunningham:** I share my hon. Friend's paranoia. I do not understand why we would put any barriers at all in the way of people's having a proper assessment within a reasonable time. Detaining someone for 14 days is effectively locking them up for 14 days. It means depriving them of their liberty and there may be no real necessity. An assessment, as quickly as possible, is essential.

Of course, if we allow those authorisations to go on for longer than 14 days or any other reasonable timeframe, we are putting people at risk of abuse, as the Law Society has said. I say to the Minister that we must put vulnerable people first. We must always put the individual first. We must have the safeguards in place, because to do anything else is to risk their liberty, and that is a risk I am not prepared to take. I hope she accepts the amendment.

**Caroline Dinenge:** Clause 2 allows caregivers, in limited situations, to deprive someone of their liberty for a short period of time prior to an authorisation being in place or in an emergency. That can be done only to provide the person with life-sustaining treatment or to prevent a serious deterioration in their condition. The clause enables a care home to place restrictions on the person for their own protection ahead of an authorisation being approved. That interim legal cover will be decision-specific and it will be targeted to life-sustaining treatment and care or to a vital act. Once those acts are completed, the conditions no longer apply and legal cover for depriving someone of their liberty ends.

In that way, the clause replicates clause 4B of the Mental Health Act 2005, already in DoLS. The emergency authorisation system applies in exactly the same way when a court application being made relates to a deprivation of liberty. There is no evidence at this time that it would lead to any lengthy deprivation of liberty, and the provision of the Bill builds on an existing and well-understood provision. The previous system also included an urgent authorisation. That has gone because it was used too often and its time limit was ineffectual.



Under the Bill, the legal cover is provided simply for as long as the life-sustaining care is needed and no longer. It is therefore a limited power and a better safeguard. An emergency is defined as a situation where there is an urgent need to act and it is not “reasonably practicable” to make an application under the liberty protection safeguards to the Court of Protection or under part 2 of the Mental Health Act. It was carefully considered by the Law Commission, which looked at the inclusion of a time limit and decided against it. We agree with its conclusion that a time limit could encourage care providers to aim for the time allowed rather than to adhere to best practice for that case and that person, which is certainly what we have seen in some urgent cases.

Given the seriousness of depriving someone of their liberty, it should be limited to the shortest possible timescale and should reflect the huge range of causes that it can be required to cover. The amendment would create a blunt, one-size-fits-all approach, rather than allowing us to reflect the different approaches called for.

**Steve McCabe:** The Minister cites the Law Commission, but is it not the case that the Law Society recommended this very type of safeguard?

**Caroline Dinéage:** I do not know about the Law Society. The Law Commission was tasked with reviewing the measure—it took three years to do so. The commission took evidence from across the sector and we have used its recommendations as the basis for this provision.

**Barbara Keeley:** It is interesting that the Minister is being so selective about which of the Law Commission’s recommendations she is accepting. I challenged her earlier about a recommendation that she had accepted at the time it was made and which has not been taken further in the Bill. This is a five-clause Bill, which Opposition Members have had to battle our way through. It is not the fifteen-clause draft Bill that the Law Commission brought forward, which had been consulted on. It is rather rich of the Minister at this point, when it suits her, to be quoting the Law Commission’s recommendations and adopting them when she has not accepted them on many other occasions, including the one on which I moved an amendment this morning.

**Caroline Dinéage:** The reason for that is quite simple. The Law Commission’s draft Bill had a whole lot more scope and took into it things that we have not been able to look at as part of this particular revision of DoLS, on which we want to focus. We are painfully aware of the fact that 125,000 people are still in a backlog, waiting for DoLS. They do not have the protections that they need; the families do not have the reassurance; and the people caring for them do not have the protection of the law. That is why, necessarily, this had to be a very narrow Bill. Where possible, though, we have taken the words of the Law Commission to its very heart.

**Barbara Keeley:** I am astonished that the Minister thinks it is okay not very long ago this morning to not accept a Law Commission recommendation and then, in her very next speech, to put forward such a recommendation as the main reason for turning down an amendment. There is an astonishing lack of logic.

Opposition Members believe that it cannot be right that emergency authorisations have no time limit. There is a concern that it could become easy to drop into using the provision given that there is no time limit on it. We can how, given how systems are designed, people can get into going to the easiest place. If it is the easiest place to deprive someone of their liberty, that situation can become dangerous.

By failing to include a time limit, the Bill fails to incentivise local authorities and the courts to hear emergency authorisation cases promptly. There is no time pressure on them—they can take as long as they like. Applications can already take too long to process and, without a hard end date, they could drag on for weeks or months. The emergency authorisations contain far fewer safeguards than full authorisations, and as such Opposition Members believe that they should be used only sparingly and for brief periods.

*Question put, That the amendment be made.*

*The Committee divided: Ayes 8, Noes 9.*

#### Division No. 22]

#### AYES

Cunningham, Alex	McCabe, Steve
Debonnaire, Thangam	Norris, Alex
Dhesi, Mr Tanmanjeet Singh	Sherriff, Paula
Keeley, Barbara	Williams, Dr Paul

#### NOES

Afolami, Bim	Morton, Wendy
Chalk, Alex	O’Brien, Neil
Dinéage, Caroline	Syms, Sir Robert
Moore, Damien	Whately, Helen
Morris, James	

*Question accordingly negated.*

**Barbara Keeley:** I beg to move amendment 17, in clause 2, page 3, line 4, at end insert—

“(10) Where this section is relied on to deprive a cared-for person of his liberty, the person relying on this section must—

- (a) inform the cared-for person and any person with an interest in the cared-for person’s welfare of that fact;
- (b) keep a written record of the reasons for relying on this section;
- (c) supply a copy of the written record of reasons to the cared-for person and any person with an interest in the cared-for person’s welfare within 24 hours of the deprivation of liberty commencing; and
- (d) if any of the following apply, make an application to the Court of Protection immediately—
  - (i) the cared-for person objects to being deprived of his liberty;
  - (ii) a person with an interest in the welfare of the cared-for person objects to the cared-for person being deprived of his liberty; or
  - (iii) the donee of a lasting power of attorney or a court-appointed deputy objects to the cared-for person being deprived of his liberty.”

*This amendment will ensure that information is shared with the cared-for person and any person of interest in the cared for person’s welfare and sets out when an application to the Court of Protection must be made immediately.*

Amendment 17 builds on the comments I made in relation to amendment 16. Throughout the two amendments, our concern has been that people subject to emergency authorisations do not currently have the

[Barbara Keeley]

same protections as others who are detained under the liberty protection safeguards. We recognise that there might be a need in certain rare cases to circumvent full assessment for a short period, but it is not acceptable that the Bill provides almost no surety against the system being misused, as we discussed in the debate on amendment 16. That amendment dealt with the length of time for which an emergency authorisation could be in force. Amendment 17, on the other hand, deals with the rights of a person who is subject to an emergency authorisation. Our aim is to ensure that a person's rights to information and appeal are not watered down because they are subject to an emergency authorisation.

11.15 am

Before I discuss the amendment in detail, I want to give hon. Members an example of why the process for urgent authorisations needs reform. The Minister and other Members will have heard the case of Oliver McGowan, which I have raised before in Committee. Oliver was autistic, had a mild learning disability and had full life expectancy. Indeed, he was fit, active and training to be an Paralympian athlete. He was admitted to A&E for absence-type seizures. He was not psychotic or mentally ill. Despite this and despite his parents raising their concerns, he was given a type of anti-psychotic medication to which he had previously had adverse reactions. He suffered a serious adverse reaction to the anti-psychotic medication which eventually killed him.

It is deeply concerning that Oliver's parents had to cope not only with this tragic and seemingly avoidable death, but with the fact that the processes surrounding his death were so faulty. I know that the Minister is concerned about this case, but it is worth looking at what happened. Despite all the difficulties surrounding consent to the use of medication in Oliver's case, the urgent authorisation form was completed on 26 October, a full five days after he was first admitted to Southmead Hospital. Despite being named on the DoLS form, Oliver's mother Paula was not consulted in the DoLS process, and she tells me that later processes for investigating Oliver's early death raised concerns about the lack of a best interest decision meeting.

In earlier discussions, the Minister seemed to rely on a best interest assessment process and believed that professionals would always take best interest into account. In this case, there was a dispute about Oliver's treatment. A best interest decision meeting did not take place and Paula says that his parents were not listened to. Shamefully, the DoLS application was made the day after the fatal anti-psychotic medication was administered to Oliver. This means that the medication was administered at a time when he may have been deprived of his liberty without due process. The processes that should have been followed—assessing his best interests, consulting with his family—were not followed. Indeed, Paula McGowan only discovered that a DoLS application had been made for Oliver when the coroner raised it in a review a year after he died.

Our amendment seeks four specific safeguards that should be put in place where an emergency authorisation is granted. First, the cared-for person and anyone with an interest in their welfare should be informed of what is happening. This seems obvious, but there is nothing

in the Bill to ensure that that will happen. It will be entirely possible for a person to be deprived of their liberty under an emergency authorisation, and for them or people interested in their welfare not to be told that this is the case. That is exactly what happened in the case of Oliver McGowan. In high pressure environments, such things may be forgotten, but we should not allow this to happen. An active duty in the Bill to provide this information means it cannot be something that falls by the wayside.

The second duty is that a written record be kept of the reasons for relying on an emergency authorisation. This will be important if a decision is challenged in the courts, because it provides a safeguard for the cared-for person and practitioners. When a case is appealed to the Court of Protection, as will happen from time to time, there needs to be a record of why certain decisions were made. If there is not, the court will inevitably have to embark on a lengthy process, relying on fallible recall to determine what the intentions were at the time. This would put practitioners at risk of their intentions being misinterpreted.

Producing such a written record should also clarify in the mind of a practitioner whether they are doing the right thing. There is a common saying that if you cannot explain something, you do not really understand it. By requiring practitioners to explain in writing why they have made certain decisions, we can make sure that they understand why they are making them.

The third requirement goes back to the right of the cared-for person and those close to them to know what is happening, and why certain decisions have been made. If they do not have this information, they have no access to their rights. We have settled for 24 hours as the period to provide such information so that it is done as quickly as possible. It is an urgent situation when there is an urgent authorisation. If this had been done in Oliver McGowan's case, it might have allowed his parents to object to his deprivation of liberty and stop the administration of the anti-psychotic medication that killed him.

The fourth requirement relates to applications to the Court of Protection. I have already spoken about the importance of not expecting the cared-for person and their family to make an application to court unaided. That is particularly important in cases where an emergency authorisation is relied upon. The timescales on which arrangements are put in place are far shorter, so the window for applying to a court before arrangements are carried out is so slim as to hardly exist.

Under extreme pressure, when the cared-for person is undergoing life-sustaining treatment, I do not feel it is reasonable to expect them or their family to make an application to the courts. That would be a stressful situation, and court applications are confusing and time consuming at the best of times. That is why we want the duty to make a referral to court to be placed on the body carrying out the arrangements. That is likely to be a hospital and, as such, it will have far greater capacity to make such an application.

The proposal would also make it clear that there is a right to apply to the Court of Protection where an emergency authorisation has been granted. That is something that must be included in the Bill. Otherwise, the legal process for applying to the Court of Protection will be further prolonged. It may not be clear to a

cared-for person or those close to them that such a right exists. If that is the case, they are unlikely to realise that there is a point in objecting, let alone in engaging such a right.

We have pinned the criteria in the amendment on objection. If someone objects to a standard application for a liberty protection safeguard within certain limits, they will be referred to an approved mental capacity professional, but there is no provision for AMCPs to work on emergency authorisations. Indeed, it might not suit their skillset to do so. We have used the same criteria to determine whether the court should be engaged.

The amendment simply seeks to ensure that emergency authorisations do not create a second-class deprivation of liberty. The fact that it is an emergency should not mean that we disregard the rights of the cared-for person, as has happened in the past with fatal consequences for that young man, Oliver McGowan. I am sure that the Minister would agree that that is the case. As such, I hope she will accept our amendment.

**Caroline Dinenege:** The ability to deprive someone of their liberty for a short period of time prior to an authorisation being in place or in an emergency is an important part of this model, as we have discussed. That can be done only to provide the person with life-sustaining treatment or to prevent a serious deterioration in their condition.

I spoke on amendment 16 about how this provision is limited to emergency and life-sustaining treatment or a vital act, and to the time limit that is legally enforced. We agree that the provision of information to the cared-for person and those who care for them is extremely important to help them understand the process and exercise their rights. I have committed in respect of other clauses to look again at information and how quickly and early it is disseminated and distributed. I agree in principle with the information part of the amendment.

My only reservation is that, given the nature of the situation, medical professionals have to work urgently in a short period of time, so the amendment might not be practical in practice. However, I agree 100% with the hon. Member for Worsley and Eccles South that

information needs to be given out and that people need to understand what is happening to them and their loved ones, so I will commit to look again at this matter.

We agree, and I confirm that, when people are deprived of their liberty, records will need to be kept and those will need to be available after the event. We will outline the details in the statutory code of practice, including how that information should be shared with others.

The amendment outlines circumstances when objections to deprivation of liberty for the provision of life-saving or sustaining treatment should be referred immediately to the Court of Protection. Under the Bill, all people in those cases will have the ability to challenge emergency authorisations in the Court of Protection via section 16 of the Mental Capacity Act, and it is unnecessary for that to be made explicit again in the Bill. The applications will also operate alongside a full authorisation made under new schedule AA1 where appropriate and, of course, there will be full recourse to the court to challenge those authorisations too. For that reason, the Government cannot support the amendment.

**Barbara Keeley:** I am disappointed that the Minister will not accept the amendment because I have given her a very powerful example of why she should. I had not understood, until I engaged with Paula McGowan recently, how defective the processes were. I know that the Minister has been engaged in that case, so I ask her to think about how it adds to the burden of grief and bereavement for the parents that the processes that should have protected a young person such as Oliver were not engaged properly.

The point about information is important; the McGowans were not informed of their rights or listened to. There was no best interest meeting for Oliver. Had that happened, his parents could have pointed out the danger of the anti-psychotic medication. The Minister has just said that medical and care professionals are busy. That is the problem, is it not? That is how these cases happen—in the busyness of urgent care. The warnings about the medication were just ignored. That is why we very much need information to be given.

11.25 am

*The Chair adjourned the Committee without Question put (Standing Order No. 88).*

*Adjourned till this day at Two o'clock.*







