



# BRITISH GERIATRICS SOCIETY

**Submission to the Law Commission in response to Consultation  
Paper 222: Mental Capacity and Deprivation of Liberty**

**2 November 2015**

## Introduction

The British Geriatrics Society(BGS) is the professional body of specialists in the healthcare of older people in the United Kingdom. The membership of the Society is drawn from consultants and doctors practicing geriatric medicine, general practitioners, nurses, allied health professionals, scientists and others with a particular interest in the care of older people, and the promotion of better health in old age.

The Society welcomes this opportunity to respond to the Law Commission's Consultation Paper on Mental Capacity and Deprivation of Liberty. Our submission first provides a summary of responses to key proposals and issues raised by the Law Commission's Consultation Paper and then provides detailed responses to specific questions.

### **BGS Summary responses:**

- We agree that the current deprivation of liberty safeguards (DoLS) are unfit for purpose and should be replaced by a new system of protective care as opposed to restrictive care.
- We believe that the scope of the new system should be kept narrow to distinguish from the current DoLS focus on restriction of liberty at the expense of Article 8 rights to privacy and family life under the European Convention on Human Rights(ECHR). We firmly believe that, following the 2014 Supreme Court judgement, the current DoLS have potential to undermine Article 8 and that any new system must seek to protect Article 8 rights.
- We have identified many instances when 'continuous supervision and control' is justified and necessary on clinical grounds by the patient's medical condition, for example to care for patients in the intensive care unit to keep them alive or to meet the needs of a distressed patient receiving end of life care in hospital, a care home or in their own home. The hypothetical test of restriction to movement in the event that such a patient may attempt to leave their current care environment is, we believe, arbitrary and irrelevant.
- We believe that all such vulnerable adults have a right (articulated within Article 8) *not* to be subject to burdensome and wholly unnecessary state interference that might occur as a result of the current DoLS focus purely on Article 5 rights to personal liberty under the ECHR and the concept of restriction.
- We believe that the designation of restrictive care must only apply where restriction of movement and choice for a patient without capacity is as a direct, intentional consequence of the *care plan*, which arises out of a best interests decision. Even then the focus must be on protection of the patient's identified best interests and on upholding both their Article 5 and 8 rights.
- Where a patient's movement and choice is restricted *primarily by their condition* (for example where they are in receipt of care which is life sustaining, for end of life or care to maintain safety and well being within existing best practice standards), we believe that the patient's best interests will be met by a system of protective care designed to uphold where practicable their Article 5 and 8 rights.

- Such a system of protective care must not be burdensome or bureaucratic and must not detract from ensuring that the patient's best interests are maintained at the centre of care planning and delivery.
- We agree that protective care should be accompanied by a clear, practicable and easily accessible code of practice.
- We broadly agree with the proposed *principles* of protective care but have concerns about their *practicability* as a system of care as follows:
- We believe the proposed system when implemented has great potential to be more bureaucratically burdensome in practise than the current DoLS.
- We believe the proposed system will have significant public service resource impacts, which we believe to be unaffordable within the existing health and social care resource envelope. An inadequately resourced system of protective care will in turn fail to achieve its desired objectives of protecting vulnerable adults with significant opportunity costs to the health and social care system.
- There are currently difficulties in assessing capacity, which is not simply present, or absent but which fluctuates; effective assessment for protective care hinges on the skills of the assessor. Staff currently struggle with capacity assessment and there will be major challenges regarding adequate staff training and implementation of any new framework.
- We are concerned that the proposals appear to distinguish mental health from physical health disorders. For persons in hospital and care homes there is a high prevalence of delirium, which may require protective care and for which there may be significant resource implications if the outlined proposals are to be delivered.
- We wish to highlight a particular concern in relation to delirium in hospital following planned care, which is both common and can lead to fluctuating mental capacity. A new system of protective care must take account of the difficulties created by delirium which may supervene following consensual admission for treatment and may subsequently resolve but which transiently leads to incapacitous refusals of care. Where the original purpose of intended care is being met, and loss of capacity is transient, we believe the Mental Capacity Act(MCA) already provides adequate safeguards to meet best interests and there should be no need for a formalised additional safeguarding procedure.
- The MCA already requires people to act in the best interests of patients. We have some concern that the ethos and spirit of the MCA could be subverted by new bureaucratic systems that are difficult to implement.
- We believe that a new legislative framework must take account of and support an evolving care system, and that this requires legislators to have greater understanding of supported living as it is delivered now and likely to be delivered in the future in order to ensure that new frameworks remain fit for purpose.
- We believe that safeguarding and decision-making about care planning should be separated to minimise risk of 'process' consuming resources that should be directed towards basic care.

- We believe that the scope of protective care as proposed should be reduced. We question whether people in hospices at the end of life, and in intensive care in hospitals during critical illness, are truly being deprived of their human rights in the way described in Articles 5 and 8.
- We believe that care homes should be regarded as palliative care settings for the purpose of protective care. BGS wishes to highlight that the short median life expectancy of older residents in care homes indicates that care homes provide final year of life care for many. We therefore question the necessity of including of all care homes within the scope of a protective care framework.
- BGS wish to highlight the potential for distress to bereaved family and carers currently caused by the requirement for Coronial Inquest following death while DoLS are in place. We believe this is largely of no purpose and subjects families and carers to unwelcome and unnecessary state interference in their bereavement. We believe a new system of protective care must not of itself subject bereaved families and their carers to unnecessary and otherwise unjustified Coronial Inquiry.
- We have concerns about a new framework leading to loss of unrealised potential of the MCA in supporting the approaches of proportionality, pragmatism, the role of professional judgement and discretion.
- We have concerns about the extension of protective care to domestic settings. We question the practicability for professionals in trying to adhere to a legislative framework in this setting. Specifically we are concerned about the potential for creating conflict in an environment, which requires collaboration between professionals, families and carers.
- Given the current economic climate and intense pressure public service funding, we question whether local authorities currently or in the future would have capacity to discharge all of the duties, which will be imposed by the proposed legislative framework. We believe the current DoLS framework is not fit for purpose but, following the 2014 Supreme Court judgement, the capacity and capability of local authorities to administer such a system have been far exceeded. We are not confident that the proposed framework is sufficiently succinct to avoid this situation recurring, leading once again to an over bureaucratized and unfit framework dominated by process and which does little to uphold article 5 and 8 rights.
- We believe that elements of the new framework appear to conflate decisions about care resource allocation and deprivation of liberty and that these two things must be clearly separated in any new framework.
- We are concerned that any new protective framework with potential impact on resource allocation must be tested fully to ensure *equal* applicability to those who are able to fund their own care and those who are dependent on state funding for care.
- Lasting Powers of Attorney (LPA) are not widely used for welfare decisions and we believe would add little in practice to the delivery of protective care which is not already adequately addressed in the MCA best interests process.

- We give qualified support for the restrictive care and treatment proposals including the development of Approved Mental Capacity Professionals. However such a role should be limited in its practical scope. It would not, for example, be the role of Assessors to oversee every action in a hospital ward.
- For persons in hospitals we believe that the best interests process which surrounds protective care planning should be centred on multidisciplinary teams led by senior decision makers.
- We believe that the MCA is a useful and effective statutory framework in clinical settings and that protective care must uphold the spirit and ethos of the MCA if it is to be utilised effectively in clinical settings.
- We also urge careful consideration of the economic impact and anticipated additional drain on challenged public services resources of a protective care framework, which is overly wide in scope and overly bureaucratic in its delivery.

## **Detailed responses to provisional proposals and questions**

### **CHAPTER 2: ANALYSIS OF THE DEPRIVATION OF LIBERTY SAFEGUARDS**

**Provisional proposal 2-1:** the Deprivation of Liberty Safeguards should be replaced by a new system called “protective care”.

**Provisional proposal 2-2:** the introduction of protective care should be accompanied by a code of practice, and the UK and Welsh Government should also review the existing *Mental Capacity Act Code of Practice*.

### **CHAPTER 3: PRINCIPLES OF PROTECTIVE CARE**

**Question 3-1:** have we identified the correct principles to underpin protective care, namely that the scheme should deliver improved outcomes, and be based in the Mental Capacity Act, non-elaborate, compliant with the European Convention on Human Rights, supportive of the UN Disability Convention, and tailored according to setting?

#### **BGS RESPONSE**

**BGS supports these proposals and is in agreement that the correct underlying principles have been identified.**

We agree that the present DoLS are seen on the ground by those administering them as a largely bureaucratic and burdensome legal process for which many health care staff have little real understanding and which do not directly benefit patients, their families and their carers. We agree that the term ‘deprivation of liberty’ can sound overly negative to patients and staff, patients, their families and carers. It can introduce a difficult narrative between professionals and families, which may interfere adversely with already distressing and difficult discussions about acute medical care, end of life care and discharge planning from hospital.

We agree that the MCA ethos of protecting and upholding autonomous choice for adults with impairment of brain and mind function has been undermined by the legal ‘fix’ of the DoLS that

seeks to reconcile Article 5 rights with the principle of necessity but takes scant regard of the equally important Article 8 rights.

We also agree that the present DoLS actually do little to safeguard the rights of vulnerable adults and have now introduced potential for conflicts of interest with managing authorities and supervisory bodies. At its worst we see DOLS as a mechanism to drive and detain vulnerable older people into care environments against their wishes and to justify poor or un-resourced care for those most in need.

Older people with dementia and delirium in hospital for example who exhibit challenging behavior, and who may require specialist care from trained and experienced staff, may instead find themselves subject to detention, sometimes under the supervision of unqualified or unsuitable staff such as security guards (even though the MCA Best Interests process should prevent this). This does nothing to enhance their well-being and nothing to protect their Article 8 rights.

We are also concerned that the use of DoLS for older people at the end of their life has led to the use of distressing language such as 'death in state detention' and has instigated a requirement to invoke Coronial processes in England which are, in many cases of expected, natural death, unnecessary and distressing for grieving families.

We therefore fully support a scheme, which is founded on delivering improved outcomes for vulnerable adults and wholly person centred, upholding the legal and natural rights of those individuals and their families. We see this as a necessary and fundamental shift away from a failed system of State-centred assurance to one which facilitates person-centred, outcome focused care while upholding the rights which remain available to all citizens, not just those with mental capacity to make decisions about the way they are cared for.

## **CHAPTER 4: THE SCOPE OF THE NEW SCHEME**

**Provisional proposal 4-1:** the scope of protective care should include hospital, care home, supported living, shared lives and domestic accommodation.

**Question 4-2:** is the definition of supported living provided under the Care Act 2015 appropriate for our scheme?

### **BGS RESPONSE**

**BGS supports the proposal including the extension of protective care to family and other domestic settings, but is of the view that a broader definition is required of supported living than that set out in the Care Act. Arguably we are also of the view that, with better monitoring, the core aim of this proposal is adequately covered already via the Best Interests process set out in the MCA.**

**Current health and care policy drivers mean that older and vulnerable adults are increasingly supported to live in their own home or with family in accommodation not specifically intended for occupation by those with care and support needs.**

**However BGS has significant reservations about how the resources to administer such a scheme would be made available in front line care settings.**

**We are also concerned that the administration of the scheme may create the potential for conflict between front line care staff, patients, family and carers in a care environment over which professional staff would have no direct influence. This may place staff in a professionally vulnerable situation and create potential for criticism if article 8 is inadvertently engaged.**

The last three decades have seen significant shifts in both the location and configuration of care for vulnerable adults with complex health and social care needs. This is currently driven by Government policy to integrate health and social care and pursue care 'closer to home' for adults with complex conditions, frailty and who may be nearing the end of their life. Many of these will lack mental capacity for decisions about how and where their care is organised at critical times in their life.

In its Fit for Frailty campaign<sup>1</sup> BGS highlights that *'many older people with frailty in crisis will manage better in the home environment but only with support systems which are suitable to fulfil all their health and care needs'*.

BGS has been long concerned about how this care will be organised and delivered by health and social care professionals working in a resource-constrained environment.

In its report Quest for Quality in Care Homes<sup>2</sup> BGS describes current NHS support for care homes. *It tells a story of unmet need, unacceptable variation and often poor quality of care provided by the NHS to the estimated 400,000 older people resident in UK care homes.*

While BGS welcomes current Government policy centred on integration of health and social care, the Society has concerns around how this will be organised and delivered<sup>3</sup>

BGS supports the call for *'More integrated and coordinated care, care more attuned to people's needs, a greater focus on dementia and mental health, beefing up the primary and community workforce and allowing closer working, budget sharing and joint service planning between health and social care. However, Government is not promising funding remotely near the additional £4b per annum recommended by the King's Fund in the Barker Commission on future funding, just to keep services at current levels.*

*Expectations of reductions in urgent activity have so far not been met– perhaps unsurprising given the parallel crises in primary care workforce and social care funding. The Five Year Forward view has made huge assumptions about our ability to generate £22bn in efficiencies and only asks for £8bn more over five years.*

BGS remains concerned that major cuts in social care funding have resulted in around 800,000 people with "substantial" care needs being unable to access services, and that social care has not been put on an equal footing (universal and free at the point of access) with NHS care, despite the 2014 Care Act.

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<sup>1</sup> <http://www.bgs.org.uk/index.php/fit-for-frailty?jij=1440335990239>

<sup>2</sup> [http://www.bgs.org.uk/index.php?option=com\\_content&view=article&id=1487&Itemid=719](http://www.bgs.org.uk/index.php?option=com_content&view=article&id=1487&Itemid=719)

<sup>3</sup> <http://www.bgs.org.uk/index.php/resources-6/newsletter/news-april15/3815-apr15-president>

In this context, BGS takes the view that care for vulnerable adults will continue to be delivered for the foreseeable future in multiple locations including hospital, care homes, supported living and domestic accommodation. In many of these settings, resources and infrastructure to support care delivery is expected to remain at best tenuous, and in some cases non-existent.

BGS is concerned that the policy drivers requiring more complex care to be delivered in a broader range of community based settings including their own home, will result in a continued shift to these settings of greater numbers of vulnerable adults currently subject to the DoLS. BGS therefore fully supports the inclusion of as broad range of care settings as feasible in the proposed new protective care scheme to ensure that the article 5 and 8 rights of these individuals remain protected wherever they may be cared for.

BGS however regards the Care Act definition of supported living to be too prescriptive and, for the purposes of protective care, this creates an artificial and in practice meaningless distinction from other forms of domestic care setting.

Of equal importance, the scale and scope of care arrangements in supported care and domestic settings remains largely undetermined looking forwards. With increasingly complex care being delivered in domestic settings the distinction drawn by Barker J that, '*In most cases the circumstances are more likely to fall into the category of a restriction rather than a deprivation of liberty*', may not continue to hold true. BGS are of the view that the MCA notion of restriction, where this is proportionate and necessary, should be maintained in any future legislation as this is more likely to be practicable.

BGS is also concerned that the necessary care infrastructure to administer the proposed protective care scheme may not be adequately resourced and supported in the foreseeable future. While the proposals seek to remove unnecessary bureaucracy and overelaborate procedures, the residual requirement for a robust and meaningful procedure, albeit 'simple and straightforward' remains concerning given that we anticipate front line staff will continue to struggle to meet their obligations to provide even basic care. BGS is of the view therefore that a new legislative framework must ensure protection for those at highest risk while not diverting resources from productive care into a bureaucratic process,

## **CHAPTER 6: SUPPORTIVE CARE**

**Provisional proposal 6-1:** supportive care should apply where a person is living in care home, supported living or shared lives accommodation, or if a move into such accommodation is being considered.

COMMENT: BGS is of the view that this is already covered within the MCA. Increasingly, and as part of the development of integrated care closer to home, there is a requirement for supportive care to be provided through bed and home-based intermediate care, early supported discharge and reablement schemes. All of these services create new interfaces of care, which will require consideration of the need to provide supportive care under the proposed scheme.

In many cases, the NHS provides these services alone or in partnership with the local authority and other care providers. Patients can stay in these services for significant periods of time and may require a further transfer of care to another care location at the conclusion of an episode.

Service users are generally older people: in the 2014 National Audit of Intermediate Care,

mean age was 82 for bed-based services, 80 for home-based. Mental health workers are rarely included in the establishment of intermediate care services and the range of 'quick and ready access' to mental health and dementia care expertise varied from 55% to 76% despite a high prevalence of dementia.

In 2014, home-based intermediate care stays averaged 30.4 days, bed-based 28 days and reablement 32.7 days<sup>4</sup>. Bed based intermediate care often occurs in care homes. At the conclusion of intermediate care, 14.6% bed-based users go to acute hospital care, 12.8% to care home and 65% return to their own home. For home-based users, 9.9% conclude with an admission to a care home.

The 2014 audit identified that the numbers of patients responding positively to the question 'I was involved in discussions and decisions about my care and support as much as I wanted to be' was 79.6% in home-based care, 60.7% in bed-based and 75.6% in reablement.

In developing a scheme for supportive care, it is important that the complexities of service delivery, its resourcing and the experiences of current users are understood and that the proposed scheme is deliverable in these 'new' care settings which are increasingly providing alternatives to hospital care for vulnerable adults.

**Provisional proposal 6-2:** supportive care should cover people who may lack capacity as a result of an impairment of, or a disturbance in the functioning of, the mind or brain, in relation to the question whether or not they should be accommodated in particular care home, supported living or shared lives accommodation for the purpose of being given particular care or treatment.

**Provisional proposal 6-3:** a local authority should be required to undertake or arrange an assessment, or ensure that an appropriate assessment has taken place, where it appears that a person may be eligible for supportive care in a care home, supported living or shared lives accommodation.

**Provisional proposal 6-4:** the local authority must ensure that the assessor has the skills, knowledge and competence to carry out the assessment and is appropriately trained. The assessor must consult a person with expertise in relation to the condition or circumstances of the individual, where the assessor considers that the needs of the individual require them to do so.

COMMENT: This could prove problematic in hospitals where patients are being assessed for transfer to supportive care (care home, supported living). Currently social care professionals are under considerable pressure to complete assessments and there is scant regard to s2 notifications for assessment until near the end of hospital stay, often when an s5 notification is issued. Timeliness of the assessment process is paramount to avoid delayed transfer of care: presently there is an escalating problem with delayed transfer of care in the NHS for both NHS and social care reasons<sup>5</sup>.

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<sup>4</sup><http://www.nhsbenchmarking.nhs.uk/CubeCore/.uploads/NAIC/NAICSummaryReport2014.pdf>

<sup>5</sup> <http://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2015/05/June-15-DTOC-SPN1.pdf>

There were 139,600 total delayed days in June 2015, of which 91,000 were in acute care. This is an increase from June 2014 where there were 124,100 delayed days, 81,200 in acute care. Of these, 61.5% of delays were attributable to the NHS, 31.4% to social care (an increase from 24.7% in 2014) and 7.1% to both. In acute care in June 2015 there were 17,900 days delayed awaiting completion of assessment (of which 25.7% were attributable to social care directly). In the same setting in June 2015, there were 7022 delayed days awaiting transfer to care home and 8287 awaiting package of care in own home attributable to social care. 11,911 delayed days (8.5% of total) were attributable to patient or family choice.

The requirements placed on the local authority under this scheme could further exacerbate this problem. BGS is concerned that the scale of this unintended consequence is fully appreciated before proceeding with a new legislative framework.

The provision of social care in intermediate care settings is also less well resourced and the requirements placed on the local authority under this scheme could have adverse consequences on the timeliness of assessment and of care delivery at the interfaces of such services. In addition, newer 'transfer to assess' models of care make the traditional interfaces between one care setting and another less tangible and may lead to difficulties in triggering assessments in a timely fashion.

**Provisional proposal 6-5:** local authorities should be required to keep under review the health and care arrangements for any person who falls within supportive care. This would include ensuring that a care plan and proper capacity assessments have been undertaken.

**Provisional proposal 6-6:** local authorities should be required to ensure that assessments and care plans record, where appropriate, what options have been considered and the reasons for the decisions reached.

**Provisional proposal 6-7:** under supportive care, a person's care plan must make clear the basis on which their accommodation has been arranged.

**Question 6-8:** are any changes needed to provide greater protection and certainty for people who lack capacity and their landlords in relation to tenancies?

BGS RESPONSE

**As per detailed comments above, BGS has concerns that the requirements placed upon local authorities may introduce delays and unintended opportunity costs in transfers of care between NHS care settings. There is therefore potential for dispute between landlord and donee or deputy to increase the number of delayed transfer of care bed days in hospital.**

**Question 6-9:** what difficulties arise when landlords require tenancies to be signed by a donee or deputy, and how might these be addressed?

BGS RESPONSE

**See above.**

**Question 6-10:** should local authorities and the NHS in England ever set personal budgets for disabled people living at home by reference to the cost of meeting the person's needs in residential care?

BGS RESPONSE

**BGS is concerned that this approach conflates DoL and resource allocation. A Best Interests assessment may say that care at home would be less restrictive. But sufficient care may, in reality, be more expensive than a care home placement. Local authorities are required to make best use of available budgets. The cost of a care home place would appear to be a reasonable ceiling for state funded care but the driver of Best Interests may lead to a requirement for greater funding. Leveraging more resource by making least restriction legally binding, no matter what the cost, would therefore need resourcing.**

**BGS also has significant concerns about the potential for causing dispute, to the detriment of patient well being, between local authorities, the NHS and families about the cost and quality of care provision at home by reference to the cost of meeting a person's needs in residential care.**

In 2015 the Government is considering delaying implementation of the Care Act £72K cap on care costs<sup>6</sup>. The Local Government Association highlights a social care-funding gap in England worsening by £700m a year and set to be at least £4.3bn by 2020. As many as 500,000 people who would have been eligible for State help with washing, dressing and meals in 2009 are not receiving any support today.

Given the size of this gap, care at home may be cheaper (although this only holds true so long as less than 4 hours per day of home care are required), but is not necessarily meeting the needs of the vulnerable adult concerned. In addition, in England there is a **six-fold variation** in the number of patients discharged to new care home places straight from acute hospital, and an **eight-fold variation** in the number of council-funded placements<sup>7</sup>. While some localities are better at maintaining people at home than others, the reasons for this are not well understood.

Patients with complex needs that span health and social care may require an intensity of support that goes beyond what primary care physicians can deliver<sup>8</sup>. A framework for decision-making, which is based upon cost, may introduce incentives to deliver care, which is insufficient to meet the needs of the individual.

In addition, current arrangements for assessing NHS continuing health care eligibility are problematic and in some circumstances have been considered not fit for purpose<sup>9</sup>. In one

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<sup>6</sup> <http://www.theguardian.com/society/2015/jul/06/ministers-consider-shelving-personal-liability-cap-long-term-care-costs>

<sup>7</sup> <http://www.kingsfund.org.uk/blog/2014/08/admission-nursing-home-can-never-become-never-event>

<sup>8</sup> [http://cdn.basw.co.uk/upload/basw\\_102418-7.pdf](http://cdn.basw.co.uk/upload/basw_102418-7.pdf)

<sup>9</sup> [http://www.parkinsons.org.uk/sites/default/files/failingtocare\\_appgfullreport.pdf](http://www.parkinsons.org.uk/sites/default/files/failingtocare_appgfullreport.pdf)

Parliamentary review, patients were noted to be dying awaiting eligibility assessment, 59% of assessments did not involve appropriate expertise and in 21% cases national guidance was not followed.

**Question 6-11:** should there be a duty on local authorities and the NHS, when arranging care home, supported living or shared lives accommodation for a person who lacks capacity to decide where to live:

(1) to secure the most appropriate living arrangement for that person, which as far as possible reflects the person's wishes and feelings; and

(2) to seek the agreement of any donee of a Lasting Power of Attorney or deputy, or a declaration from the Court of Protection.

BGS RESPONSE

**We believe this duty is already set out in the MCA. BGS supports the requirement for local authorities and the NHS to include the wishes and feelings of the individual in making arrangements for care. This promotes a person-centred care approach to care planning and delivery.**

Uptake of LPA for older people has been poor. 61% people aged over 45 were not interested in setting up an LPA when asked and 40% do not think they will lose capacity in the future despite the fact that 1 in 3 people over 65 are expected to develop dementia<sup>10</sup>.

**BGS has concerns about the poor uptake of LPA and the potential within the framework for continued or escalating need to seek declaration from Court of Protection to the detriment of patient care delivery, where there is dispute between family members or patient representatives about the prior or present wishes and feelings of the individual.**

**Question 6-12:** should local authorities and the NHS be required to report annually on issues relating to living arrangements and community support, such as the number of living arrangements made and how often these arrangements were inconsistent with the person's wishes and feelings?

BGS RESPONSE

**BGS supports this proposal given that presently there are little or no data to indicate to what extent the wishes and feelings of vulnerable adults are respected with regards to living arrangements. BGS does have reservations about the practicalities of collecting and reporting such data however.**

**Provisional proposal 6-13:** all registered care providers should be required to refer an individual for an assessment under the relevant protective care scheme if that person appears to meet the relevant criteria.

**Question 6-14:** should the duty to make referrals for protective care be a regulatory requirement which is enforced by the Care Quality Commission, Care and Social Services

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<sup>10</sup>[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/359864/opg-lpa-infographic.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/359864/opg-lpa-infographic.pdf)

Inspectorate Wales, or Healthcare Inspectorate Wales?

BGS RESPONSE

Yes.

## CHAPTER 7: RESTRICTIVE CARE AND TREATMENT

**Provisional Proposal 7-1:** the restrictive care and treatment scheme should apply to people who lack decision-making capacity as a result of an impairment of, or a disturbance in the functioning of, the mind or brain.

**Provisional proposal 7-2:** a person would be eligible for safeguards if: they are moving into, or living in, care home, supported living or shared lives accommodation; some form of “restrictive care and treatment” is being proposed; and the person lacks capacity to consent to the care and treatment.

**Provisional proposal 7-3:** restrictive care and treatment should include, but should not be limited to, any one of the following:

- (1) continuous or complete supervision and control;
- (2) the person is not free to leave;
- (3) the person either is not allowed, unaccompanied, to leave the premises in which placed (including only being allowed to leave with permission), or is unable, by reason of physical impairment, to leave those premises unassisted;
- (4) barriers are used to limit the person to particular areas of the premises;
- (5) the person’s actions are controlled, whether or not within the premises, by the application of physical force, the use of restraints or (for the purpose of such control) the administering of medication – other than in emergency situations;
- (6) any care and treatment that the person objects to (verbally or physically);
- (7) significant restrictions over the person’s diet, clothing, or contact with and access to the community and individual relatives, carers or friends (including having to ask permission from staff to visit – other than generally applied rules on matters such as visiting hours).

The Secretary of State and Welsh Ministers could add to and amend this list by secondary legislation.

**Question 7-4:** should the restrictive care and treatment safeguards be available to people who lack capacity to consent to their care plan, in any of the following cases:

- (1) the person is unable, by reason of physical or mental disability, to leave the premises, including:
  - (a) unable to leave without assistance;
  - (b) able to leave without assistance but doing so causes the adult significant pain, distress or

anxiety;

(c) able to leave without assistance but doing so endangers or is likely to endanger the health or safety of the adult, or of others; or

(d) able to leave without assistance but takes significantly longer than would normally be expected;

(2) the person has high care needs and consequently is dependent on paid carers; and

(3) the person has limited ability to direct their own care or to access existing safeguards?

#### BGS RESPONSE

**BGS has concerns about the use of restrictive care and treatment safeguards for people in all of the above circumstances. We believe that the guiding principles should be proportionality, necessity and affordability.**

**We are concerned that the proposal set out at 7-3 does not in effect change the ‘acid test’. We believe it is important to avoid the situation where otherwise well cared for people are regarded as ‘deprived’ because they are being protected from likely harmful consequences of their condition (such as wandering inadvertently into a hazardous situation). We believe that the notion of ‘freedom’ this implies for people with moderate or severe cognitive impairment is intrinsically faulted since their condition of its nature restricts their freedoms. BGS supports a return to the principle of necessity (to prevent harm) as the determinant in identifying whether safeguards need to be applied.**

**We also question the need for safeguards to be applied where people are physically unable to leave purely by consequence of their condition. Excluding such individuals from the scope of safeguards would in our view represent a low risk. Including them is unlikely to improve or ensure proper care planning.**

**We also question the practicability of the inclusions of limiting barriers which may be in place for reasons other than to restrict the movement of an individual without capacity such as swipe access security, toilet door locks for privacy, digital pad locks to facilitate carer entrance to property.**

**We also question the inclusion of dietary restrictions which may be in place to protect a person’s physical health such as in diabetes.**

**Question 7-5:** are there any specific forms of care and treatment that should automatically mean that the person is eligible for the restrictive care and treatment safeguards?

#### BGS RESPONSE

**BGS consider the use of assistive technologies should be included within this category. Specifically tracking devices to enable people to live at home with dementia but monitor movement outside of a specific area.**

**Provisional proposal 7-6:** the local authority should be required to ensure that an assessment

for restrictive care and treatment takes place, and confirm that the restrictive care and treatment is in the person's best interests.

**Question 7-7:** should the restrictive care and treatment assessment require a Best Interests assessment to determine whether receiving the proposed care or treatment is in a person's best interests, before deciding whether it is necessary to authorise restrictive care and treatment?

BGS RESPONSE

**Yes and this is already provided for within the MCA: however BGS has concerns about the timeliness of such a Best Interests process and the reliance on the local authority to complete such an assessment. BGS also regards such decisions as requiring full multidisciplinary participation when applied to adults with complex care needs.**

**Question 7-8:** should a person be eligible for the restrictive care and treatment scheme if restrictive care and treatment is necessary in their best interests – taking into account not just the prevention of harm to the person but also the risks to others?

BGS RESPONSE

**BGS question whether this undermines the MCA. Any treatment for a person lacking capacity must be in their best interests as properly assessed, otherwise it has no legal justification.**

**Provisional proposal 7-9:** cases involving serious medical treatment should be decided by the Court of Protection.

**Question 7-10:** should all significant welfare issues where there is a major disagreement be required to be decided by the Court of Protection?

BGS RESPONSE

**BGS are concerned that, currently, many serious medical treatment decisions such as insertion of feeding tubes or DNACPR decisions must be made by clinicians in difficult and time-dependent circumstances. Given the number of such decisions made currently in the NHS on a daily basis for older people in hospital, it is questionable whether a Court process could ever authorize all such cases.**

**Provisional proposal 7-11:** restrictive care and treatment assessments should be referred to an "Approved Mental Capacity Professional" (currently, the best interests assessor) who would be required to arrange for the assessment to be undertaken by a person already involved in the person's care (eg the person's social worker, nurse or doctor) and quality assure the outcome of that assessment or oversee or facilitate the assessment; or undertake the assessment themselves.

**Provisional proposal 7-12:** the "Approved Mental Capacity Professional" (currently, the Best Interests Assessor) would be required to specify the duration of restrictive care and treatment, which may not exceed 12 months.

**Provisional proposal 7-13:** the Secretary of State and Welsh Ministers should have powers in

secondary legislation to provide for equivalent assessments, timescales for the completion of assessments and records of assessments.

**Question 7-14:** what should the timescales be for the assessments under protective care and what records should be contained in the assessment?

BGS RESPONSE

**BGS are concerned that the present DoLS timescales for authorisation are not being met. The complexity of care provision through service integration set out above whereby vulnerable adults move across interfaces in the care system every few weeks requires that assessments under protective care must be sensitive to the needs of the person under consideration and should not impede their delivery of care in whatever location this is provided.**

**BGS also recommends that the care records are fully transferable with the person to whom they relate as they move through the care system and contain sufficient detail about the purpose and rationale for protective care, together with the associated care plan and details of the professionals involved in administering the delivery of protective care.**

**Provisional proposal 7-15:** restrictive care and treatment should enable Approved Mental Capacity Professionals (currently, Best Interests Assessors) to use equivalent assessments where this is necessary.

**We agree**

**Provisional proposal 7-16:** the new scheme should establish that the “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) acts on behalf of the local authority but as an independent decision-maker. The local authority would be required to ensure that applications for protective care appear to be duly made and founded on the necessary assessment.

**We agree**

**Provisional proposal 7-17:** the Health and Care Professions Council and Care Council for Wales should be required to set the standards for, and approve, the education, training and experience of “Approved Mental Capacity Professionals” (currently, Best Interests Assessors).

**We agree and significant responsibility should not become unobtainable as much of the complex decision making skills and knowledge can be gained during professional training and experience. The legal requirements are the additional elements.**

**Provisional proposal 7-18:** the ability to practise as an “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) or Approved Mental Health Professional should be indicated on the relevant register for the health or social care professional.

**We agree**

**Question 7-19:** should there be additional oversight of the role of the “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) and a right to request an

alternative assessment?

#### BGS RESPONSE

**Yes. This is in effect a new form of health qualification, which gives significant responsibility to the professional. To ensure quality and consistency, as with all professional groups these individuals must be themselves subject to an assurance process. At the very least their role should be subject to regular supervision, appraisal and continuing professional development (mindful that the law will continue to evolve) with a view to annual revalidation. This has implications for workforce planning, cost and the professional regulatory body for these professionals, particularly where there is no system of revalidation currently in place.**

**Provisional proposal 7-20:** the “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) should be responsible for setting conditions and making recommendations in respect of the person’s care and treatment.

**Provisional proposal 7-21:** the “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) should be given responsibility for monitoring compliance with conditions. This could be delegated to health and social care professionals who are allocated to the case, and advocates and the appropriate person would be required to report any concerns about non-compliance with conditions.

**Question 7-22:** should the new scheme allow for conditions or recommendations to be made that are more restrictive of liberty than the application is asking for?

#### BGS RESPONSE

**BGS gives qualified support to this proposal. Given that the Approved Mental Capacity Professional(AMCP) will be seen as a key independent element of the new scheme, it makes sense that, in some cases, this person should have responsibility for making conditions which personalise the protective care of the person to whom it relates.**

**BGS is of the view that recommendations for conditions should specifically and only be directed at promoting the person’s health, wellbeing and positive outcomes of care delivery.**

**However BGS has concerns about the meaningful effect of such conditions in practice, particularly where there may be direct or indirect implications for resources to support care or impacts on the provision of medical care and treatment.**

**BGS supports the view that conditions must contain clear instructions and further suggest that their scope be limited, including the formation of ‘recommendations’ to public authorities about the care plan. If this is not done, there is scope for creating dispute between professionals responsible for commissioning and/or delivery of care and the AMCP, which could interfere with the delivery of care.**

**BGS also has concerns that, where recommendations are not followed, this could have adverse regulatory impacts on health and social care professionals when the outcomes of care planning and delivery are subject to criticism.**

**Question 7-23:** should there be specific sanctions for a failure to comply with a condition, and if so, what should they be?

BGS RESPONSE

**In our view this would depend on who has responsibility to provide resources which support the condition: in addition it is difficult to see how they could be enforced if the recommendations are to remain optional.**

**Provisional proposal 7-24:** an “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) should be allocated to every person subject to the restrictive care and treatment scheme. This should not be the same professional who authorised the restrictive care and treatment.

**Provisional proposal 7-25:** the “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) should be required to keep under review generally the person’s care and treatment, and given discretion to discharge the person from the restrictive care and treatment scheme.

**We are concerned about the practicability of this proposal. The AMCP, if responsible for overseeing the review would need to be within a framework as they would not otherwise be able to ensure personally that all cases were compliant – precedent for this difficulty already exists for CCGs managing CHC cases. It would need to be embedded in to a process and there would need to be a facility to delegate day to day responsibility**

**Provisional proposal 7-26:** the “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) should be able to review and vary conditions without necessarily holding a full reassessment of best interests.

**We agree where indicated by Multi-Disciplinary Team (MDT) review and change of condition situation**

**Provisional proposal 7-27:** the local authority should be given general discretion to discharge the person from the restrictive care and treatment scheme. Local authorities could consider discharge themselves, or arrange for their power to be exercised by a panel or other person.

**We agree but ensuring that, where health personnel are the managers of care, this is in collaboration**

**Provisional proposal 7-28:** the “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) and local authority must review the care and treatment following a reasonable request by the person, a family member or carer, or an advocate or appropriate person.

**We believe there must be clarity regarding the role of health professionals when they are solely responsible for the person’s care under Continuing Healthcare(CHC).**

**Provisional proposal 7-29:** if a person who is eligible for the restrictive care and treatment scheme needs to be deprived of liberty in his or her best interests, this must be expressly authorised by the care plan.

**We agree.**

**Provisional proposal 7-30:** cases of deprivation of liberty concerning those living in a family or domestic setting must be authorised by the Approved Mental Capacity Professional and subject to the same safeguards as those provided under the restrictive care and treatment scheme.

**Provisional proposal 7-31:** the Approved Mental Capacity Professional (currently, the Best Interests Assessor) should ensure that before a deprivation of liberty is authorised, objective medical evidence be provided by a doctor or psychologist who is independent of the detaining institution. If appropriate evidence already exists, a fresh assessment should not be required.

**Provisional proposal 7-32:** the medical assessment should confirm that the person is suffering from a disability or disorder of mind or brain and lacks capacity to consent to the proposed care and treatment.

**Question 7-33:** should the medical assessment address other matters such as providing a second opinion on treatment already being provided or proposed?

BGS RESPONSE

**Yes: it is good practice where there is disputed medical opinion to seek second opinion. Given that very junior staff in hospitals administer many of the current DoLS, there may also need to be a requirement that only medical staff above a particular training grade can undertake the medical assessments required for restrictive care and treatment. This may of course generate significant resource impacts on medical time at a more senior level.**

**Question 7-34:** should doctors be eligible to act as Approved Mental Capacity Assessors (currently Best Interests Assessors)?

BGS RESPONSE

**Yes and in many cases will be best placed to do so, mindful of the above recommendations in respect of training and experience. This is not a duty which should be delegated to inexperienced or training staff below a given grade.**

**Provisional proposal 7-35:** an Approved Mental Capacity Professional (currently Best Interests Assessor) should be able to authorise restrictive care and treatment in urgent cases for up to 7 days, and to extend this period once for a further 7 days, pending a full assessment.

**We agree that self authorisation with accountability has virtues especially for timeliness but also has significant resource implications.**

**Provisional proposal 7-36:** the restrictive care and treatment scheme should include powers to authorise transportation, leave, suspension and transfers. It should also enable care and treatment to be authorised in multiple settings.

**We agree**

## **CHAPTER 8: PROTECTIVE CARE IN HOSPITAL SETTINGS AND PALLIATIVE CARE**

**Provisional proposal 8-1:** a separate scheme should be established for hospitals and palliative care settings.

**Provisional proposal 8-2:** a person may be deprived of liberty for up to 28 days in a hospital setting based on the report of a registered medical practitioner. A responsible clinician must be appointed and a care plan produced. Further authorisations for a deprivation of liberty would require the agreement of an Approved Mental Capacity Professional (currently a Best Interests Assessor).

**‘Registered medical practitioner’ includes any doctor above FY1 (first post qualification year) level and we question whether doctors at this level will be adequately trained and supported to undertake such a process.**

**Question 8-3:** is the appointment of an advocate always appropriate in all hospital cases, or is there a need for an alternative safeguard (such as a second medical opinion)?

BGS RESPONSE

**It is not always appropriate and could, with appropriate training and support be incorporated into the roles of appropriately specified (by training and grade) hospital staff. The requirement for second medical opinion may provide additional safeguards but would need to be articulated within an operational framework to ensure quality and consistency. We also question whether an uncontested hospital stay for the express purposes of medical investigation and treatment for up to 28 days constitutes a true deprivation of liberty, and whether such an otherwise uncontested hospital stay is simply an inevitable consequence of acute medical illness.**

## **CHAPTER 9: ADVOCACY AND THE RELEVANT PERSON’S REPRESENTATIVE**

**Provisional proposal 9-1:** an independent advocate or an appropriate person must be appointed for any individual subject to protective care. The individual must consent to such support or if the individual lacks capacity to consent, it must be in their best interests to receive such support.

**Provisional proposal 9-2:** the provision of advocacy should be streamlined and consolidated across the Care Act and Mental Capacity Act (in its entirety), so that Independent Mental Capacity Advocates would be replaced by a system of Care Act advocacy and appropriate persons.

**Question 9-3:** should the appropriate person have similar rights to advocates under the Care Act to access a person’s medical records?

BGS RESPONSE

**Yes.**

**Question 9-4:** should Independent Mental Health Advocacy be replaced by a system of Care Act advocacy and appropriate persons?

## BGS RESPONSE

**BGS are supportive of any proposal to consolidate and streamline complex processes to ensure best use of scarce resource and reduce the scope for conflict and inefficiency in delivering care to vulnerable adults with complex care needs.**

**Provisional proposal 9-5:** a “relevant person’s representative” should be appointed for any person subject to the restrictive care and treatment scheme (or the hospital scheme) and who is being represented by an advocate. The person must consent to being represented by the representative, or if they lack capacity to consent, it must be in the person’s best interests to be represented by the representative.

**Provisional proposal 9-6:** where there is no suitable person to be appointed as the representative, the person should be supported by an advocate or appropriate person.

**Provisional proposal 9-7:** the Approved Mental Capacity Professional (currently Best Interests Assessor) should have discretion to appoint a representative where the person is being supported by an appropriate person.

**Provisional proposal 9-8:** the Approved Mental Capacity Professional (currently Best Interests assessor) should be required to monitor the relevant person’s representative and ensure they are maintaining contact with the person.

**Question 9-9:** does the role of relevant person’s representative need any additional powers?

## BGS RESPONSE

**No.**

**Consultation question 9-10:** should people always where possible be provided with an advocate and a relevant person’s representative, and could these roles be streamlined?

## BGS RESPONSE

**Advocacy has an important role in planning and delivery of healthcare to vulnerable adults with complex needs. However there is already significant shortfall in the supply of advocates, including those who can address the linguistic, cultural, religious and spiritual needs of patients. Streamlining of roles may be helpful but BGS has ongoing reservations about the ability of a resource constrained care system to supply adequate volume and quality of advocacy going forwards.**

## CHAPTER 10: THE MENTAL HEALTH ACT INTERFACE

**Provisional proposal 10-1:** the Mental Health Act should be amended to establish a formal process for the admission of people who lack capacity and who are not objecting to their care and treatment. The safeguards provided would include an independent advocate, a requirement for a second medical opinion for certain treatments and rights to appeal to the mental health tribunal. The Mental Capacity Act (and our new scheme) could not be used to authorise the hospital admission of incapacitated people who require treatment for mental disorder.

**We believe that the distinction of mental and physical illness is artificial in an acute medical setting caring for older people. Approximately one third of acute medical and acute surgical and trauma admissions exhibit delirium that arguably constitutes a mental disorder.**

## **CHAPTER 11: RIGHT TO APPEAL**

**Provisional proposal 11-1:** there should be a right to apply to the First-tier Tribunal to review cases under our restrictive care and treatment scheme (and in respect of the hospital scheme), with a further right of appeal.

**Provisional proposal 11-2:** an appeal against the decision of the First-tier Tribunal should lie on points of law in all cases and on law and fact where the issues raised are of particular significance to the person concerned.

**Question 11-3:** which types of cases might be considered generally to be of “particular significance to the person concerned” for the purposes of the right to appeal against the decision of the First-tier Tribunal?

BGS RESPONSE

**We agree with these proposals and believe that cases of family dispute with the decision should be considered ‘of significance to the person concerned’.**

**Provisional proposal 11-4:** local authorities should be required to refer people subject to the restrictive care and treatment scheme (or the hospital scheme) to the First-tier Tribunal if there has been no application made to the tribunal within a specified period of time.

**Question 11-5:** in cases where there has been no application made to the First-tier Tribunal, what should be the specified period of time after which an automatic referral should be made?

BGS RESPONSE

**28 Days in keeping with other proposed time standards.**

**Question 11-6:** how might the First-tier Tribunal secure greater efficiencies – for example, should paper reviews or single member tribunals be used for relatively straightforward cases?

BGS RESPONSE

**Yes, but with the ability to request updated clinical assessment of the person if required.**

**Question 11-7:** what particular difficulties arise in court cases that raise both public and private law issues, and can changes to the law help to address these difficulties?

**Question 11-8:** should protective care provide for greater use of mediation and, if so, at what stage?

BGS RESPONSE

**Yes from supportive living upward.**

## **CHAPTER 12: SUPPORTED DECISION-MAKING AND BEST INTERESTS**

**Provisional proposal 12-1:** a new legal process should be established under which a person can appoint a supporter in order to assist them with decision-making. The supporter must be able, willing and suitable to perform this role. The Approved Mental Capacity Professional (currently Best Interests Assessor) would be given the power to displace the supporter if necessary (subject to a right of appeal).

**Provisional proposal 12-2:** section 4 of the Mental Capacity Act should be amended to establish that decision-makers should begin with the assumption that the person's past and present wishes and feelings should be determinative of the best interests decision.

**We believe there should be preparation to undertake the role of supporter – this might be something as simple as an on line course.**

**We agree with 12-2 but highlight that loss of insight is problematic in a clinical setting. Arguably protection of the right to make an unwise decision carries greater weight than protection from risk or exploitation. In addition, previous experience such as a failed home discharge, often in reality heavily influences assumptions and decisions made in best interests.**

## **CHAPTER 13: ADVANCE DECISION-MAKING**

**Provisional proposal 13-1:** the ability to consent to a future deprivation of liberty should be given statutory recognition. The advance consent would apply as long as the person has made an informed decision and the circumstances do not then change materially.

**We agree particularly when life limiting diagnosis is given.**

**Provisional proposal 13-2:** the restrictive care and treatment scheme and the hospital scheme would not apply in cases where they would conflict with a valid decision of a donee or advance decision.

**Question 13-3:** how (if at all) should the law promote greater use of advance decision-making?

BGS RESPONSE

**As detailed above, the uptake of LPA has been poor and adults rarely consider themselves to be vulnerable to loss of capacity for decision-making. Considerable awareness-raising by public and third sector bodies may in time improve uptake but this is anticipated to remain a problem in the long term. There is no single or easy solution.**

## **CHAPTER 14: REGULATION AND MONITORING**

**Provisional proposal 14-1:** the Care Quality Commission, Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales should be required to monitor and report on compliance with the restrictive care and treatment scheme and the hospital scheme.

**Question 14-2:** how might the new legal framework encourage greater joint working between

the various health and social care bodies and regulatory schemes and alternative forms of regulation?

BGS RESPONSE

**There needs to be a greater degree of sharing of best practice and proactive approaches to provision of support from the regulators.**

**Question 14-3:** is greater regulatory oversight needed of individual decision- makers and local authorities and the NHS for the purposes of protective care?

BGS RESPONSE

**Yes but this then requires regulatory oversight of a considerable number of people.**

## **CHAPTER 15: OTHER ISSUES**

**Provisional proposal 15-1:** protective care should apply to persons aged 16 and over.

**Question 15-2:** is the concept of the zone of parental responsibility appropriate in practice when applied to 16 and 17 year olds who lack capacity?

BGS RESPONSE

**These issues do not fall within our remit.**

**Question 15-3:** what are the current difficulties that arise when identifying the supervisory body for the purposes of the DoLS? Are there any current areas that could be usefully clarified under the new scheme?

BGS RESPONSE

**The ongoing reorganisation of health care systems both in provider and commissioning bodies, particularly as integrated care evolves is a major obstacle. Taking traditional hospital services out into the community and closer to home continues to cause difficulty in networking and identifying who is responsible for identifying a potential DoL patient and for triggering assessment and authorisation. Health and social care professionals are poorly informed and lacking in skills in this already difficult and complex area of law. Considerable effort will be required to ensure that all relevant staff are made aware of the required processes in the new scheme.**

**Question 15-4:** is a fast track determination scheme needed for cases where a person is deprived of liberty and there is a dispute over the person's ordinary residence?

BGS RESPONSE

**Yes: delays in this area of care planning currently contribute significantly to delays in transfer of care for older people in hospital and crossing the interfaces of the health and care system.**

**Question 15-5:** should a new criminal offence of unlawful deprivation of liberty be introduced?

## BGS RESPONSE

**No. We are concerned that this could discourage collaborative approaches to care planning and delivery, and create greater potential for conflict which would be at best distracting and at worst lead to risk averseness among professionals.**

**Provisional proposal 15-6:** the Criminal Justice Act 2009 should be amended to provide that inquests are only necessary into deaths of people subject to the restrictive care and treatment scheme where the coroner is satisfied that they were deprived of their liberty at the time of their death, and that there is a duty under article 2 to investigate the circumstances of that individual's death.

**Question 15-7:** should coroners have a power to release the deceased's body for burial or cremation before the conclusion of an investigation or inquest?

## BGS RESPONSE

**Yes: present coronial processes are overly intrusive and unnecessary leading to distress for bereaved families and attendant care staff. DoLS may currently be in place and not removed despite anticipated death of an older person in hospital or care home leading to an entirely unnecessary investigation or inquest for 'death while in state detention'.**

**Question 15-8:** is the current law on the reporting of deaths to the coroners satisfactory?

## BGS RESPONSE

**NO: see above**

**Question 15-9:** should people be charged for their accommodation when they are being deprived of liberty in their best interests – and are there any realistic ways of dealing with the resource consequences if they are not charged?

## BGS RESPONSE

**No: we believe that this conflicts with current social and health care policy.**

## Further Enquiries

This submission has been prepared for the British Geriatrics Society by Dr Martin J Vernon advised by a working group comprising Ms. Jane Buswell, Dr. Premila Fade, Ms. Dawne Garrett, Dr. Adam Gordon, Dr. Rowan Harwood and Ms. Soline Jerram, Ms. Patricia Conboy.

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