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HOUSE OF COMMONS
OFFICIAL REPORT
GENERAL COMMITTEES

Public Bill Committee

MENTAL CAPACITY (AMENDMENT) BILL [*LORDS*]

Fourth Sitting

Thursday 17 January 2019

(Afternoon)

CONTENTS

SCHEDULE 1, as amended, under consideration when the Committee adjourned till Tuesday 22 January at twenty-five minutes past Nine o'clock.

Written evidence reported to the House.

No proofs can be supplied. Corrections that Members suggest for the final version of the report should be clearly marked in a copy of the report—not telephoned—and must be received in the Editor’s Room, House of Commons,

not later than

Monday 21 January 2019

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

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| † 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) |
| † Dinéage, 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) | † attended the Committee |
| † Morris, James (<i>Halesowen and Rowley Regis</i>) (Con) | |

Public Bill Committee

Thursday 17 January 2019

(Afternoon)

[MARK PRITCHARD *in the Chair*]

Mental Capacity (Amendment) Bill [Lords]

Schedule 1

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

2 pm

The Minister for Care (Caroline Dinéage): I beg to move amendment 5, in schedule 1, page 14, line 6, leave out “prescribed connection” and insert

“connection, of a kind prescribed by regulations.”

This amendment is to make it clear that a regulation making power is being conferred by paragraph 18(3) of the new Schedule AA1.

The Chair: With this it will be convenient to consider Government amendments 6 and 7.

Caroline Dinéage: It is a great pleasure to serve under your chairmanship, Mr Pritchard. A warm welcome to the Committee—albeit not quite as warm as it would have been had you been here on Tuesday.

These technical amendments build on important amendments tabled by the Government in the other place. They ensure that a person with a connection to a care home cannot conduct the assessments needed for an authorisation or the pre-authorisation review, and thereby eliminate any potential conflict of interest. It is vital that assessments and pre-authorisation reviews are completed independently. The amendments not only ensure there is no conflict of interest in the process but prevent the approval of over-restrictive arrangements that are in a care home’s interest but not in the best interests of the individual.

The amendments clarify that the definition of a person with a connection to a care home will be set out in regulations; the Bill therefore confers regulation-making powers. That may not have been sufficiently clear in previous drafting, so those connections will be laid out in regulations, which will allow us to provide the necessary detail and ensure that all care home staff and those connected to a care home are excluded from completing assessments and pre-authorisation reviews. Consideration was given to setting that out in the Bill, but we concluded that regulations would better serve our intention of ensuring that we exclude agency staff and others who do not work directly for the care home. I hope the Committee supports these clarifying amendments.

Barbara Keeley (Worsley and Eccles South) (Lab): It is a real pleasure to serve under your chairmanship, Mr Pritchard. The atmosphere is so much nicer than it was on Tuesday, when we were so horribly hot. You avoided being in a sauna for a few hours.

It is a pleasure to speak to such uncontroversial amendments. We will discuss conflicts of interest further, so I will not say too much now, but I wish to make one comment. The amendments make clear that assessments and reviews should not be carried out by people who have certain relationships with a care home, but I hope the Government take a broad view of the kinds of relationships that should be ruled out. The regulations must not provide that the only people with a prescribed relationship with a care home are its employees. I also hope the Government take an open and consultative approach to drawing up the regulations. Many stakeholders will have strongly held views about the kinds of relationships that should be prescribed, and the Government should ensure that they take all that expertise on board.

Amendment 5 agreed to.

Amendment made: 6, in schedule 1, page 15, line 4, leave out “prescribed connection” and insert

“connection, of a kind prescribed by regulations.”—(*Caroline Dinéage.*)

This amendment is to make it clear that a regulation making power is being conferred by paragraph 19(4) of the new Schedule AA1.

Barbara Keeley: I beg to move amendment 34, in schedule 1, page 15, line 34, at end insert—

“(3A) Where the person consulted under sub-paragraph (2) has parental responsibility for the cared-for person, the consultation shall seek to ascertain that person’s wishes and feelings in relation to the arrangements.”

This amendment introduces a requirement to consult parents about their child’s care arrangements.

The amendment follows on from amendment 30 on parental consent and amendment 38 on approved mental capacity professional reviews for 16 and 17-year-olds. It would provide an additional and equally important tool to ensure that 16 and 17-year-olds, who will now be subject to the Mental Capacity Act 2005, are afforded the proper safeguards.

I have previously welcomed the inclusion of 16 and 17-year-olds in the Bill, as it is important that they do not fall through the cracks in the system. Their inclusion provides consistency with the remainder of the Mental Capacity Act, which makes no distinction between 16 and 17-year-olds and people older than them, but the Bill does not go as far as was recommended by the Law Commission, which wanted the Government to carry out a full review of mental capacity law as it relates to children and young people. I hope the Government are still considering that recommendation. The current system leaves children under 16 in an uncertain legal position as there is no provision for them to be subject to mental capacity legislation, so I hope a review is forthcoming.

The amendment focuses on the consultation process that must be carried out before an authorisation is either granted or renewed. That is one of the most important processes that will be carried out under the liberty protection safeguards, as it will ensure that the cared-for person and others who are interested in their welfare have a say. Since we will not cover consultation in great detail in future, I will briefly outline why the process is of such importance in the context of the amendment.

In this area, the Bill goes considerably further than the existing deprivation of liberty safeguards system. It is welcome that we are moving on from a situation where consultation is optional to one where it is mandatory.

That is a crucial part of understanding whether the arrangements are in a person's best interests, particularly in cases where a person has communication issues—we explored that this morning. Those with an interest in a person's welfare may be the best placed to comment on their wishes and feelings. That is a broad group, which is why the phrase “people with an interest in the cared-for person's welfare” is so vital. It covers family members, but goes further where it needs to. It could include anyone, from fellow members of a church congregation to a neighbour who keeps an eye out for the cared-for person. The consultations are not optional; the Bill contains provision that those people must be consulted. Unfortunately, how the results of the consultation should be integrated with other assessments is not mentioned. I suspect that, again, that will appear in the much-fêted code of practice when it is finally published.

I hope it will become clear that the results of the consultation should be given appropriate weight in considering whether arrangements are necessary and proportionate. In most cases, that will be sufficient, but the views of some of the groups to be consulted that are mentioned, and one crucial group that is not specifically mentioned, should be given greater weight. This amendment refers specifically to 16 and 17-year-olds, and there is a group with a specific legally grounded interest in their welfare: the individuals who have parental responsibility for the cared-for person. We want to ensure that people with parental responsibility have their different role recognised. Amendment 30 on parental objection was one way that could be achieved; amendment 34 is another.

In the Mental Capacity Act 2005 there are a number of provisions, as part of the best interest requirements, that would be integrated into the consultation process. I will quote from those briefly. Section 4(6) of the Act requires an assessment to be made on

“the person's past and present wishes and feelings...the beliefs and values that would be likely to influence his decision if he had capacity, and...the other factors that he would be likely to consider if he were able to do so.”

Those are not necessarily things that would be obvious to just anyone interested in a cared-for person's welfare. In particular, beliefs and values are often deeply personal. To ensure those are properly captured, we must ensure that those people who know the cared-for person best are not only consulted but given a meaningful say on the arrangements.

When the Bill was published, the requirement was that anybody with an interest in the cared-for person's welfare must be consulted, but as I said, it went no further than that and did not specify what the consultation would seek to do. Because the Bill extends to 16 and 17-year-olds, that provision is now clearly deficient. Parents have a greater stake in their children's welfare than others, but more than that, parents can give a greater insight into the beliefs, values, wishes and feelings of their children than those who have other relationships. Legislation such as the Children Act 1983 recognises that fact and provides parents with a far greater say over what their children do than is normally given to other family members. In particular, existing legislation creates a presumption that a person with parental responsibility has a significant say over where a child or young person lives. We are talking about an age group that requires parental permission to get married or even to get a tattoo. It is clear that the parents of 16 and

17-year-olds have rights and responsibilities that vastly outstrip those found in other relationships. The amendment would reflect that importance.

This is a distinct issue from the one raised in amendment 30 on the role of parental consent in authorising arrangements. We have touched on that before. Inevitably, there will be cases where parents do not wish to withhold their consent completely, but none the less have reservations or suggestions that should be taken on board, particularly in the case of 16 or 17-year-olds, who may sometimes display challenging behaviour. In those circumstances, parents may not wish to veto arrangements completely, as that may leave them without the support they need.

We are taking about situations where parents may find themselves pitted against professionals. We all know the feeling of being told by a doctor that something is in our best interests; mostly, we do not challenge those assertions, but that does not mean that professionals are infallible. In cases of such importance, where we are dealing with people's fundamental human rights, it is important that we test such presumptions.

I have spoken previously about the case of Bethany, who was held inappropriately in St Andrews independent hospital. Despite the difficulties, in some ways Bethany is fortunate that her father is able to stand up for her and argue against what professionals are telling him is in her best interests. Steven Neary, whose case I also mentioned, was also fortunate that his father worked tirelessly to have him moved from the unit in which he was being held so inappropriately.

There is another deeply tragic case, illustrating the difficulties parents have in challenging professionals' determination of what is in a patient's best interest—that of Oliver McGowan. I know the Minister met Oliver's mother Paula following her successful petition for a debate on the treatment of people with autism and learning disability. Oliver was autistic, but had a full life expectancy. He had previously had adverse reactions to the type of antipsychotic medication that eventually killed him, yet despite his parents' raising concerns, the clinician treating him continued to administer that medication and Oliver died. That tragic case highlights what parents can be up against.

The unfortunate reality is that parents such as Bethany's dad and Steven Neary's father, who have been able to challenge decisions affecting their children, are notable for being the exception, not the rule. There are any number of parents of children in this situation who have been told so often by professionals that the arrangements are in their children's best interests that they find it hard to persist in challenging that over months and years. It is particularly hard for parents who do not have the resources, time or confidence to draw public attention to their case. Other parents need to be proactively supported to comment on the proposed arrangements.

To summarise my argument, some parents will not feel confident enough to try to overrule professionals who are telling them that certain arrangements are in their child's best interest. That does not mean we should not pay particular attention to their views on whether the arrangements are proportionate or on whether there may be less restrictive options available.

One point that must be considered is where parents would prefer that their child continue to live in the family home. I spoke earlier about the importance of

[Barbara Keeley]

never depriving somebody of their liberty unless that is the only option, but the unfortunate reality is that local authorities face severe funding pressures, and professionals sometimes tend toward ensuring physical safety at the cost of all else. That can lead to parents who may want to keep their child at home being told that the only way to keep the child safe is to move them elsewhere. Giving their views particular weight at the consultation stages is one way to ensure that arrangements are not authorised when a less restrictive option is desirable.

The amendment provides a dedicated outlet for parents to give their views. It reflects the greater role that parents and those with parental responsibilities play in caring for their children. The purpose is to strengthen the role that parents can play throughout the process of authorising a deprivation of liberty. Our amendment 30 would have required them to give their approval to any arrangements, but there is a final reason to specify that those with parental responsibility must have their views considered. I discussed at length earlier some cases where care homes restricted contact between a cared-for person and their family. That can be done for no reason, with only spurious grounds given. The cases I raised earlier all related to an older cared-for person, but the same provisions are sometimes put in place for younger people, with parents restricted from seeing their own children. However widespread that practice may be, it is another instance where a single case of a parent being denied a say on their child's care for no good reason would be too many. I hope amendment 34 makes it clear that the responsible body, or whoever else is organising the consultation, cannot simply sideline those with parental responsibilities. The amendment is about ensuring that the parental voice is heard throughout the process and can shape the form that arrangements may take.

We are talking about a cohort of young people with immensely complex needs. They need the people who know them best to be not only informed, but actively consulted on the arrangements they will be subject to. By doing that, we can ensure that when 16 or 17-year-olds are subject to the liberty protection safeguards, it is done in their best interests.

Alex Norris (Nottingham North) (Lab/Co-op): It is a pleasure to serve under your chairship, Mr Pritchard. This morning we talked a lot about the role of parents in these circumstances, so I will not rehearse all those arguments again. We tested the view of the Committee on the principle that there would be a parental override, and the decision of the Committee was that that was not appropriate. Amendment 34 is perhaps a step back from that, but would still give parents a very important place and role in exceptionally difficult decisions. I hope it might find a little more traction with colleagues.

2.15 pm

We have not seen the code of practice and we do not really know how things will be documented, but a section of an assessment made will state clearly that professionals have put arrangements in place for an individual but that that individual's nearest loved ones do not think that placement is appropriate. At that moment, that would change nothing—as with the decision we dealt with this morning, the professionals will have

the ultimate say—but it might mean something as the placement is monitored by the commissioner and responsible bodies.

We talked about fluctuating need and the possibility of meeting that through the code of practice, and perhaps during a reassessment—we will come on to periodic reassessments—or in any sort of monitoring, the professional who picks up the case, having seen lots of other cases, could then see a very clear flashing light that says, “This is a vulnerable young person”—which alone should be enough to grab the attention—“and their family and loved ones, their nearest and dearest, do not think that this is a good placement for them.” That is a good flashing light, a safeguard for the individual, ensuring that that is held in people's minds during any reassessment.

We have said that there is to be no parental override. Okay, but if we do not make the provision we propose and have some sort of clear and obvious sign of parental objections, how else will the parental voice be heard? If we just left that to the memory of the assessor, who might have done the case first time, or to the institutional memory of the provider, with all the pitfalls that we talked about on Tuesday, I do not think that we will have passed the test. When talking about the most vulnerable 16 and 17-year-olds, we will have lost the voices of their parents. That would be a big risk.

Caroline Dineneage: I thank the Opposition for raising this issue. As we have heard, the amendment would require that parents' wishes and feelings about the proposed arrangements for their 16 and 17-year-old child are ascertained. That would be in addition to the main purpose of the consultation, which is to ascertain the wishes and feelings of the cared-for person.

I understand that hon. Members are concerned to ensure that parents' voices are heard—so, of course, are the Government. Parents have a vital role in caring for their children, especially when they lack mental capacity. We would fully expect the responsible body to consult parents about their views of the arrangement, where appropriate, while ascertaining the wishes and feelings of the person. We therefore believe the amendment to be unnecessary, because parents involved in the care of their child will already be included in the consultation process, where appropriate. I refer Members to my earlier comments on the safeguarding issues that must also be taken into consideration.

The other thing to be taken into consideration, which I mentioned earlier, is the Birmingham case which is being considered by the Supreme Court. That will bring further clarity to parental responsibility for young people lacking mental capacity.

Barbara Keeley: I hope that the Minister was listening to the cases that I cited—I know that she has been involved in and heard of those cases, and sometimes met the individuals. Parents, however, were not consulted in desperately difficult and at times tragic circumstances. She knows that Paula McGowan and Oliver's father were not consulted; in fact, they were ignored. On a number of occasions, I have talked about the case of Y, whose parents were ignored—the social worker just ignored them—to the real damage of that young person, who was held for two years. The Minister says somewhat glibly, if she will excuse me saying that, that parents will be consulted, but they are too often ignored. It seems to

me that the working practice of many professionals in this field is to ignore the parents. I do not think that the amendment is unnecessary, because it creates a situation in which we draw attention to the importance of the input that parents can make. I have certainly seen no evidence that that is routinely used at the moment.

Caroline Dinéage: I very much take on board the hon. Lady's concerns, and she knows that I have enormous respect for her work in this field. As she said, I have met with a number of parents involved in these tragic cases—she mentioned Paula McGowan and her son, Oliver. It was not just Oliver's parents whose wishes and feelings were ignored; it was Oliver's. In the initial period he said that he could not have the medication that they were giving him, and they still gave it to him anyway. Her point is incredibly valid, but it needs a lot more than this to achieve what we are aiming for. That is why we are bringing forward the consultation on the appropriate training for people who work in health and care settings, on how to be able to communicate with, understand and properly look after people with autism and learning disabilities.

Barbara Keeley: I respect that the Minister has taken on board Paula McGowan's campaign, but how much more powerful would the training of medical professionals and others involved with the care and treatment of people like Oliver be, when it is started, if it could be said in the consultation that they have to listen to the views of the parents? That would be a change, because clearly they are not doing so at the moment.

Caroline Dinéage: I completely agree with the hon. Lady. We are making it clear that parental voices must be heard, but we have to be careful about putting anything in the Bill that could create unintended consequences. We have spoken about it before and those safeguarding issues have to be taken very seriously. To our cost, we have learned from previous Bills that a loophole in the law can take the whole policy off in a way that we had not entirely expected. We do not want to recreate that. I hope that with that reassurance hon. Members feel they are able to withdraw the amendment.

Barbara Keeley: No, I am afraid I do not. Amendment 34 requires the views of parents to be given particular weight in the consultation process, when the cared-for person is 16 or 17 years old. That is the third of our amendments designed to ensure that 16 and 17-year-olds have proper safeguards. It is necessary, because of the greater safeguards that this age group currently receives under the Mental Health Act. I think there will be a shift in which piece of legislation is used in regard of 16 and 17-year-olds. We cannot have a situation where the safeguards are less under the mental capacity legislation than they are under the Mental Health Act or a court order. We will press this to a vote.

Question put, That the amendment be made.

The Committee divided: Ayes 8, Noes 9.

Division No. 8]

AYES

Cunningham, Alex	McCabe, Steve
Debbonaire, 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.

Barbara Keeley: I beg to move amendment 35, in schedule 1, page 15, line 41, after “is” insert “employed by an organisation”.

This amendment would prohibit the pre-authorisation review from being carried out by any person employed by an organisation involved in the day-to-day care of the cared-for person, or involved in providing any treatment to the cared-for person.

The Chair: With this it will be convenient to discuss amendment 36, in schedule 1, page 16, line 2, at end insert “or independent hospital.”

This amendment would ensure that the person conducting the pre-authorisation review does not have a prescribed connection with an independent hospital.

Barbara Keeley: Paragraph 21 of the new schedule AA1 makes provision for certain people to be excluded from carrying out the pre-authorisation review of a liberty protection safeguards application. In this section, the Bill specifically prohibits pre-authorisation reviews from being carried out by anybody involved in the day to day care of the cared-for person or in providing any treatment to the cared-for person. We are glad to see the safeguard is in the Bill. It would not be appropriate for a paid member of care staff to be the independent person safeguarding a person's liberty as well.

We have previously discussed the issue of conflict of interest and we have tabled amendments to eliminate this, but the safeguards are still fallible. We have tabled amendments 35 and 36 because we believe the Bill requires further clarification to ensure that the independent reviewer is not in any way connected with the organisation conducting the pre-authorisation review. We are concerned that it is not only people directly involved in providing care or treatment to a person who may be incapable of providing that truly independent check we want to see. There are other individuals, for instance, within the same care home provider, who would still lawfully be allowed to conduct a pre-authorisation but who could not be described as truly independent. That would still represent a wholly unacceptable conflict of interest. It would be a shame if, having accepted the principle that there must be no conflict of interest in this Bill in relation to care home managers, the Government allowed it to creep in via the back door, in this way.

Amendment 36 is designed to address further potential conflicts of interest in cases where the cared-for person is held in an independent hospital. I raised the real concerns from across the sector, both on Second Reading and earlier in Committee, about the potential relationship between independent hospitals and the approved mental capacity professionals who will review cases. Our concern is that there is nothing to prevent an independent hospital from entering into a cosy relationship with an approved mental capacity professional. The AMCP could then review the cases going through that independent hospital, effectively removing a vital safeguard against the improper deprivation of liberty.

[Barbara Keeley]

The Government have repeatedly said that that would not be permissible under their proposals. Our amendment attempts to clarify the position, so that stakeholders and others can be reassured that the Bill will have its intended effect. The Minister's agreeing to the amendment would be welcome, given the speed at which the Bill is progressing and the concerns raised by stakeholders about not only the contents of the Bill but the perfunctory way that stakeholders have been consulted.

The Bill was amended in the Lords to ensure that nobody with a prescribed connection to a care home can carry out the pre-authorisation review. The Minister said that the Government will bring forward regulations in due course that will set out the different kind of relationships to a care home that will be prescribed. I have already made some comments on that, which I will reiterate briefly. It is important that the Government take a broad view of the relationships that should be prescribed and, indeed, proscribed. These few lines are in fact some of the most important safeguards in the Bill.

Alex Cunningham (Stockton North) (Lab): It is a pleasure to serve under your chairmanship for the first time this afternoon, Mr Pritchard. Opposition Members have expressed very real concerns about the additional responsibilities placed on care homes by the Bill and have questioned how that can work, particularly in situations in which there might not be a care home manager or if the care home management might be considered inadequate or not fit for purpose.

The Bill would allow care homes to choose any staff who they consider appropriate to undertake assessments. Who will make those decisions? If there is no manager, who else will take the decision? If the manager is deemed incompetent and does not know how to run a care home, how on earth can they make a decision on an assessor? I cannot understand that.

One best interests assessor expressed worry that care homes will want to undertake assessments as cheaply as possible, so many independent reviewers will only be able to review documents, rather than actually meeting the person in care and/or their family. I cannot understand how the Minister or Government Members think that care homes and hospitals should not consult with a range of independent reviewers, rather than potentially just one.

As hospitals will be able to employ their own independent reviewers, is the title of "independent reviewer" misleading and potentially dangerous? They will have a vested interest in the future care of a patient, and care providers, with their well-documented financial pressures, will have an interest in retaining the people that they care for. Surely the Minister agrees that assessors should be completely independent from care homes or hospitals and not just independent in name only. Does she agree that we have to do everything we can to remove this conflict of interest?

Another best interests assessor told me at a December meeting of the all-party parliamentary group on social work, which I chair, that although most care homes practise with integrity, the new proposal leaves the system open to abuse. I know that it would only be the odd one here and there, but that is the odd one too many. Under strict time and financial pressures, care

home managers are likely to keep recommissioning the same assessors who are sympathetic to the desires of the care provider. The Minister must agree that that is unsatisfactory and could effectively lead to a deprivation of liberty for the people in the care home.

If there is even a tiny danger of that because of the way the Bill is constructed, the Minister could be culpable for a person losing their freedom simply because, in some cases, "independent" turned out to be anything but. I know she will reflect on that, and I hope she will accept the amendment, but if she chooses not to, she must spell out exactly how she will ensure that some vulnerable person is not caught in a trap of her Government's making.

2.30 pm

Alex Norris: This debate harks back to what we talked about on Tuesday—the perverse incentives for those providing care to let individuals remain on care packages for their own commercial interests, whether consciously or subconsciously. There is definitely a conflict of interest there. We have not taken previous amendments on that, but at some point I believe a line will have to be drawn stating, "These are the very clear in law protections that we are putting down to ensure there is no conflict of interest."

It is entirely possible that the code of practice will refer to that and at the first stroke make it clear that it would be highly inappropriate for the assessments or reviews to be done by individuals who have a close connection or employment relationship with the provider themselves. That might be so, but we do not have that code of practice yet, and in any case, it is probably something that would be better in the Bill than in guidance, notwithstanding what the Minister has said previously about the standing of the code of practice.

We know that care facilities have narrow financial constraints. Their finances are tight and, as my hon. Friend the Member for Stockton North says, there is a pressure to provide as cheaply as possible. That is a clear and present danger. To avoid that concern and send a clear signal about those who conduct these types of reviews, now is a good time to put it in the Bill.

Caroline Dinéage: I am grateful to the hon. Members who have raised this important issue. I will address each amendment in turn.

On amendment 35, I agree that the independence of the pre-authorisation reviewer is of the utmost importance for ensuring that there is no conflict of interest in the pre-authorisation review. The Bill provides for separation between those who will authorise arrangements and those who will carry them out. The Bill is clear that anyone involved in a person's day-to-day care or treatment or with a prescribed connection to a care home cannot complete a pre-authorisation review. That was an amendment made to the Bill after discussion in the other place.

Dr Paul Williams (Stockton South) (Lab): Even though somebody might not have a prescribed relationship, informal relationships can develop, as my hon. Friends said. Our concern is that the existence of those informal relationships—they have been described as "cosy"—may well not be precluded by the protections afforded in the Bill.

Caroline Dinenage: That is what we must guard against. It cannot be done in the Bill, because coverage has to be extensive; that is exactly where the regulations that run alongside the Bill come into their own. They will set out how, if someone is working for a care home in a different location but run by the same provider, they will be excluded. They will also take a broader view, encompassing things such as agency staff, volunteers and other areas where people may have very reasonable concerns, as well as, of course, everybody who is employed in the care home.

Another point I want to stress is that the amendment would put hospital trusts, clinical commissioning groups and local health boards in a position where they are unable to arrange for someone in their organisation who is separate from delivering care and treatment to complete the pre-authorisation review. They would instead have to organise someone external, which to me seems a wildly unnecessary and bureaucratic exercise. We trust our NHS staff with our lives every single day. I am sure that is an unintended consequence and that Opposition Members are not saying that we cannot trust our NHS staff to complete those reviews. That is when I talk about unintended consequences of amendments to Bills.

Steve McCabe (Birmingham, Selly Oak) (Lab): This is a genuine question: what will the arrangement be for inspecting the work of the people who carry out the reviews? The Minister says that we trust our NHS staff, but we have a whole series of inspection and review processes to ensure that decision makers are complying with the law as intended. I think I asked a similar question the other day about the Care Quality Commission in relation to homes, which she said that she would look at. Will there be some similar oversight or random review process of the work that these people do? That would be one way—not a guaranteed way—of picking up whether there was an unsuitable relationship. At the moment, part of the fear is that we could end up in a situation where these people are set free to do this work, but without any guaranteed oversight of how they carry it out.

Caroline Dinenage: I laughed when the hon. Gentleman said, “This is a genuine question,” as if all the others he has asked have not been. I am sure that is not what he intended to suggest.

Steve McCabe: If the Minister will forgive me, it is just that she looks as if she does not believe me sometimes.

Caroline Dinenage: I think that might just be my natural resting face. I understand what the hon. Gentleman is saying, but it depends who we are looking at. If the pre-authorisation review is being conducted by a local authority for a care home, the oversight of the senior members of the local authority would apply, as well as the Care Quality Commission, which deals with the quality of care homes. If it is something like a hospital, people will monitor other people’s work as happens already within hospitals, CCGs and health boards.

The Bill says that somebody who is involved in the direct care of a particular person cannot mark the homework of another person. In something as big and broad as a local health board, a CCG or a hospital trust, which can be enormous, exclusively saying that

there could not be two people, who have never met each other before, looking at each other’s work seems to me a huge leap.

Amendment 36 is designed to prevent anyone with a prescribed connection to an independent hospital from conducting pre-authorisation reviews. I am sure that we can all agree that the pre-authorisation review is critical to the effective operation of the liberty protection safeguards in providing independent reviews of proposed arrangements that may deprive people of their liberty. We are talking about the most precious and vital of our human rights. The reviews have to be conducted by someone independent, who is not involved in the day-to-day provision of care or treatment of the cared-for person. That provides the necessary degree of separation to ensure that the model is compliant with the European convention rights.

By requiring authorisations in independent hospitals to be considered by an AMCP, regardless of whether the individual objects, we add a further level of security and build on other safeguards within the model. The AMCP will meet with the person, complete any relevant consultation and review assessments to decide whether the authorisation conditions are met. They can effectively veto proposed arrangements, if they feel that the proper conditions are not met. AMCPs will be professionals, such as experienced social workers, learning disability nurses and psychologists. Their practice will be regulated by and they will be accountable to their professional bodies—in answer to what the hon. Gentleman said earlier.

Alex Cunningham: The Minister just used the expression—I have lost my train of thought. I beg your pardon, Mr Pritchard.

Caroline Dinenage: I will take an intervention from the hon. Member for Worsley and Eccles South.

Barbara Keeley: I can see the Minister’s drift, but I do not understand how the Bill deals with a person who has a prescribed connection with a care home, but not a prescribed connection to an independent hospital. If it is important to have that in the Bill for a care home, why is it not important to have that in the Bill for an independent hospital?

Caroline Dinenage: It is in there—it is in both. In addition we have the AMCPs. As I said when discussed amendment 19, I fully understand hon. Members’ concerns around independent hospitals. I know the hon. Lady shares my concerns, and this matter has been raised by Members across the House. I said to her, in relation to amendment 19, that I wanted to go away and consider it further.

Alex Cunningham: I did not realise I was going to have to declare an interest in the Bill, in view of my lapse a few minutes ago. My question is about the reference the Minister made to the AMCP always meeting the person. Does the AMCP meet the person in every circumstance? We tabled amendments because we want everybody to have access to that sort of professional person—not just for them to see a report, but to actually see the person.

Caroline Dinenage: Yes, by requiring authorisation in independent hospitals to be considered by an AMCP, we add that extra level of scrutiny and build those safeguards into the model.

[*Caroline Dinanage*]

Given that I have committed to look at independent hospitals again, as I said in relation to amendment 19, I hope that the hon. Lady is willing to withdraw the amendment.

Barbara Keeley: I tried to ask the Minister another question. I do not want her just to go away and think about it. Is she prepared to look at adding the words “independent hospital”? Amendment 36 is a fairly simple addition of a few words. Is that what she is considering?

Caroline Dinanage: At this stage, I am prepared to say that I fully take on board and share the concern felt by the hon. Lady and others about ensuring that independent hospitals are not only seen to be above board, but are above board in every way that we can manage. That is why I have committed to looking again at everything that we have said so far to see if there is anything further we can do.

Barbara Keeley: I thank the Minister for saying that. She will need to go further and say that she is prepared to amend it on Report. Otherwise we will have to press our amendment to a vote. It is very important. I do not really understand the difference.

Ministers have accepted in the Lords that they want to prevent this important independent review from being conducted by a person with a prescribed connection to a care home. Responsible bodies include independent hospitals. I do not understand. If the Minister is prepared to go away and table a Government amendment we will not press this amendment to a vote. Otherwise, we will.

Caroline Dinanage: I appreciate the hon. Lady’s tenacity and dedication to this matter. I am afraid that, at the moment, all I can say is that I am committed to looking at it again.

Barbara Keeley: That was helpful to know, because for us it is unacceptable for an independent reviewer to be employed by the same organisation that delivers care and support. That is unacceptable in a care home and in an independent hospital. The Bill is drafted too narrowly and precludes only individuals who are personally involved in the delivery of care. We certainly need to vote on the amendment. It seems to me to defy logic to have such a provision for care homes, but not to be every bit as cautious about independent hospitals.

Question put, That the amendment be made.

The Committee divided: Ayes 8, Noes 9.

Division No. 9]

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
Dinanage, Caroline	Syms, Sir Robert
Moore, Damien	Whately, Helen
Morris, James	

Question accordingly negated.

Amendment made: 7, in schedule 1, page 16, line 1, leave out “prescribed connection” and insert—
“connection, of a kind prescribed by regulations.”.—(*Caroline Dinanage.*)

This amendment is to make it clear that a regulation making power is being conferred by paragraph 21(1)(b) of the new Schedule A1.

2.45 pm

Amendment proposed: 36, in schedule 1, page 16, line 2, at end insert “or independent hospital.”.—(*Barbara Keeley.*)

This amendment would ensure that the person conducting the pre-authorisation review does not have a prescribed connection with an independent hospital.

Question put, That the amendment be made.

The Committee divided: Ayes 8, Noes 9.

Division No. 10]

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
Dinanage, Caroline	Syms, Sir Robert
Moore, Damien	Whately, Helen
Morris, James	

Question accordingly negated.

Amendment proposed: 38, in schedule 1, page 16, line 4, after “if” insert—

“the cared-for person is aged 16 or 17 and in other cases if”.—(*Barbara Keeley.*)

This amendment makes provision for an AMCP to be involved in all cases involving 16 and 17 year olds.

Question put, That the amendment be made.

The Committee divided: Ayes 8, Noes 9.

Division No. 11]

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
Dinanage, Caroline	Syms, Sir Robert
Moore, Damien	Whately, Helen
Morris, James	

Question accordingly negated.

Amendments made: 8, in schedule 1, page 16, line 8, leave out “or”.

This amendment is consequential on Amendment 9.

Amendment 9, in schedule 1, page 16, line 12, at end insert—

“(c) the arrangements provide for the cared-for person to receive care or treatment mainly in an independent hospital, or

- (b) the case is referred by the responsible body to an Approved Mental Capacity Professional and that person accepts the referral.”—(*Caroline Dinéage.*)

This provides for two additional situations where a pre-authorisation review must be carried out by an Approved Mental Capacity Professional.

Amendment proposed: 37, in schedule 1, page 16, line 12, at end insert—

- “(c) the arrangements include the use of physical restraint, or
- (d) the arrangements include the use of sedating medication, or
- (e) a person interested in the cared-for person’s welfare has objected to the arrangements, or
- (f) the cared-for person owns or has the right to occupy a different property to the property in respect of which the arrangements apply, or
- (g) the cared-for person is receiving covert medication, or
- (h) the cared-for person is restricted from having contact with named persons, or
- (i) the cared-for person is being detained in a mental health establishment for the purposes of treatment of a mental disorder, or
- (j) there is a less restrictive option for the cared-for person’s care or residence available, or
- (k) the cared-for person, or a person interested in the cared-for person’s welfare, requests the review be by an Approved Mental Capacity Professional.”—(*Barbara Keeley.*)

This amendment provides for access to an Approved Mental Capacity Professional in specific circumstances.

Question put, That the amendment be made.

The Committee divided: Ayes 8, Noes 9.

Division No. 12]

AYES

Cunningham, Alex	McCabe, Steve
Debbonaire, 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.

Amendment proposed: 39, in schedule 1, page 16, line 12, at end insert—

- “(c) the arrangements provide for the cared-for person to receive care or treatment, and it is reasonable to believe that the cared-for person does not wish to receive the specific kinds of care or treatment which the arrangements provide for, or
- (d) it is reasonable to believe that the cared-for person does not wish to receive care or treatment overall.”—(*Barbara Keeley.*)

This amendment broadens the criteria of objection in the Bill, so that it applies to objections to the kinds of proposed care or treatment to be given, or to an overall objection to care or treatment.

Question put, That the amendment be made.

The Committee divided: Ayes 8, Noes 9.

Division No. 13]

AYES

Cunningham, Alex	Dhesi, Mr Tanmanjeet Singh
Debbonaire, Thangam	Keeley, Barbara

McCabe, Steve	Sherriff, Paula
Norris, Alex	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.

Amendment made: 10, in schedule 1, page 16, line 31, leave out

“(whether or not paragraph 21(2) applies)”.—(*Caroline Dinéage.*)
This amendment is consequential on Amendment 9.

Barbara Keeley: I beg to move amendment 42, in schedule 1, page 16, line 38, leave out

“if it appears to the Approved Mental Capacity Professional to be appropriate and practicable to do so”.

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

The Chair: With this it will be convenient to discuss amendment 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”.

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

Barbara Keeley: Much of our conversation on the Bill has so far focused on the role of approved mental capacity professionals, when they should be appointed and who they should be. We have given this topic so much time because AMCPs are a fundamental safeguard built into the proposed LPS system. This independent review process will prevent the deprivation of liberty from being applied for and approved within one system.

We tabled several amendments designed to strengthen the provisions of this safeguard and prevent anybody from being wrongly deprived of their liberty. I am sorry that the Government have not accepted our amendments, which would have provided for more people to have access to an approved mental capacity review. These reviews would have ensured that it is not only people who actively object to arrangements or are in independent hospitals who have access to the safeguard that an AMCP review would provide.

None the less, we are determined to continue to improve the Bill, so that those people who do not have access to an AMCP review are treated properly. Amendments 42 and 43 provide for AMCPs to meet the cared-for person in all cases that they review. We just had a little exchange about this, and the Minister seemed to say that there would always be meetings. I hope she meant that.

Mr Tanmanjeet Singh Dhesi (Slough) (Lab): On requiring the AMCP to meet the cared-for person before making their determination, the wording—

“appropriate and practicable to do so”—

is just not correct. Does my hon. Friend agree that we have a duty of care to each and every individual? Surely each and every life is as important as the next. We must do our level best in all circumstances, not only when it is appropriate and practicable to do so.

Barbara Keeley: I absolutely agree. My hon. Friend makes such a good point.

The Minister in the Lords, Baroness Stedman-Scott, said:

“We are clear that our intention is for approved mental capacity professionals to meet with the cared-for persons in almost all cases.”—[*Official Report, House of Lords*, 15 October 2018; Vol. 793, c. 371-72.]

That qualification—“almost all cases”—creeps in again. Our proposal would go a little further and require AMCPs to meet the cared-for person in every case that they review. This is a crucial part of reviewing an application. It cannot be right that the role of the independent reviewer should be limited to simply reading a set of papers and certifying that what is contained within them meets the requirements to authorise a deprivation of liberty. That would be no safeguard at all.

I have mentioned the case of *Y v. Barking and Dagenham*, which saw a young man held in an inappropriate care setting for more than two years. One major failing of the local authority and the independent social worker in that case was to simply accept the assertions made by care home staff, which led to nobody challenging the changes in *Y*'s condition, denying him the safeguards he so badly needed.

There are, so far as I can see, only two objections to requiring the AMCP to meet the cared-for person. The first is that it might be an excessive burden on the cared-for person. My response to that is simple: we are not asking for the AMCP to carry out a protracted, in-depth cross-examination of any cared-for person. It need not take hours or involve directly checking every minute detail of the authorisation record with the cared-for person, which would be burdensome in itself. We would not want to implement a system that requires somebody to go through a lengthy experience like that. However, that is not the same as not wanting the AMCP to meet the cared-for person, which could be for only a few minutes.

Steve McCabe: Does my hon. Friend share my surprise that these words have actually been included in the Bill? We have heard quite a bit from the Minister about the things she has not wanted to add to the Bill because she has not wanted to send the wrong signal or be too rigid in her approach. Does my hon. Friend agree that, if the Minister's argument is that there could be genuine circumstances where it is not necessary to meet the person and the phrase would apply, that would be a matter of professional judgment that could be spelled out in the code of practice? By putting it in the Bill, the Minister succeeds in giving a clear signal that she expects there to be lots of circumstances where the person will not be seen.

Barbara Keeley: That is really worrying.

As I was saying, the meeting could be for just a few minutes to confirm that the cared-for person appears to present with the behaviours that are described in the application for deprivation of liberty. A meeting, no matter how short, could confirm or deny what is written in that application—whether a person is visibly happy or unhappy with arrangements and whether the arrangements appear to be proportionate.

To give a hypothetical example, physical restraint is not unheard of in cases under the deprivation of liberty safeguards—we know of many cases where restraint is

being used. It might not be unreasonable to look at a level of physical restraint on paper and feel that it is needed to prevent harm to others, but seeing that person in the flesh may make it clear that the subject of the application is underfed and would not present a significant physical threat. Cases such as that would perhaps be rare, and I do not want to suggest that care providers would seek to over-restrain people as a matter of course, but the Minister and I, and many hon. Members, understand that it does happen. In such a case, the meeting with the cared-for person would tell the AMCP whether the arrangements were overly restrictive.

A second objection might be that meeting a cared-for person would involve extra cost. As it stands, the responsible body decides whether an AMCP should be brought in to review a case, so responsible bodies, including local authorities, must be properly resourced to bring AMCPs in on all cases where they are needed. We will touch on resources later in the debate. The reason that the meeting is important is simple: it may be that the cared-for person is not completely as they are described on paper or by other people that the AMCP meets in the process of their review.

I return to the case of *X*, whom I discussed previously, to illustrate why that is so important. For hon. Members who cannot remember that far back in our discussion—we have had several case studies—*X* was a 99-year-old woman residing in a nursing home. Daily, if not hourly, she was objecting to where she was. She wandered up and down the care home objecting to the arrangements that had been put in place. Of course, nobody in the care home had bothered to identify that *X* was objecting to the arrangements and that, as such, she would require a deprivation of liberty safeguards application to be made.

The Government's refusal to accept some of our earlier amendments on approved mental capacity professionals means that *X* would not have received an AMCP review, given that nobody had identified an objection. If an AMCP had been appointed, however, it would have been critical that they met *X*, because anything else would have led them to simply accept the word of the nursing home, which clearly felt that *X* was content with the arrangements, despite the evidence to the contrary.

Meeting the cared-for person would allow the AMCP to stress-test the other elements of the application that they are reviewing. It would provide them with primary evidence, against which they can hold everything else they are given. I hope that the Minister agrees that that is important—indeed, that is undoubtedly why the Bill contains provision for approved mental capacity professionals to meet most of the cared-for people whose cases they are reviewing. Our amendment would simply extend that slightly to ensure that nobody falls between the cracks.

As we have discussed, the AMCP will not be involved in the majority of pre-authorisation reviews. They will be involved only in higher-risk cases where extra safeguards are needed. Given that the AMCP is being brought into the process because the cared-for person is at risk of being inappropriately deprived of their liberty, it seems perverse not to require that they at least meet the cared-for person.

The Bill provides for the approved mental capacity professional to
“meet with the cared-for person, if it appears”
to them
“to be appropriate and practicable to do so”.

Dr Williams: On that word “appears”, the only information that the AMCP will have to judge that on is information provided by other people. If they do not get the chance to make any kind of independent assessment themselves, there is the risk that other people’s judgment will influence their judgment.

3 pm

Barbara Keeley: I agree, and it is words like those that we have a problem with. The Government have said that there will be guidance in the code of practice that will address what that means and what should be done in cases where it is neither “appropriate” nor “practicable”. The Opposition cannot yet see the code of practice and, therefore, we simply cannot accept assurances about its contents. The only way that we can guarantee that the Bill will work as intended is to put provisions in the Bill.

I made a point on Tuesday about the code of practice that I will repeat now, because it is an important one. Statutory codes do not exist without a statute, and the majority of laws do not have a code of practice. Codes are there only for when non-legal people are using a law directly. No one expects non-legal people to read or necessarily understand a statute, and so a code is provided. Such a code follows what is in statute and sets it out in lay terms and at length, but it does not exist if the obligation in law is not clearly set out. That is what we want to address. Where a case requires review by an AMCP, that professional should be required to carry out their review in the fullest manner possible, and that must mean that they meet the cared-for person.

If the Government want to set out the limited set of circumstances where they do not feel that that should be the case, they should do so in the Bill, as then we can give their proposals the scrutiny that they are due. This is not an issue that should be relegated to a code of practice. If the circumstances in which a meeting is not required are too broad, there is a risk that people will be inappropriately deprived of their liberty, despite having had a review from an approved mental capacity professional. That would be unacceptable. We cannot allow decisions of such importance to be made in a code of practice that we cannot see. As such, I hope that the Government will accept the amendment, and ensure that all the high-risk cases to which we are referring receive the full review that they need, including a meeting with the AMCP.

Alex Cunningham: I know that the Minister is well intentioned with this Bill, but it remains the case that the cared-for person is not always at the heart of it. That is a major worry, not just for us, but for people across our society. The issue has been brought to me by the Law Commission, by the Alzheimer’s Society, by experts who work for pro-liberty groups and by constituents who have taken the time to write to me on this point specifically.

It is baffling to me that the approved mental capacity professional is not required in the Bill to meet the cared-for person. Yet they are the professional who will decide the future of that person—whether or not they

lose their liberty. None of us would want that for one of our relatives, would we? We simply would not want that to happen.

It may well be that the person in care does not have the capacity for a meaningful conversation to express their wishes and beliefs, but the assessor does not know that unless they meet them. It is essential. If the person in care does have some capacity, which I suspect would be identified by the assessor, surely their views, however communicated, ought to be taken into consideration—and, who knows, we might avoid the deprivation of liberty for that person.

I have already raised the importance of the role of speech and language therapists. I think the hon. Member for Faversham and Mid Kent mentioned them this morning, and I know the Minister accepts the role that they have to play. They may well help identify the wishes of the cared-for person simply by enabling them to communicate, and surely there should be a separate assessment of the person’s views. If they are opposed to the accommodation or the care plan, an independent advocate should act in that person’s best interest.

Evidence submitted by Rethink Mental Illness raises the important point that nobody should have an advocate forced upon them, especially if they do not want one. However, advocates should still be appointed, even if they are then removed. That would ensure that the opinions of both the advocate and the person in care are taken into consideration, and that a judgment is made by a professional on the need for representation. We will debate advocacy later on in this Committee and I will speak to it in more detail then.

Ultimately, the amendment is about ensuring that the approved mental capacity professional has met with all the appropriate parties, including the person in care themselves, so that they can make the most informed decision possible. Not only does mandating the AMCP to meet the cared-for person before making the decision ensure liberty and respect is given to the person in care; it makes the professional’s job considerably easier, as diagnosis is more effective when they have met the person. As was raised in the evidence-gathering, in some cases simply meeting the cared-for person can make it obvious whether the person has capacity. As I said earlier, I suggest that no one but a professional is fully equipped to make that judgment.

Kay Matthews, from the deprivation of liberty safeguards team in the Borough of Poole local authority, wrote to the Committee and said that she would like to see the

“Wishes of the person—past and present”—

I emphasise “past and present”—taken into consideration in the Bill. She went on to say:

“I would like the person’s wishes—what they want, what they would have wanted—to be central to the assessment. I would like it stipulated that people making decisions on behalf of the person ought to support the person who lacks capacity to make the decisions they would have made if they still had capacity; that the person’s wishes are to be followed unless there is evidence that there is or could be seriously dangerous or significantly distressing consequences for the person.”

Ms Matthews says that that is vital because,

“in practice, some staff and relatives see a lack of capacity as a green light to over-ride the wishes of the person to meet their own needs (which are usually to feel less personally or professionally anxious about the person).”

[Alex Cunningham]

She says that in her 10 years of experience she has seen it happen “again and again”. It is not only ineffective, but potentially dangerous that the Bill would allow the AMCP to basically come up with a verdict by just reading the in-care person’s file or talking to everyone else apart from the person themselves. I understand that because of tight budgets and cuts, care homes need to save money and time, but that comes at the cost of the in-care person.

While I am on the subject of costs in care homes, can the Minister tell me what assessment she has made of the potential costs that will fall on care homes from their extended role in the process? Has she had any data from the industry on that and, assuming she has, will she publish that assessment and data so that the Committee can understand the additional financial burden she is placing on the sector? Can she also advise us of who will be responsible for those costs? Will it be the hard-pressed care home that has to absorb them? Will there be a charge on the individual if they happen to meet their own care costs? If they do not, will that pass to the local authority, the health board or the clinical commissioning group? Who will pick up those costs? If the Minister does not have the data, will she commit to getting some before Report stage?

Returning to the amendment, do the Government want to be seen to be ignoring the voices of people in care? Most of all, does the Minister want to see people in care deprived of their liberty for the sake of what I see as one essential step in the process? The Mental Capacity Act should be an Act that is designed to support, listen to and respect the opinions of those being cared for. It should not make it easy for other people to quash or ignore the decisions of that individual.

Alex Norris: I have specific trouble with the word “practicable”. From my time in local government—I know things have not got better in the 18 months since then—I would argue strongly that the current assessment workload is not practicable for the individual. Earlier in our consideration of the Bill, my hon. Friend the Member for Birmingham, Selly Oak compared social work case loads when he was active in the profession with what they might be today. Putting in legislation how practicable it is for an individual to go and do an assessment creates the chance of a loophole that does something that we do not intend the Bill to do.

It is striking, as my hon. Friend the Member for Birmingham, Selly Oak said, that the Minister has at all turns been careful about what has been put in the Bill so as not to create future loopholes. We know that traditionally, this area has been tested very heavily in case law and it will be tested again in court. She has been very careful not to put those words in there, but this one is problematic. We know that in a time of rising demand and diminished resources, there will be pressures. To put something in that suggests that if it is just too difficult for a social worker to go and do an assessment, that assessment will not take place, is dangerous. I do not think that is what we are trying to do. I believe that it will lead to a serious problem.

The market for providing very high-need care is not very developed. We are talking about very small numbers of people, so there are not masses and masses of providers. When it comes to all of us being older, there are

facilities in all constituencies and communities for older people to have residential care, because it is a high-demand area. The very specific, individualised care packages that involve things such as depriving liberty are not found in every community. Often, we hear horror stories in children’s mental health of people being sent a long way away to find the right facility. Are we then saying that a reassessment might not be practical, because the AMCP is in Nottingham and the care placement is a long way out on the east coast in Lincolnshire? That might not be considered by an individual to be a “practicable” thing to do, so I have a real problem with that word.

If the Government are saying that there are circumstances—my hon. Friend the Member for Worsley and Eccles South mentioned the exchange in the other place—where they are relaxed about an AMCP not seeing an individual face-to-face, I think that is a bad idea, for the reasons detailed by my hon. Friend the Member for Stockton North. If the Government are saying that there are circumstances where they are relaxed about that, they should name them and put them on the face of the Bill and be exhaustive with them, so that we can be clear and test the will of the Committee as to whether we agree.

We need to have a greater sense of what we are saying in respect of dialling back people’s rights to see a qualified professional when they are having their liberty removed. If we are rolling that back, let us be really clear about how we are rolling it back—the exact circumstances and what recourse they might have if they or their carers believe that to be wrong. I think this is out of step with all the discussions we had on Tuesday and this morning. I believe it creates a loophole and we need greater clarification.

Caroline Dinanage: I thank those hon. Members who have spoken and tabled these amendments. Amendments 42 and 43, as we have heard, would require an approved mental capacity professional to meet with the person in every case where they are carrying out a pre-authorisation review, rather than—as we propose and as is written on the face of the Bill—where it is “appropriate and practicable”.

The Bill currently states that where an AMCP is carrying out a pre-authorisation review, they must meet with the person where practicable and appropriate. In the vast majority of circumstances it will be practicable and appropriate. This qualification comes from the Law Commission draft Bill, which recognised—we agree with this—that the AMCP will be required to meet with the person in virtually every case. This is an important protection within the liberty protection safeguard system.

Alex Cunningham: Will the Minister give way?

Caroline Dinanage: Let me make a bit of progress and I will hopefully answer the hon. Gentleman in the process, but if I do not, he can intervene again.

The exceptions where it would not be practicable and appropriate would depend on the circumstances of the case. Things such as workload, cost and distance would not count under the qualification of not appropriate or practicable. It might be not appropriate or practicable, for example, where the person is in a coma and the family has requested that the AMCP does not interview the person, because it would cause distress. Another

example is where someone at the very end of their life needs to be deprived of their liberty in their last few days, and they do not want to see an AMCP. In many cases, we feel it would not be appropriate to override the person's best interests and force them to meet with an approved mental capacity professional.

Mr Dhesi: The Minister makes some very good points that I have sympathy with, but why cannot we simply include what she says in the code of practice? Setting it in stone in the Bill gives completely the wrong signal to medical care professionals: it makes it the norm rather than the exception.

3.15 pm

Caroline Dinéage: I might turn that point round on the hon. Gentleman: we are indeed including it in the code of practice. The Bill states that the AMCP will meet the cared-for person except in the very rare circumstances in which that is not practicable or appropriate. We will set out those rare exceptions, including case studies, in the code of practice—a much better place for them than the Bill, which cannot include such case studies to flesh out what we are trying to achieve.

Dr Williams: As the Minister describes it, the assessment will take place unless it is inappropriate or impractical, so perhaps the Bill ought to say that.

Caroline Dinéage: I thank the hon. Gentleman for that clarification, but we may be dancing on the head of a pin slightly. To my mind, the meaning of amendment 42 is that in all cases the AMCP should turn up and see the person, whereas we are saying that that should happen in all cases, with some very small exceptions. With that reassurance, I hope that the hon. Member for Worsley and Eccles South will withdraw the amendment.

Barbara Keeley: The Opposition believe, as the debate has shown, that the amendment would be a crucial safeguard. We have spent a lot of time discussing the code of practice, which is beginning to seem a bit like a unicorn—it is something out there that might or might not appear and be useful.

The amendment is important because the AMCP will have to be satisfied that the reality of the situation matches what is in the application. I am sorry that we are so often having to doubt care home managers and people working in independent hospitals, but that is only because we come across such appalling cases. Earlier today I cited the case of a young man in a care home who was deprived of his liberty for two years and restrained hundreds of times; other cases include people having their arms broken through the use of restraint techniques. All these things happen, and it does not help if an AMCP is prepared to accept the word of the care staff or the people in the independent hospital—the very people who have used the restraint that broke the arm or caused the damage.

I am afraid that we therefore wish to persist in pressing the amendment. I have made it clear that the meetings would not need to be burdensome, and I fully accept that there are circumstances in which a person doing such work will have to be flexible, but I would expect people with the appropriate knowledge, skills and experience to understand how to deal with an end-of-life care case and with the needs of very vulnerable people.

Alex Norris: Unless I am missing something, the Bill states that

“the Approved Mental Capacity Professional must...meet with the cared-for person, if it appears to the Approved Mental Capacity Professional to be appropriate and practicable to do so”.

The word “if” does not imply to me that the exception should apply only in an extraordinarily small minority of cases.

Barbara Keeley: As we have discussed, the AMCP is likely to be engaged only in high-risk cases anyway, so we are not proposing something burdensome. The meeting need only be a few minutes long; I am not suggesting that it has to be exhaustive. It needs to confirm that the condition of the cared-for person matches what is in the application. In a case involving deprivation of liberty, I think family members would welcome someone saying, “I am only here to check that the facts bear out what I am reviewing.” It would be a further safeguard for people in high-risk cases.

We should reject anything that would undermine the AMCP's ability to make a full and thorough assessment of every case. We wish to press the amendment to a vote.

Question put, That the amendment be made.

The Committee divided: Ayes 8, Noes 9.

Division No. 14]

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 negatived.

Barbara Keeley: I beg to move amendment 40, in schedule 1, page 17, line 2, at end insert—

“23A If the Approved Mental Capacity Professional determines that—

- (a) the authorisation conditions are not met, or
- (b) that the authorisation conditions are met but that—
 - (i) the cared-for person or a person interested in the cared-for person's welfare objects to the arrangements, or
 - (ii) the cared-for person would wish to object to the arrangements but cannot communicate an objection

the Approved Mental Capacity Professional must notify the responsible body within 48 hours that a referral to the court is likely to be required.”

This amendment requires an AMCP to notify the responsible body within 48 hours if they determine that the authorisation conditions are not met, or an objection has been raised to the arrangements.

With your permission, Mr Pritchard, I will discuss amendments 40 and 41 together, because they make sense together. They are an important means of filling a statutory grey area in the Bill. They set out what would

[Barbara Keeley]

happen if the AMCP—the person we have just been discussing—decides to reject an application after they have reviewed it. This is not currently contained within the Bill. We believe it leaves a statutory grey area, which needs addressing.

It is important because it is bound up first with the cared-for person's entitlement to appeal to the Court of Protection and secondly with the enablement of their right to appeal. As the judgment in the case of Steven Neary found, the entitlement to appeal is more subtle than simply giving someone the right to appeal. Article 5, paragraph 4 of the European convention on human rights is not a mere "entitlement" to appeal against any deprivation of liberty, rather that the person must be supported and enabled to do so if they wish. Previous European case law has established that this support must not rely on the good will or discretion of others, or require the person to have any particular prospects of success. Support to exercise rights of appeal should be based on whether the person wishes, or would wish, to appeal.

The case of *S v. Russia* may be particularly instructive to the Committee. *S* was a man with learning disabilities, who had been deprived of his liberty by a court order made without his knowledge. The order had also made his mother his legal guardian and representative. Not only did she not facilitate an appeal to a higher court, she applied to have *S* placed in a psychiatric hospital. Despite repeated attempts, authorities denied his request to appeal. When *S* took his case to the European Court of Human Rights, it was made clear that his rights under article 5, paragraph 4 had been breached, as the right to appeal had not been made directly available to him. I hope Members will bear that case in mind as we proceed. Relying on family members, who may have different wishes or feelings from the cared-for person when it comes to the right of appeal, is fraught with risks. We have touched on this previously.

This is an area in which the current system is woefully deficient, and the Government are missing an opportunity to improve the situation. The deprivation of liberty safeguards system places a huge amount of weight on the cared-for person, or those close to them, to initiate the rights of appeal. At the moment, it is only as the very last resort that the supervisory body—what we now know as the responsible body—is expected to ensure that a case is referred to the Court of Protection, and even this provision has only recently been established.

Case law in this country has reinforced the concept of enablement of appeal. In the Neary judgment, when it became apparent that the DoLS placed too great a burden on family or friends to exercise rights of appeal, the Court of Protection concluded that

"there is an obligation on the State to ensure that a person deprived of liberty is not only entitled but enabled to have the lawfulness of his detention reviewed speedily by a court."

The fact that this has so far been established only through case law means it is not an explicit statutory obligation.

However, the process for appealing to the Court of Protection is convoluted and unclear because so many players bear responsibility for initiating appeals. In the more recent case of *AJ*, the judge held that the primary responsibility still lies with the relevant person's

representative. An advocate must expedite the application if the RPR has failed to do so. I apologise for the amount of acronyms that are involved in this Bill; it makes it quite hard work. If these have failed and the person's right of appeal has not been enabled, then the supervisory body must apply itself. This can pit a single, unpaid family member against what can seem like a forbidding system. I have heard of one case where the cared-for person wanted to appeal to a court and was being represented by their 89-year-old friend. This friend reported that she felt that

"the full force of the state was battling against her."

Moreover, she said that she faced constant suspicion and was at a constant disadvantage when she was challenging the local authority. That is a major burden to place on somebody who will probably not have any legal expertise, but the Government have done nothing in this Bill to change it.

An alternative and more straightforward approach would be to place a clear statutory duty on the responsible body to ensure that applications to the Court of Protection are made when the person's article 5(4) rights are "engaged". The role of family members, as "appropriate persons", and that of the independent mental capacity advocates, or IMCAs, would then become the backstop position, although I hesitate to use the word "backstop" at the current time. [Laughter.] However, in this case it looks as if one would be useful.

The responsible body is much more likely than a family member to understand the relevant guidance and case law on when rights of appeal are "engaged". It should know whether alternative means to resolve any dispute are likely to be successful. And unlike the person's family, friends and even advocates, responsible bodies will have ready access to in-house legal advice, and skilled and experienced professionals who work with the Mental Capacity Act 2005. The code of practice and developments in case law can provide guidance to responsible bodies about when these rights of appeal are "engaged", which would be far more transparent, and much less complex and ad hoc, than the current system.

Once again, I want to be clear that something that is set out in the code of practice is not a right. As is set out in the European convention on human rights, and as was reinforced by the Neary case, support to appeal is a right. As such, it should appear in the Bill. There is an important point about what the Government have achieved through amendment 4, which has already removed one protection in relation to one crucial prerequisite to the right of appeal, and that is information being given in advance.

The removal of paragraph 13 and the provision in sub-paragraph 5 are also critical changes that weaken the right of appeal. Before it was altered, that paragraph read:

"The responsible body must ensure that cases are referred to court when the cared-for person's right to a court review is engaged."

In deleting paragraph 13, the Government have also removed obligations on advocates—the IMCAs—to assist the cared-for person in understanding and exercising their relevant rights, and the obligation on the responsible body to

"ensure that cases are referred to court when the cared-for person's right to a court review is engaged."

In deleting paragraph 13, the Government have reverted to the deficient system that we currently have. They have removed any provision for the responsible body to enable appeals, instead returning the full weight of this burden to the cared-for person and those close to them. For Labour Members, that is not acceptable and the Government must reinstate that provision as soon as possible. Ensuring that the responsible body has a duty to refer cases to the Court of Protection when this right is engaged is the only way to ensure that appeals are not hampered by lack of resources, confidence or legal know-how.

In cases where the authorisation conditions are not met, we are calling for the approved mental capacity professional, or AMCP, to be required to inform the responsible body that a referral to the Court of Protection is likely to be required within 48 hours. That would provide certainty about what should be done in cases where the authorisation conditions are not met, and it would counteract the weakening of the safeguards through the removal of sub-paragraph 5 of paragraph 13.

An important principle is being missed here, a point that was made by Lucy Series in the evidence that she submitted to the Committee. Recourse to the Court of Protection is not, as it is sometimes characterised in debates on the Bill, a sign of failure. Instead, it is a sign that the system is working effectively to place limits on the powers of health and social care professionals to impose a course of action on a person or their family against their wishes, without independent judicial oversight.

I hope the Minister will respond to this issue directly, because it is of crucial importance that her desire to create—as the Government see it—a “streamlined” system does not interfere with the fundamental right of cared-for people to appeal.

Before I press this amendment to a vote, I will also make a brief comment on the Court of Protection more generally. In its report, the Law Commission recommended that there should be a review to determine the appropriate court to rule on these matters. It said that such a review should be carried out

“with a view to promoting the accessibility of the judicial body, the participation in the proceedings of the person concerned, the speedy and efficient determination of cases and to the desirability of including medical expertise within the panel deciding the case.”

The Government initially accepted that proposal, but they have made no move to include it in the Bill. It seems a bit late in this process to adopt the radical reforms that would be needed to the practice and procedure of the Court of Protection, but will the Minister commit to engage with stakeholders to try to improve the way the court operates?

3.30 pm

Before I conclude, I want to return to the case of Steven Neary, which made it absolutely clear that rights cannot exist in isolation; they must be enforceable and enactable. Cared-for people have a right to appeal to the Court of Protection. If the state expects that to be carried out solely by a friend, a family member or even a paid advocate, it is not enabling the use of that right, and that is simply not acceptable. The Court of Protection is the final safeguard for people who are deprived of their liberty incorrectly. The Government should encourage the use of that system, rather than make it even harder to access. Our amendments aim to rectify that, and I hope the Government will accept them.

The Chair: I call the Minister.

Caroline Dinenge: Am I speaking to amendments 41 and 40?

The Chair: We are debating amendment 40 now, and 41 later.

Caroline Dinenge: Thank you for that clarification, Mr Pritchard.

I thank hon. Members for tabling this amendment. I agree that it is vital that where authorisation conditions are not met and the proposed arrangements are reconsidered, the care or treatment that is provided should not deprive someone of their liberty. Arrangements should be more proportionate in such cases. It is essential that the responsible body and others, such as care providers, are notified swiftly. The new model will include a wide range of people with very different circumstances. In some cases, the responsible body should be notified very quickly.

May I seek further clarification?

The Chair: May I say, to help the Minister and the Committee, that the amendments 40 and 41 were coupled together due to agreements that were made outside the Committee? The Minister will have an opportunity—probably next week—to speak to amendment 41.

Caroline Dinenge: But amendment 40 talks about a 48-hour time limit.

The Chair: For the ease of the Committee, if the shadow Minister is happy, the Minister can speak to amendments 40 and 41 if she wishes. She may want to speak again next week, or she might want to let that opportunity go by. For the flow of the Committee—if the Committee is happy—let us do it now and crack on.

Caroline Dinenge: I am very grateful for that clarification, Mr Pritchard. I have mixed my contributions on the two amendments together, so I will combine the two, if that is all right with the Committee.

The Chair: We are delighted to hear about amendment 41 earlier.

Caroline Dinenge: I am sure we all agree that the role of an AMCP is incredibly important in ensuring that cases under liberty protection safeguards are identified as needing to be referred to a Court of Protection, particularly because they will be reviewing arrangements where objections have been raised by the cared-for person or other people on their behalf. We are very clear that if a person wants to challenge their authorisation in the Court of Protection, they have the right to do so.

I assure hon. Members that the responsible body has a responsibility to ensure that individuals who want to bring a challenge, in line with their article 5 rights, have access to the Court of Protection, as they currently do under the DoLS scheme. That applies, in particular, where a person should have had their case taken to court for a decision, but for some reason that has not occurred. The Bill does not change that. We agree that we expect AMCPs to communicate the outcome of their review swiftly to the responsible body. That will include cases where cared-for people raise objections that may require referral to the Court of Protection.

[Caroline Dinenage]

However, it is not only AMCPs who may be aware of objections. For example, people may raise matters directly with a responsible body or someone providing care or treatment, who may, in turn, raise concerns directly with the responsible body. Reviewers may become aware of an objection during a review of an arrangement that has been authorised. I am concerned that if we specify in the Bill that AMCPs have that duty, it may be felt that only AMCPs can and should identify such cases. Others, such as healthcare staff, should also be able to raise concerns directly with the responsible body, which can consider whether an application to court is swiftly required.

On amendment 40, I agree that it is vital that where authorisation conditions are not met, the proposed arrangements are reconsidered. The new model will include a wide range of people with different circumstances. In some cases, the responsible body should be notified much sooner than after 48 hours. My big concern is that 48 hours risks becoming a target.

The Bill already provides for people to have access to the court to challenge an authorisation, so if, after a review by an AMCP, a decision is made that the conditions are met but the cared-for person or carer still objects, they could take the case to the Court of Protection for challenge. The amendment also requires that where a cared-for person would wish to object but cannot communicate that, that is notified to the responsible body within 48 hours, as likely requiring a referral for challenge at the Court of Protection.

Finally, that is also why it is important that the LPS assessments are of good quality, and that the consultation takes place with the range of people necessary to identify the person's wishes and feelings, including family and carers. I hope that I have been able to provide the necessary reassurance and that the hon. Member for Worsley and Eccles South is willing to withdraw the amendment.

The Chair: Before I call the shadow Minister, I inform the Committee that the vote on amendment 41—if there is a vote—will be taken next week, although the Committee has agreed to hear representations from the Front-Bench spokespeople on both amendments today. Amendment 40 will be taken shortly.

Barbara Keeley: Thank you for making that clear, Mr Pritchard. It is a small Bill, but grouping some of the amendments is quite difficult.

Our amendments set out what would happen if an AMCP decided to reject an application on review, which is a critical moment for the cared-for person. I hope that I have made it clear that people must be not only allowed to exercise their right to appeal, but enabled and supported to do so. As I said earlier, the Government have weakened that ability, because their amendment 4 removed paragraph 13 of proposed new schedule AA1, which said that

“cases are referred to court when the cared-for person's right to a court review is engaged.”

In large part, our need to press these amendments is a consequence of what the Government have done.

I hope that I have made it clear that we cannot expect cared-for people and their family members to manage the process of appealing through the courts totally

unaided. It is a massive burden. I gave the example of an 89-year-old trying to help somebody take a case through appeal.

The reason for notifying the responsible body is that it is best placed to enable and support the right to appeal, which is the key thing that we want to bring forward. Responsible bodies must be under a duty to facilitate appeals. The Government have removed that duty through their amendment on the right to information. Our amendments seek to undo that damage and support cared-for people to exercise their right to appeal.

Question put, That the amendment be made.

The Committee divided: Ayes 8, Noes 9.

Division No. 15]

AYES

Cunningham, Alex	McCabe, Steve
Debbonaire, 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.

Steve McCabe: I beg to move amendment 48, in schedule 1, page 17, line 30, leave out “12 months” and insert “3 months”.

This amendment is designed to encourage reviews and appropriate authorisation by making it harder to detain someone for such a lengthy initial period.

The Chair: With this it will be convenient to discuss the following:

Amendment 49, in schedule 1, page 18, line 24, leave out “12 months” and insert “3 months”.

Amendment 44, in schedule 1, page 18, line 24, leave out from “less” to end of sub-paragraph (1)(b).

This amendment limits the period of renewal of any authorisation to twelve months.

Amendment 50, in schedule 1, page 18, line 25, leave out “3 years” and insert “6 months”.

This amendment would limit renewal periods to a maximum of 6 months.

Steve McCabe: It is a pleasure to see you in the Chair, Mr Pritchard. I should probably begin by saying to the Minister, just so there is no doubt, that these are genuinely probing amendments. As the Minister will know, Sir Simon Wessely recommended much shorter periods of detention in his original proposals regarding the Mental Health Act 1983, and of course there have been strong arguments—which the Government appear to have resisted—for this legislation to be more fully considered and developed in conjunction with that Act.

A recurring criticism of the operation of mental health legislation is that too many patients are only considered for discharge during preparation for a tribunal hearing. Effectively, the concern is that once a person is captive, as it were—once that person is detained—the

authorities are content to leave them there. Under the Bill, a vulnerable person can be deprived of their liberty for three years, as opposed to the previous maximum of 12 months. Given some of the anxieties and concerns about the arrangements in the Bill that we have discussed, both on Tuesday and today—the sense that there may be conflicts of interest, which mean that a person's interests will not always be safeguarded, and that some of the guarantees do not look as strong as we would like—those rather lengthy periods of detention become an added cause for concern.

I am struggling to understand the justification for having a renewal period of three years, other than on the grounds of cost; I hope the Minister can make that clear to me. She may tell me that it is to cover situations in which the person's condition is well established and unlikely to change. I presume that if that is the case, what she means is, "We can foresee this situation carrying on, and therefore there is not much point in having further intervention or authorisation regarding the detention arrangements."

However, what about a condition such as dementia? As I understand it, dementia is a progressive condition, so a person with dementia experiences changes over time. It could be that as a person's dementia progresses, they need less restrictive care because their condition changes, but it is highly unlikely that that sort of change in what they need would be detected. If that person was already subject to a three-year order, who would be looking to say, "It is obvious that Mrs B's condition has moved on, and the arrangements that were made 12 months ago can now be altered"? The likelihood is that if that person needed less restrictive conditions, she would be causing less trouble in the establishment that she was living in. She would be one of the patients or residents who was of least concern to the staff, so the improvement in her condition that would merit a lessening of the restrictions on her freedom would be completely missed, because the staff would know perfectly well that she was there for three years. That is how that would be viewed.

I notice that the wording on first renewals says "12 months or less". What proportion does the Minister consider will be for less than 12 months? What proportion of renewals that can be for three years does she think will actually be made for less than three years? For how long are people normally deprived of their liberty under the present arrangements? What does she think will be the average period under the arrangements she proposes?

3.45 pm

Does the Minister or the Department have any plans to monitor that? I and those who take an interest in this matter are curious to know. Will one unintended consequence of the Bill be that people end up being detained for longer periods? We will only know if there is some reasonable monitoring system. The Department of Health and Social Care is not particularly good at monitoring what happens in a whole variety of situations. I have a file in my office that is probably 2 inches thick of parliamentary answers in which I am told that the Department does not collect particular statistics or does not have particular data, or that it thinks it might be uneconomic to provide particular information. I am curious about how we will find out if an unintended consequence of the Bill is that we detain people for much longer periods. Has the Minister thought about that, and does she have any plans to monitor it?

My point is quite straightforward: the higher the maximum period specified in the Bill, the more likely that that period will become the norm. That is why it is right for us to be concerned about this. If the Minister is to change that period, we should monitor it to find out if I am right. She is not setting out to achieve that, but it may be what she ends up achieving.

As I said, these are probing amendments. I am genuinely interested to understand how the Minister arrived at the periods specified in the Bill. What gives her confidence that they are right? Is there any evidence that we can draw on that shows that 12 months is the right time for the first determination? I have deliberately picked much shorter periods partly because, as I say, Sir Simon Wessely envisaged that in his review of the Mental Health Act 1983, but also to challenge what the Minister says. If it is clearly wrong to specify shorter periods, what evidence shows that a 12-month period is right? I would be really interested if she could answer that.

It could be argued that, for a person with a treatable condition whose mental capacity might actually improve as a result of that treatment, the shorter the period of detention, the greater the incentive to get on with treating that person properly. The longer the period of detention, the greater the temptation will be to simply warehouse that person, rather than treating them.

I am curious to know how the Minister arrived at these periods, and likewise I would like to know why it is 12 months for the first renewal and three years for the second. Will she tell us whether the Government received representations from any bodies or organisations on the maximum periods? Were they lobbied by any particular organisations? If so, could she tell us which ones, and what they were doing?

As I said, mine are probing amendments. I want to ensure that a person can lose their liberty only for the period that is absolutely necessary, and that there is the maximum incentive to restore that liberty as soon as possible where it is feasible and practicable to do so.

Barbara Keeley: I will speak to amendment 44, which appears in my name, and refer to the amendments tabled by my hon. Friend the Member for Birmingham, Selly Oak, although I am mindful of the time.

Under the deprivation of liberty safeguards, there is no explicit renewal mechanism. If an authorisation has come to its end but is still needed, a fresh assessment must be carried out, including of whether the arrangements are in the cared-for person's best interests. The Law Commission suggested that that was not necessarily what was happening in practice. It found practitioners referring to an annual DoLS review, even though it was effectively a fresh application. That suggests that all applications other than the initial one are becoming a rubber-stamping process, which they should not be.

There is a clear need for a proper renewals process to be put in place. It is not appropriate, as Members on both sides of the Committee have said repeatedly, for full authorisations to be routinely undermined by being treated as tick-box exercises. The other side of that is that we do not want to put people through an unduly stressful experience when there is little prospect of any change being made to the arrangements to which they are subject. We are not intrinsically opposed to a new renewals process that cuts down on duplicated assessment, but we must be aware that any such system of renewal

[Barbara Keeley]

periods contains far fewer safeguards than there should be in the current system. We should implement it only with the utmost caution.

All that must be done to renew an authorisation is to carry out a consultation and certify that the authorisation conditions continue to be met. In most cases, that will be done by the responsible body but, as I said on Tuesday, in some cases it will be done by a care home manager. It has been made clear in the House of Lords and in this place, by Members on both sides, that assessments should not be carried out by care home managers—or indeed, as we have discussed, by anyone with an interest in keeping the person detained.

Let us be clear: at renewal we are doing just that. Such a situation may be acceptable, given the independent nature of the initial medical and capacity assessments, provided that it comes with suitable safeguards. Under the Bill, the initial duration of the liberty protection safeguard can be up to 12 months. After that, a renewal will be needed.

At the first instance, a renewal can last another 12 months. On the face of it, that is not unreasonable. Beyond that, however, authorisations can be renewed for three years, then another three years and another three years. Indeed, they can keep on being renewed for three years indefinitely. The only condition is that the responsible body, or the care home manager, thinks that the authorisation conditions are still met, and will continue to be met for the duration of the authorisation. Three years is a long time. It is so long that, frankly, making any kind of prediction becomes a fallible exercise.

To assume that any change in a cared-for person's condition could be foreseen over that period is simply unreasonable. Yet that power is being given to independent hospital managers and, in some cases, to care home managers. They are people who have a vested interest in keeping the cared-for person where they are. Particularly in the care home sector, where, as we have mentioned, margins are narrowing and financial planning is becoming harder, a resident whom managers know will stay for at least three years may prove very hard to turn down. The Opposition simply cannot support that.

I have already talked about some of the issues that independent hospitals can pose. We know that under the current system people can be trapped in inappropriate placements for years. My hon. Friend the Member for Birmingham, Selly Oak asked an interesting set of questions about the data that exists. What do we know about this? We know from NHS Digital data that the average length of stay in an assessment and treatment unit in an independent hospital is more than five years. Under the current regime, one in seven people held in such a unit has been there for more than a decade. One in five people in an ATU has not had a review in the past year. Imagine what could happen if the renewal period needs to be applied only every three years, which is a real fear.

As the Government opposed our amendment, independent hospitals will not be answerable to anybody when authorising or renewing deprivations of liberty. I ask the Minister: how can it be appropriate for these institutions to deprive somebody of their liberty for three years without any external checks?

When the Law Commission recommended a 12-month initial authorisation period, it said that that would match the minimum recommended timescale for reviews under the Care Act 2014 and the Social Services and Well-being (Wales) Act 2014, and therefore help to minimise the duplication of assessments. I have already said that that is a positive aim. If care plans are being reviewed anyway, it does not seem overly burdensome to ask that the authorisation of the deprivation of liberty be renewed in the same time period. No small amount of effort has gone into ensuring that the liberty safeguards scheme is closely aligned with the care system, and that assessments will work in harmony. That is a positive aim if it ensures that the cared-for person receives a better service, but it cannot be right that we end up inappropriately depriving people of their liberty for years at a time.

Given the serious impact of depriving a person of their liberty, the obligations on the responsible body at renewal are not onerous. The condition or circumstances of the cared-for person might change significantly within a much shorter period, and different or less restrictive arrangements might become possible. This point needs to be addressed. It is not an authorisation condition that no less restrictive options are available. There is no obligation to give that full consideration at renewal or at any other time, but there is a clear principle that we should always seek to avoid depriving somebody of their liberty where possible. I hope the Minister will tell us what the Government will do to ensure that renewals take that into account.

Amendment 44 seeks to limit the length of any authorisation to 12 months before it must be renewed, which would allow renewals to be bound up with the renewal of other elements of the person's care. That would ensure that it is not an excessively burdensome exercise either for the responsible body or for the cared-for person. At a time when local government resources are stretched thinly, I can understand the desire to take work off their shoulders by allowing them to renew authorisations for longer. Another way to ease the pressures on local authorities is to resource them properly to carry out their duties. It is unacceptable for the Bill to undermine crucial protections that cared-for people need in order to disguise the cuts that local government has had to bear. I have said that before in this debate and I am sure that I will say it again.

A renewal period of three years appears to be a cost-cutting exercise. I understand that the Minister is very concerned that we do not place too extreme a burden on family members and others with an interest in the cared-for person's welfare. However, their involvement in the renewal process is limited to being consulted. I do not believe that being asked once a year for one's opinion on whether a relative's care has changed can be seen as excessively burdensome. Most family members would welcome the fact that their opinion was being sought and that efforts were being made to ensure that their relative's best interests were protected.

The other safeguard provided to reassure us that a three-year renewal is appropriate is that a series of regular reviews will be carried out. Will the Minister tell us what that means? After all, the Bill makes no mention of what a regular review entails. I presume it is something that will be contained in the code of practice, like an awful lot of other things.

We are talking about a fundamental right. If a review is the safeguard being proposed, it must exist in statute. Anything else risks people's rights being undermined. I am not alone in my concern about the length of the renewal period. My hon. Friend the Member for Birmingham, Selly Oak made a very good case for examining the renewal periods and has asked some very probing questions about them. A cross-sector group of organisations including Mencap, Disability Rights UK and Liberty has written to me expressing deep concern that the provision will lead to people being deprived of their liberty for inappropriate lengths of time. Perhaps most significantly, the group includes the Alzheimer's Society. People with dementia are one of the groups for whom frequent renewals may not be appropriate, yet even the organisation speaking in the interests of those people feels that three years is too long.

4 pm

In the House of Lords, it was recognised that there are real and valid concerns about this measure. The then Minister, Lord O'Shaughnessy, said:

"There is clear concern about a proper system of oversight and regular review".—[*Official Report, House of Lords, 22 October 2018; Vol. 793, c. 715.*]

Will the Care Minister tell us what the Government are doing to address that clear concern? More than that, they appear to be swimming against the tide with this change. By tripling the length of the authorisation period, they are creating a stark difference between the Mental Capacity Act and the Mental Health Act. We cannot risk the Mental Capacity Act providing second-class protection of liberty, with fewer safeguards and longer authorisation periods. To do so would be to let down the people who, due to the vague nature of the area covered by the the Acts, fall under mental capacity provisions, not mental health legislation.

As we have already heard, there were calls for the Government to move in the other direction. Sir Simon Wessely recommended that renewal periods should be cut, not extended. A wide range of voices are telling the Government that their proposed period is simply not appropriate, and I cannot understand why the Government have not yet listened. The amendments give them another chance to do so. By limiting the period of an authorisation to 12 months, whether that is the first authorisation or the 10th, we can ensure that nobody is inappropriately deprived of their liberty for long periods.

Caroline Dinéage: I thank the hon. Members who have tabled the amendments on authorisations up to three years. I stress that this was a recommendation of the Law Commission, in particular for people with long-term progressive conditions from which they are unlikely to recover. It was suggested because many people and their families told the Law Commission, throughout its extensive consultation and work, that they felt that starting the process from scratch every year was unnecessary and cumbersome.

I should also stress that the three-year authorisation period starts only after there have been two one-year authorisations, and the periods set are maximums, not minimums or targets. The Bill does not prevent a responsible body from approving an authorisation for the period set out in the amendment if that is appropriate. Furthermore, the responsible body is required to specify a continuous

programme of reviews. If a person's circumstances change significantly, the authorisation will be reviewed and may be found to no longer be valid. That could easily be the case with somebody with dementia, as has already been highlighted. In that way, I believe that the provision actually brings in additional safeguards.

I hope that has provided clarification and I ask hon. Members to withdraw the amendments.

Steve McCabe: My amendments were probing amendments, so I do not wish to push them to a vote. I hope the Minister will reflect again on what I said about monitoring how the detention periods are used, because I fear there is a greater risk here than people may have anticipated. I beg to ask leave to withdraw the amendment.

Barbara Keeley: Can I just make a couple of points? There is near unanimity in the sector that three years for renewals is too long. Even the Alzheimer's Society is worried about the impact it could have. The power on renewals lies with the managers of independent hospitals or care homes, who are people with a vested interest in renewing the authorisation and keeping the cared-for person as a client. In the amendment, we suggest a 12-month period, which would allow the renewal process to be built on the all the other assessments that cared-for people undergo annually as part of their care programme. That would avoid the process placing an excessive burden on them.

Caroline Dinéage: I am sorry for pushing everybody's patience, but I need to clarify something the hon. Lady said. I am sure she said it inadvertently. She said that a care home manager can renew an authorisation. That is not correct. Only a responsible body can renew an authorisation and only when the responsible body is satisfied that the conditions continue to be met.

Barbara Keeley: The point remains for independent hospitals. In other amendments, we have tried to move that independent hospitals are not responsible bodies, but the Government did not accept those amendments.

Amendment, by leave, withdrawn.

Amendment proposed: 44, in schedule 1, page 18, line 24, leave out from "less" to end of sub-paragraph (1)(b).— (*Barbara Keeley.*)

This amendment limits the period of renewal of any authorisation to twelve months.

Question put, That the amendment be made.

The Committee divided: Ayes 7, Noes 8.

Division No. 16]

AYES

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

NOES

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

*[Lords]**Question accordingly negatived.*

4.6 pm

Ordered, That further consideration be now adjourned.
*—(Wendy Morton.)**Adjourned till Tuesday 22 January at twenty-five minutes
past Nine o'clock.*

Written evidence reported to the House

- MCAB40 British Medical Association
- MCAB41 Dan Baker, Mental Capacity Act and Deprivation of Liberty Safeguards Lead Officer, Central Bedfordshire Council
- MCAB42 Jess Flanagan, Senior Associate solicitor, Health and Welfare Court of Protection, Clarke Willmott LLP
- MCAB43 Hywel Dda University Health Board
- MCAB44 Royal College of Psychiatrists (RCPsych)
- MCAB45 David Thornicroft, Managing Director, St Thomas Training
- MCAB46 Inclusion London and People First Self-Advocacy
- MCAB47 Professor Rosie Harding, Chair in Law and Society, Birmingham Law School, University of Birmingham
- MCAB48 Lincolnshire County Council
- MCAB49 North East Lincolnshire MCA Group (formerly the Strategic Network)
- MCAB50 Marc Robertson
- MCAB51 Court of Protection Practitioners Association
- MCAB52 Irwin Mitchell
- MCAB53 Ray Colyer, Deprivation of Liberty Safeguards Manager, Islington Council
- MCAB54 Best Interest Assessors, Sheffield City Council
- MCAB55 Dimensions
- MCAB56 Christiane Plaum, MCA DoLS Team Manager, Deprivation of Liberty Safeguards Team, West Sussex County Council
- MCAB57 Tracey Cave, Social Worker/AMHP/BIA, BIA Team, Middlesbrough Council
- MCAB58 MIND
- MCAB59 Independent Age
- MCAB60 Law Society
- MCAB61 The Relatives and Residents Association
- MCAB62 Eleanor Tallon and Annette Wilby, staff members in the MCA and DoLS team at Calderdale Council

