

MENTAL CAPACITY AND DEPRIVATION OF LIBERTY

SUMMARY

Introduction

For more information, see chapter 1 of the consultation paper

1. The Law Commission's consultation paper on deprivation of liberty was published on 7 July (Law Commission, *Mental Capacity and Deprivation of Liberty: A Consultation Paper* (2015), CP No 222). The consultation paper considers how the law should regulate deprivations of liberty involving people who lack capacity to consent to their care and treatment arrangements.
2. The deprivation of liberty safeguards ("DoLS") establish an administrative process for authorising deprivations of liberty in a hospital or care home. In broad terms the DoLS provide for a professional assessment – conducted independently of the hospital or care home in question – of whether the person lacks capacity to decide whether to be accommodated in the hospital or care home for the purpose of care or treatment, and whether it is in their best interests to be deprived of liberty. The authorisation can be challenged through an administrative review procedure or in the Court of Protection.
3. The DoLS have been subject to considerable criticism ever since their introduction. In March 2014 two events inflicted significant damage. First, the House of Lords post-legislative scrutiny committee on the Mental Capacity Act 2005 published a report which, amongst other matters, concluded that the DoLS were not "fit for purpose" and proposed their replacement. A few days later, a Supreme Court judgment (known as "Cheshire West") widened the definition of deprivation of liberty to a considerable extent. The practical implications have been significant for the

public image of the DoLS, and the regime has struggled to cope with the increased number of cases. As a result of these events the Government asked the Law Commission to undertake a review of the DoLS.

Analysis of the DoLS

For more information, see chapter 2 of the consultation paper

4. As noted, the DoLS have been subject to heavy criticism since their inception. The main problems discussed in the consultation paper are:
 - The narrow focus on article 5 rights to liberty: the concept of deprivation of liberty is poorly understood and the DoLS fail to take sufficient account of the person's article 8 rights to family life.
 - Disconnect with the Mental Capacity Act 2005: the DoLS are seen as incompatible with the style and empowering ethos of the Mental Capacity Act, to which they are attached.
 - Local authority conflicts of interest: tensions arise between local authority commissioning and safeguarding functions, and their role as supervisory body under the DoLS.
 - Limited scope: the DoLS apply only to hospitals and care homes, and not to other care settings such as supported living and shared lives accommodation.
 - A one-size-fits-all approach: the DoLS impose a single approach irrespective of setting. Thus, deprivations of liberty in an intensive care hospital ward are dealt with in the same way administratively as they would in a long-stay care home.
 - Lack of oversight and effective safeguards: particular

difficulties arise in monitoring compliance with conditions attached to a standard authorisation, and the person faces many practical obstacles in challenging decision-makers.

- Length and complexity: the statutory provisions are seen as tortuous, complex, extensive and overly bureaucratic.
 - Ill-suited and inadequate terminology: terms such as “deprivation of liberty safeguards” are widely criticised as cumbersome and Orwellian;
 - Scale of the problem: the DoLS were designed to provide a comprehensive set of safeguards for a relatively small number of cases. They were not intended to deal with the numbers of cases that have been apparent post Cheshire West.
5. The consultation paper proposes that the DoLS should be replaced by a new system called “protective care”. It also proposes that there should be a new code of practice, and that the UK and Welsh Governments should also review the existing Mental Capacity Act Code of Practice.

Principles of Protective Care

For more information, see chapter 3 of the consultation paper

6. There are a number of important principles that have informed the new scheme. These are listed below.
- A scheme that delivers improved outcomes: protective care must secure the support of disabled people, their family or carers, and professionals. To do this it should deliver – and be seen to deliver – tangible benefits and improved outcomes.
 - A Mental Capacity Act-based scheme: the new

scheme should be in keeping with the approach, language and empowering ethos of the Mental Capacity Act.

- A non-elaborate scheme: our provisional proposals seek to remove the unnecessary bureaucracy and overly-elaborate procedures that are apparent in the DoLS, while also protecting legal rights and providing meaningful procedural safeguards.
- A convention compliant scheme: it is a basic tenet of our review that the new protective care scheme must be fully compatible with the European Convention on Human Rights.
- A scheme that is supportive of the UN Disability Convention: we are keen to ensure as far as possible that the new scheme is not only compatible with the UN Disability Convention, but is supportive of its aims and aspirations.
- A tailored scheme: the new scheme should be flexible and establish different approaches in particular settings.

The scope of the new scheme

For more information, see chapter 4 of the consultation paper

7. A deprivation of liberty must be imputable to the state in order to engage article 5. According to the Strasbourg court this may happen as a result of the “direct involvement” of public authorities in the person’s detention, or where the state fails in its positive obligations to protect the person against interferences with their liberty carried out by private persons. The reach of article 5 is potentially broad. It will extend to cases far removed from the paradigm example of imprisonment to include, in some

circumstances, deprivation of liberty in domestic settings. If article 5 is engaged, appropriate safeguards must be made available.

8. The consultation paper proposes that the new scheme should apply to hospitals and care homes, albeit that the nature of the safeguards provided should differ according to the setting. These are already covered by the DoLS and are the settings in which a deprivation of liberty within the meaning of article 5 is most likely to be necessary in a person's best interests. It is also proposed that our scheme should include other forms of accommodation which are intended for those with health and care needs, namely supported living and shared lives accommodation. Those living in such settings can be just as vulnerable to being deprived of liberty as those in care homes.
9. On balance the consultation paper also provisionally proposes that protective care should extend to family and other domestic settings. It would be unacceptable to require that every case of deprivation of liberty in a domestic setting be taken to a court. This would be unnecessarily onerous and expensive for public authorities, and potentially distressing for the individual and family concerned.

Supportive care

For more information, see chapter 6 of the consultation paper

10. "Supportive care" is one element of the wider scheme of protective care. It would 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. Supportive care is intended to provide suitable protection for people who are in a vulnerable position, but not yet subject to restrictive forms of care and treatment (including deprivation of

liberty). In other words, it is intended to establish a preventive set of safeguards that reduce the need for intrusive interventions in the longer term.

Who is covered by supportive care?

11. Supportive would 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.

Assessments for supportive care

12. Where it appears to a local authority that a person may be eligible for supportive care, the local authority would be required to arrange an assessment, or to ensure that an appropriate assessment has taken place. This assessment would focus on the person's capacity to determine whether they should be living in the relevant accommodation.
13. The assessor would be required to establish whether the person lacks capacity in relation to the question of whether or not they should be accommodated in the relevant care home, supported living or shared lives accommodation for the purpose of being given the relevant care and treatment. If it is established that the person lacks capacity, further safeguards would apply (outlined below).
14. In most cases we do not think that the capacity assessment will require a fresh process to be initiated. Where it is proposed that a person who may lack capacity be moved into the relevant accommodation, we would expect that an assessment process would already have been carried out, for instance under the Care Act 2014 or NHS continuing health care regulations. So it

should be just a matter of making sure these additional capacity considerations form part of the existing assessments. But for some self-funders, this may be the first independent check of their capacity, and care and treatment arrangements, and therefore resource implications may arise.

Care planning safeguards

15. If a person has been assessed as being eligible for supportive care, the consultation paper proposes that a number of further and ongoing safeguards should be made available to that person. These safeguards are as follows:

- the local authority would be required to keep under review the person's health and care arrangements and whether a referral to the restrictive care and treatment part of protective care is needed;
- care plans must include a record of capacity and best interests assessments and any restrictions imposed (including confirmation that the restrictions are in the person's best interests);
- the local authority would have discretion to appoint an "Approved Mental Capacity Professional" to oversee the case);
- an advocate or appropriate person must be appointed (if not already appointed); and
- the advocate and appropriate person would be responsible for ensuring that the person has access to the relevant review or appeals process.

Public law and the Mental Capacity Act

16. The courts have warned of the danger of blurring the distinction between statutory duties in a private law context (namely considering the best interests of a

person lacking capacity under the Mental Capacity Act), and public law decisions (such as the provision of services and care planning). The consultation paper proposes that under supportive care, public bodies be much clearer in future about the basis on which decisions are being made. If an NHS body or local authority is considering a placement on the basis of the person's best interests, it will need to record what choices have been considered, and confirm that the principles and best interests checklist in the Mental Capacity Act have been applied. Alternatively, if the NHS body or local authority is making a public law decision, it must demonstrate that the accommodation meets the needs of the person, taking into account all relevant considerations including the views of the person and their family, resources, and the likely benefits for the person.

Mental capacity and tenancies

17. The consultation paper considers the tenancy arrangements that apply when people who lack capacity are moving into care home, supported living or shared lives arrangements. The current framework includes the Mental Capacity Act and various common law provisions. It is argued that the current law offers a number of legally based (as well as some more informal) mechanisms to ensure, in practice, that people who lack capacity and their carers and landlords are protected. But also decision-makers should be clearer about the basis on which accommodation is being arranged. The consultation paper therefore proposes that, as a requirement of supportive care, local authorities must ensure that this is stated clearly in the person's care plan.

Safeguards when a placement is being considered

18. The decision to move into care home, supported living or shared lives accommodation can have significant consequences and will frequently engage article 8 rights. Under our scheme, the main form of protection for the person, and their families and carers, when a move into accommodation is being considered consist of greater access to advocacy both under the Care Act and under our proposals. We are nevertheless interested in exploring the possibility of additional safeguards for the person, and their family and carers, when a move into accommodation is being considered. The consultation paper therefore invites views on the proposals in this regard put forward in the “LB Bill”.

Referrals

19. The consultation paper provisionally proposes that 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. It also asks if the duty to make referrals for protective care should be a regulatory requirement which is enforced by the Care Quality Commission, Care and Social Services Inspectorate Wales, or Healthcare Inspectorate Wales.

Restrictive care and treatment

For more information, see chapter 7 of the consultation paper

20. The proposed system of restrictive care and treatment provides the direct replacement for the DoLS. But, importantly, it is not organised around the concept of deprivation of liberty. Instead it provides safeguards for those whose care and treatment arrangements are becoming sufficiently restrictive or intrusive to warrant

this. This will include individuals deprived of liberty, but also some whose arrangements fall short of this.

Qualifying requirements

21. The restrictive care and treatment scheme would apply in respect of a person who is moving into, or living in, care home, supported living or shared lives accommodation and some form of “restrictive care and treatment” is being proposed. In addition, the person must lack capacity to consent to the care and treatment, and the lack of capacity must be the result of an impairment of, or a disturbance in the functioning of, the mind or brain.
22. The meaning of restrictive care and treatment scheme would be determined by reference to a non-exhaustive list. This is intended to be a more straightforward approach which makes sense to practitioners, and is easier to explain to the relevant person and their families and carers. The consultation provisionally proposes that restrictive care and treatment would include any one of the following:
 - continuous or complete supervision and control;
 - the person is not free to leave;
 - 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;
 - barriers are used to limit the person to particular areas of the premises;
 - 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;

- any care and treatment that the person objects to (verbally or physically); and
- 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).

23. Cases involving “serious medical treatment” would continue to be decided directly by the Court of Protection, and would not be authorised through the restrictive care and treatment scheme).

Approved Mental Capacity Professional

24. The role and expertise of the best interest assessor is a highly regarded aspect of the DoLS, and would continue to be central to the new system of restrictive care and treatment. The consultation paper proposes that in order to reflect its status, the title should be changed to “Approved Mental Capacity Professional” (AMCP).

25. All restrictive care and treatment assessments would be referred to an AMCP. The AMCP would retain overarching responsibility for ensuring that the assessment is carried out, however they would be given wide discretion over how this is achieved. In some cases the AMCP might decide that the assessment should be carried out by the professional already working with the person. The AMCP might also act as a general source of advice for the assessor – to assist them to apply the principles of the Mental Capacity Act and share good practice. In other cases, the AMCP could take charge of the restrictive care and treatment assessment themselves and thereby ensure that an independent assessment takes place. This would depend on the

circumstances of the case.

26. AMCPs would be in the same position legally as Approved Mental Health Professionals. In other words, they will be acting as independent decision-makers on behalf of the local authority. The local authority would be required to ensure that applications for protective care appear to be “duly made” and founded on the necessary assessments.
27. In order to further reflect the importance of the AMCP the consultation paper provisionally proposes that the Health and Care Professions Council and Care Council for Wales would be required to set the standards for, and approve, the education, training and experience of AMCPs. The ability to practise as an AMCP would be indicated on the relevant register for the health or social care professional.

Conditions

28. Under restrictive care and treatment, the responsibility for imposing conditions would rest directly with the AMCP. In other words, they would not make recommendations to the supervisory body; they would issue the conditions directly. In addition, AMCPs would be given powers to make “recommendations” to public authorities about the care plan. The AMCP would 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.

Ongoing oversight and reviews

29. Where a person becomes subject to restrictive care and treatment, an AMCP would be allocated to their case. The AMCP would be required to ensure that care

arrangements continue to comply with the relevant legal requirements (for example, under the Care Act and Mental Capacity Act).

30. The AMCP would be required to keep under review generally the restrictive care and treatment that has been authorised, and have a general discretion to discharge the person from the restrictive care and treatment scheme. The AMCP would need to ensure that reviews take place at the most appropriate time for the individual. There would also be a duty to review the care and treatment following a reasonable request by the person (including someone making the request on their behalf), the representative, a family member or carer, the care provider, and the advocate or the appropriate person.
31. The local authority would also 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.

Deprivations of liberty

32. Under restrictive care and treatment, some people may need to be deprived of liberty. In such cases the deprivation of liberty must be expressly authorised in the care plan. The AMCP would need to certify in the care plan that objective medical expertise had been provided and that the deprivation of liberty was in the person's best interests.

Domestic settings

33. The consultation paper argues that where a deprivation of liberty is proposed as a part of care or treatment offered in a domestic setting, the safeguards of the restrictive care and treatment scheme should apply. An AMCP would be required to authorise the deprivation of liberty, or seek alternative solutions (such as the

provision of services by a public authority to end the deprivation of liberty). In some cases the matter may need to be settled by the court. If the deprivation of liberty is authorised, the person would be subject to the same safeguards as those provided under the restrictive care and treatment scheme.

Urgent authorisations

34. It is important that restrictive care and treatment enables professionals to respond in cases of emergency. However, enabling self-authorisation by care providers is considered to be one of the least satisfactory elements of the DoLS. The consultation paper therefore proposes that, in emergencies, the first recourse of the care provider should be an AMCP who would be able to give temporary authority (or up to 7 days and to extend this period once for a further 7 days) for the care and treatment pending a full assessment.

Protective care in hospital settings and palliative care

For more information, see chapter 8 of the consultation paper

35. The consultation paper proposes a separate bespoke system for hospitals and palliative care. This would enable the authorisation of deprivations of liberty in NHS, independent and private hospitals where care and treatment is being provided for physical disorders, and in hospices. The hospital scheme would apply when the following conditions are met:
- the patient lacks capacity to consent to the proposed care or treatment; and
 - there is a real risk that at some time within the next 28 days the patient will require care or treatment in his or her best interests that amounts to a deprivation of liberty; or

- the patient requires care or treatment in their best interests that amounts to a deprivation of liberty; and
- deprivation of liberty is the most proportionate response to the likelihood of the person suffering harm, and the likely seriousness of that harm.

36. The consultation paper also asks whether the “acid test” may need to be elaborated in order to make it more relevant to hospitals. This could include clarifying that assessors – when considering the “not free to leave” limb of the test – will often need to focus on what actions the staff would take if, for instance, family members or carers sought to remove them.
37. If the criteria are met, the patient may be deprived of liberty for up to 28 days once a registered medical practitioner has examined them and certified in writing to the managers of the hospital that the conditions above are met. The hospital managers would then be required to appoint a responsible clinician in charge of the care and treatment of the patient.
38. The responsible clinician would be responsible for preparing a written care plan for the patient. Before preparing the care plan the responsible clinician would be expected to consult the patient, any carer, and any other person interested in the person’s care. Copies of the plan should be given to these people following the authorisation of a deprivation of liberty. Also, an advocate or an appropriate person must be appointed for the patient.
39. A deprivation of liberty may only extend beyond 28 days if an AMCP has also assessed the person and confirmed that the conditions are met, whereupon a deprivation of liberty may be authorised for up to 12 months.

Advocacy and the relevant person's representative

For more information, see chapter 9 of the consultation paper

40. The consultation paper argues that it is vital that independent advocacy continues to play a central role in our new scheme. It is provisionally proposed that, in all cases, an advocate should be instructed for those subject to protective care. It is also considered that there may be benefits in streamlining and consolidating advocacy provision across the Care Act and Mental Capacity Act, and that Independent Mental Capacity Advocates should be replaced with a single system of Care Act advocates and appropriate persons.
41. Whilst the remit of our review does not extend to the Mental Health Act 1983, the consultation paper also welcomes views on whether Independent Mental Health Advocacy should also be replaced by a single system of Care Act advocates and appropriate persons.
42. The consultation paper also provisionally proposes to maintain the role of the relevant person's representative for people subject to restrictive care and treatment. In cases where an advocate has been appointed, this will help to ensure that the important role of the family, friends or carers is recognised. However, we do not propose to maintain the paid representative role. In cases where there is no person suitable to act as the representative, we consider that an advocate should be appointed.
43. In cases where an appropriate person has been appointed we also do not propose that a representative should always be appointed. This is because otherwise it is likely that in many cases the same person would be appointed to both roles, which are very similar. However, the AMCP would have discretion to appoint a

representative where this would improve the person's outcomes.

The Mental Health Act interface

For more information, see chapter 10 of the consultation paper

44. The consultation paper provisionally proposes to extend the Mental Health Act to enable all necessary deprivations of liberty for mental health patients for the purposes of mental health treatment. This would mean that our new scheme could not be used to authorise the detention in hospital of incapacitated people who require treatment for a mental disorder. Instead, there would be a new mechanism under the Mental Health Act to enable the admission to hospital of compliant incapacitated patients in circumstances that amount to deprivation of liberty, while those who are objecting could be detained under the existing provisions of the Mental Health Act.
45. The safeguards would be similar to those provided to incapacitated compliant supervised community treatment patients who have not been recalled to hospital (Part 4A of the Mental Health Act), and would consist of:
 - the right to a Mental Health Act Advocate;
 - a power to provide treatment if a donee of a lasting power of attorney, a deputy, or the Court of Protection consents to the treatment on the person's behalf;
 - a requirement that treatment cannot be given under this power if it is contrary to a valid advance decision or if force is needed to administer it;
 - a requirement that a second medical opinion is needed for certain treatments including medication;

- rights for the patient and the nearest relative to seek a review of the treatment plan; and
- rights to apply to the mental health tribunal for an order to discharge the patient.

Right to appeal (Chapter 11 of the consultation paper)

For more information, see chapter 11 of the consultation paper

46. People subject to the proposed restrictive care and treatment scheme (and the hospital scheme) would have the right to challenge their care and treatment arrangements before a judicial body. The consultation paper considers whether the Court of Protection should perform this role, or whether a tribunal system should be established.
47. It is argued that the key advantages of the tribunal system are the diversity of training of its members, its ability to bring about the patient's participation, the flexibility and informality of its processes, and the capacity to deliver cost savings from these characteristics. However, the advantages need to be balanced against the considerable expertise that has been developed amongst Court of Protection judges, and the need for complex determinations under the new scheme.
48. On balance, the consultation paper provisionally proposes that a First-tier tribunal should be established to review cases under the restrictive care and treatment scheme (and in respect of the hospital scheme). It is also provisionally proposed that there should be a right to appeal against a tribunal decision, either to the Court of Protection or to a chamber of the Upper Tribunal. Local authorities would 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.

Supported decision-making and best interests

For more information, see chapter 12 of the consultation paper

49. Supported decision-making refers to the process of providing support to people whose decision-making ability is impaired, to enable them to make their own decisions wherever possible. The consultation paper argues that there are a number of clear benefits in introducing a formal legal process in which a person (known as a “supporter”) is appointed to assist with decision-making. In particular, it would give greater certainty and transparency for individuals, families, carers, professionals and service providers, and could help to ensure that the Mental Capacity Act works as intended. It is therefore provisionally proposed that 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 AMCP would be given the power to displace the supporter if necessary (subject to a right of appeal).
50. The consultation paper also argues that the law fails to give sufficient certainty for best interest decision-makers on how much emphasis should be given to the person’s wishes and feelings, and that greater priority should be given to a person’s wishes and feelings. This is something that would be consistent with the aims and aspirations of the UN Disability Convention. It is therefore provisionally proposed that 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.

Advance decision-making

For more information, see chapter 13 of the consultation paper

51. The consultation paper considers the existing legal framework for advance decision-making and how it might be reflected under the new scheme. It is argued that advance decision-making can have a number of important benefits, for instance it gives a person greater control over his or her circumstances and so reduces the chances of potentially distressing situations, and it gives health and social care professionals greater clarity over treatment options.
52. It is provisionally proposed that 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. It is also proposed that 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. Views are also sought on the ways in which advance decision-making, in general, could become more central to health and social care.

Regulation and monitoring

For more information, see chapter 14 of the consultation paper

53. Currently, the DoLS are monitored by the Care Quality Commission, Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales. The consultation paper argues that the existing regulatory scheme complies at a national level with the Optional Protocol to the Convention against Torture, and it is provisionally proposed that the DoLS regulators should be required to monitor and report on compliance with the restrictive care and treatment scheme and the hospital scheme. The consultation paper also asks for further views on how the new legal framework might encourage greater joint working between the various health and social care bodies and regulatory schemes, the practicality of alternative forms of regulation, and whether greater regulatory oversight is needed of individual decision-makers and local authorities and the NHS for the purposes of protective care.

Other issues

For more information, see chapter 15 of the consultation paper

54. The consultation paper also considers certain other matters which are relevant to the proposed protective care scheme. These are listed below.
- Protective care would apply to 16 and 17 year olds, as well as those aged 18 and over. Views are also sought on whether the zone of parental responsibility is appropriate in practice.
 - The consultation paper seeks further views on the

operation of the ordinary residence rules in respect of the DoLS and whether there are any current areas that could be usefully clarified under the new scheme. It also asks whether a fast track determination scheme is needed for cases where a person is deprived of liberty and there is a dispute over the person's ordinary residence.

- The consultation paper asks whether a new criminal offence of unlawful deprivation of liberty be introduced.
- It is provisionally proposed that the Criminal Justice Act 2009 should be amended to provide that coroner's 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. The consultation paper also asks if coroners should have a power to release the deceased's body for burial or cremation before the conclusion of an investigation or inquest.
- Views are sought on whether people should be charged for their accommodation when they are being deprived of liberty in their best interests – and whether there any realistic ways of dealing with the resource consequences if they are not charged.
- The consultation paper asks whether the law concerning foreign detention orders causes difficulties in practice, and whether difficulties arise when a person needs to be deprived of liberty and has been placed by a local authority in England or Wales into residential care in a different UK country.

Conclusion

55. The consultation paper makes a number of provisional proposals for law reform. Some, but not all, have been highlighted in this summary. In doing so, we emphasise that these represent our initial view about how the law should be reformed and that we will be reviewing these proposals on the basis of the responses to this consultation paper.
56. We will be undertaking a wide consultation process in order to gather as many different views and as much information as possible. We welcome responses from all interested parties. Details of how to respond can be found on the inside front page of the consultation paper.
57. An analysis of consultation responses will be published on our website. The next stage will be to produce and submit a report to the Lord Chancellor by the end of 2016. Taking into account the responses we receive to the consultation paper, the report will contain our final recommendations and the reasons for them. A draft bill, giving effect to our final recommendations, will also be included.