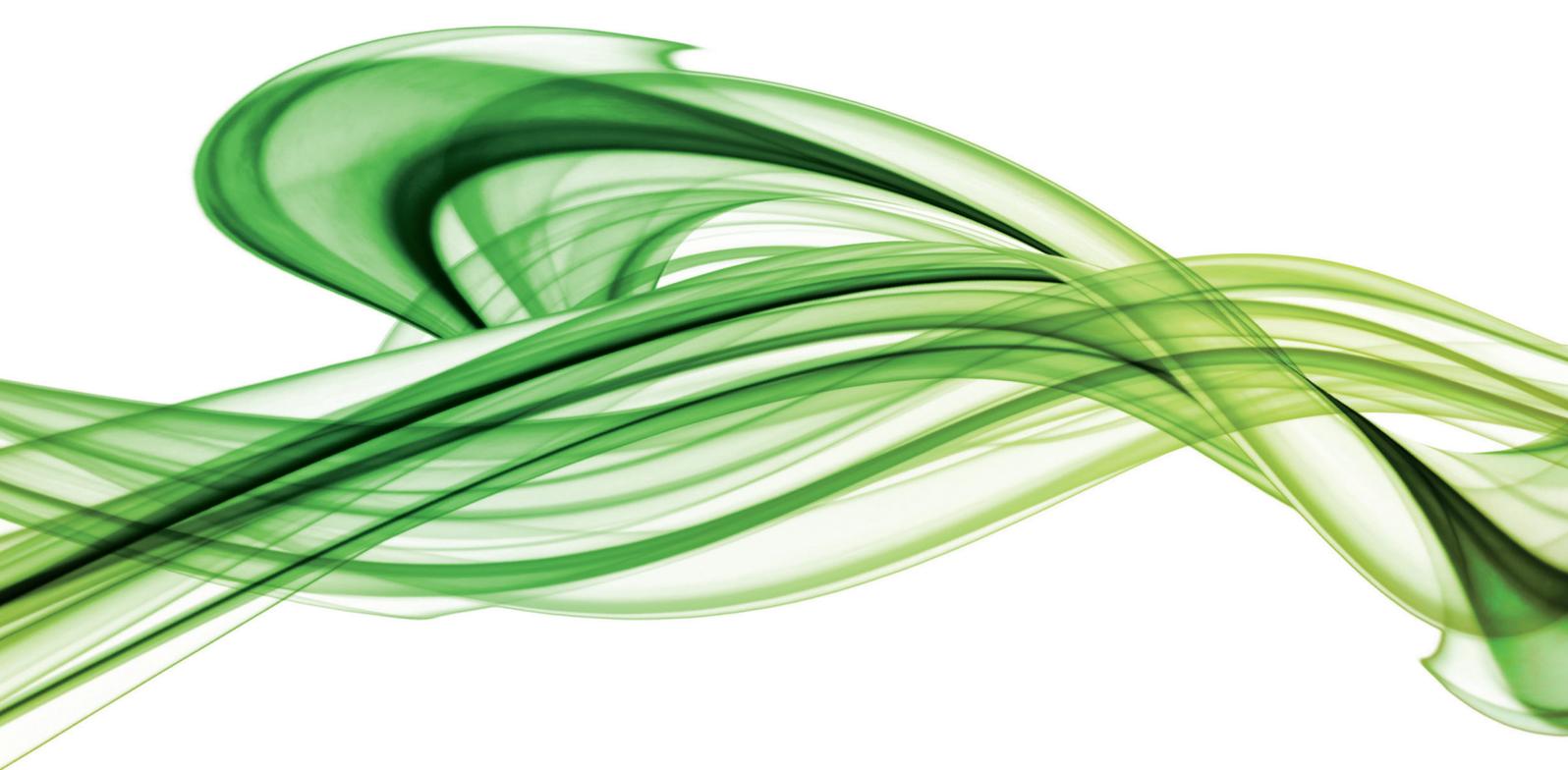




The Law Society

Identifying a deprivation of liberty: a practical guide



This guidance does not constitute legal advice, which must be sought - if necessary - on the facts of any specific individual case. While care has been taken to ensure the guidance is accurate, up to date and useful, no legal liability will be accepted in relation to it.

There are many people in different settings who are deprived of their liberty by virtue of the type of care or treatment that they are receiving, or the level of restrictive practices that they are subject to, but they cannot consent to it because they lack the mental capacity to do so. In March 2014, the Supreme Court handed down judgment in two cases: [*P v Cheshire West and Chester Council and P & Q v Surrey County Council*](#) [2014] UKSC 19. That judgment, commonly known as *Cheshire West*, has led to a considerable increase in the numbers of people in England and Wales who are considered to be “deprived” of their liberty for the purposes of receiving care and treatment. The judgment also emphasised the importance of identifying those who are deprived of their liberty so that their circumstances can be the subject of regular independent checks to ensure that decisions being made about them are actually being made in their best interests.

The Department of Health commissioned guidance to assist those professionals most directly concerned with commissioning, implementation and oversight of arrangements for the care and treatment of individuals who may lack the capacity to consent to such arrangements. Its purpose is to provide practical assistance in identifying whether they are deprived of their liberty, and hence to ensure that appropriate steps can be taken to secure their rights under Article 5 of the European Convention on Human Rights (‘ECHR’). It serves – in some ways – as an informal update to Chapter 2 of the DOLS Code of Practice, although it does not have the same statutory status, and the views expressed in it are those of the authors rather than representing Department of Health policy. It does not constitute formal legal advice, which should always be sought where necessary on the facts of difficult cases.

This guidance is not a panacea for Article 5 ECHR: there are a number of important limitations. First, it relates only to those who lack the mental capacity to consent to their residential and care arrangements: it does not cover situations where those with capacity are objecting to the same. Second, those of any age could potentially be deprived of their liberty; however, this guidance focuses solely on those aged 16 and over because that is the minimum age at which the Court of Protection can authorise a deprivation of liberty. Third, its principal aim is to assist in identifying a deprivation: it does not address in detail how that deprivation ought to be authorised. Nor does the guidance consider the law regarding the challenging of a deprivation of liberty under Article 5(4) ECHR; resources addressing that question can be found in Chapter 11.

The guidance starts in Part I with an overview of the legal framework and of the key legal questions that must now be asked following the decision of the Supreme Court. Part II is the heart of the guidance, applying the legal principles across the following settings: the hospital setting, the psychiatric setting, the care home setting, supported living/shared lives/extra care, at home, and in relation to those aged 16 and 17. Where relevant, the guidance identifies particular sub-divisions within the care setting covered in the chapter (for instance, Accident and Emergency departments and Intensive Care Units within the hospital setting).

For each setting or sub-category, a list of potentially ‘liberty-restricting’ factors are given that may indicate that a deprivation of liberty is occurring; three scenarios are also given, one illustrating a deprivation of liberty, one a potential deprivation of liberty depending on the circumstances, and one a situation unlikely to amount to a deprivation of liberty. Each chapter then concludes with a list of questions that professionals may want to ask themselves whenever they are confronted with a situation which may amount to a deprivation of liberty. Each chapter can be downloaded separately, as can the list of questions for that chapter, so professionals need only have with them those parts of the guidance that are most relevant to the circumstances they are likely to encounter.



In Part III is to be found summaries of key cases (including those which must in light of *Cheshire West* be read with a health warning) and further information and resources for those needing to keep themselves abreast of developments. The law is stated as at the end of February 2015.

Given that there remain a significant number of areas in which the law has yet to be clarified by the courts, this guidance serves as much to provoke professionals to seek further specific advice in difficult cases as it does to give answers. It will, inevitably, be superseded in due course by further judgments of the court but will at least provide a starting point to assist professionals to ask the right questions.

We use the following abbreviations in this guidance:

Abbreviation	Definition
A&E	Accident and Emergency
ATUs	Assessment and Treatment Units
CAMHS	Children and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
<i>Cheshire West</i>	The judgment of the Supreme Court in <i>P v Cheshire West and Chester Council and P & Q v Surrey County Council</i> [2014] UKSC 19
CPN	Community Psychiatrist Nurse
CQC	Care Quality Commission
CSSIW	Care and Social Services Inspectorate Wales
CTO	Community Treatment Order
DDA	Disability Discrimination Act 1995
DOLS	The deprivation of liberty safeguards regime introduced by Schedule A1 to the MCA 2005
DOLS Code	The Code of Practice accompanying Schedule A1 to the MCA 2005
ECHR	European Convention on Human Rights
ECtHR	The European Court of Human Rights
IMCA	Independent Mental Capacity Advocate
ICU	Intensive Care Unit
LPA	Lasting Power of Attorney
MCA 2005	Mental Capacity Act 2005
MHA 1983	Mental Health Act 1983
RPR	Relevant Person's Representative



- 1.1 There are many people in different settings who are deprived of their liberty by virtue of the type of care or treatment that they are receiving, or the level of restrictive practices that they are subject to, but they cannot consent to it because they lack the mental capacity to do so. In most cases, the care and treatment is necessary and is being delivered in their best interests even though it amounts to a deprivation of liberty. The Deprivation of Liberty Safeguards ('DOLS') were brought into force in April 2009 to ensure that professionals applied checks and balances when they had to deprive people lacking capacity of their liberty.
- 1.2 The State is under an obligation to make sure that where deprivation of liberty is delivered by social care or health care professionals, who are in law treated as "State agents," that there is lawful authority for that deprivation. Such authority is required to comply with Article 5(1) of the European Convention on Human Rights ('ECHR'), made part of English law by s.6 Human Rights Act 1998, which places strict limits upon the circumstances under which individuals can be deprived of their liberty.
- 1.3 In March 2014, the Supreme Court handed down judgment in two cases: [*P v Cheshire West and Chester Council and P & Q v Surrey County Council*](#).¹ That judgment, commonly known as *Cheshire West*, has led to a considerable increase in the numbers of people in England and Wales who are considered to be deprived of their liberty for the purposes of receiving care and treatment. The Supreme Court decided that when an individual lacking capacity was under continuous or complete supervision and control **and** was not free to leave, they were being deprived of their liberty. This is now commonly called the "**acid test**."²
- 1.4 Thus, after reviewing the restrictions on an individual, and if those restrictions amount to a deprivation of liberty, authority must be sought. Depending on the circumstances, that may be by way of a DOLS authorisation, under the Mental Health Act 1983, or by way of a court order.
- 1.5 This guidance was commissioned by the Department of Health to assist those professionals most directly concerned with commissioning, implementation and oversight of arrangements for care and treatment of individuals who may lack the capacity to consent to such arrangement. Its purpose is to provide practical assistance in identifying whether they are deprived of their liberty, and hence to ensure that appropriate steps can be taken to secure their rights under Article 5 ECHR.
- 1.6 To that end, the guidance seeks to draw together the assistance that can be found from the case law decided to date and from the practical experience of the authors, who are all lawyers who (in different contexts) advise upon and act in cases involving questions of deprivation of the liberty. The authors particularly wish to thank the members of the formal practitioner group who provided detailed and helpful assistance at stages in its production, as well as a number of other individuals who provided ad hoc input.³
- 1.7 Whilst the guidance was commissioned by the Department of Health, it does not represent a statement of Department of Health policy, but rather the views of the authors.

1 [\[2014\] UKSC 19](#)

2 Because Lady Hale, at paragraph 48 of the judgment, started her analysis by asking: "[s]o is there an acid test for the deprivation of liberty in these cases?"

3 Full details of the authors, the practitioner group and other acknowledgments can be found in the Appendix.

A: Audience for the guidance

- 1.8 Whilst we anticipate that some of those who will read the guidance will be legally qualified, the primary audience are frontline social and health professionals who need to be able to weigh up whether an individual they are concerned with may be deprived of their liberty and then to take appropriate action. To that end, its primary focus is upon the practical application of the legal principles in the most common care and treatment settings in which questions of deprivation of liberty are likely to arise.
- 1.9 This guidance can be seen as an informal update to Chapter 2 of the Code of Practice accompanying Schedule A1 to the MCA 2005 (often called the ‘DOLS Code’⁴). However, this guidance (unlike the DOLS Code) does not have a statutory basis and professionals do not therefore have to have regard to it in the same way as they do the DOLS Code.⁵

B: Outline of the guidance

- 1.10 The guidance is divided into chapters as follows:

Part I: Overview

- Chapter 1: Introduction
Chapter 2: The law
Chapter 3: Key questions after *Cheshire West*

Part II: Specific settings

- Chapter 4: The hospital setting
Chapter 5: The psychiatric setting
Chapter 6: The care home setting
Chapter 7: Supported living
Chapter 8: Deprivation of liberty at home
Chapter 9: Under 18s

Part III: Further information

- Chapter 10: Summaries of key cases
Chapter 11: Further resources

Appendix:

Note on authors and the practitioner group and acknowledgments

- 1.11 Throughout the guidance, we provide hyperlinks to freely available transcripts of the case law to which we refer, as well as other relevant materials.

⁴ Available at http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087309.pdf

⁵ The status of Chapter 2 of the DOLS Code and the way in which it is to be read in light of subsequent developments is discussed in more detail at paragraphs 2.59 and 2.61.

C: How to use this guidance

- 1.12 As discussed in more detail in Chapter 2, there is no statutory definition of a deprivation of liberty and so professionals must look to the DOLS Code of Practice, case law since the Code was introduced and this guidance as to what circumstances amount to a deprivation of liberty. Ultimately if professionals and their lawyers cannot agree upon whether a deprivation of liberty is occurring for a particular individual, it would be for a court to determine the matter. At the time of writing this guidance, however, the courts have not yet decided upon how the ‘acid test’ applies to all the contexts with which health or social care professionals may be concerned.⁶
- 1.13 It is the gap between the decisions of the courts to date and the practical circumstances facing professionals on the ground which this guidance seeks to fill, but it is important that those referring to this guidance are clear as to how it is to be used.
- 1.14 In Part II, we detail the most common settings in which a deprivation of liberty may occur. For each, we:
- 1.14.1 Identify a number of factors that may point towards there being a deprivation of liberty. After careful consideration, we have decided that it is not helpful to seek to break these down further to address specific elements of the ‘acid test’ identified in *Cheshire West*, (continuous or complete supervision and control and lack of freedom to leave) but there will be some which go more obviously to one or other limb of the test. We call these factors ‘liberty-restricting measures.’ They are practices that social workers or healthcare staff may or may not normally consider to be restrictive;
 - 1.14.2 Suggest a scenario which we consider is very likely to amount to a deprivation of liberty; a scenario which we consider may amount to a deprivation of liberty; and a scenario (if they exist in any given setting) in which it is likely that the restrictions will not amount to a deprivation of the individual’s liberty. We highlight after each the key factors underlining our thinking. Each scenario is fictitious, as are the names of the individuals used, although some of them are based upon actual cases decided by the courts (and where they are, we make this clear);
 - 1.14.3 Pose a number of questions that professionals can ask to identify which side of the line a specific situation confronting them may fall.
- 1.15 It is important to emphasise that:
- 1.15.1 The test for considering whether to engage the DOLS process, the MHA 1983 or go to the Court of Protection is never whether the professional is **certain** that there is a deprivation of liberty, but rather there is a **risk** of a deprivation of liberty.⁷ If there is such a risk, that should trigger further assessment;
 - 1.15.2 Where a scenario is not based upon the facts of a particular case decided by the courts, it cannot be a substitute for a court decision upon similar facts;

⁶ The guidance is based upon the law as it stands in February 2015; at chapter 11 we provide useful resources which can be used to keep up to date.

⁷ See *AM v South London and Maudsley NHS Trust* [2013] UKUT 0365 (AAC): “... the DOLS regime ... applies when it appears that judged objectively there is a risk that cannot sensibly be ignored that the relevant circumstances amount to a deprivation of liberty” (paragraph 59, emphasis added).

- 1.15.3 It may well be that some of the scenarios that we outline provoke debate and discussion amongst front-line professionals - especially those we identify as being a potential deprivation of liberty. If nothing else, this means that if professionals come across similar facts they should stop and think very carefully about whether they are confident about whether they represent a deprivation of liberty or not (and, if necessary, seek legal advice);
- 1.15.4 The lists of factors that we identify in each chapter **are not** to be taken as a checklist to be applied mechanically. In some cases, the presence of one factor will be sufficient to indicate that the individual is likely to be deprived of their liberty. In others, several of the factors may be present but the individual may still only be subject to a restriction, rather than a deprivation of liberty, of their liberty. The factors – together with the questions we suggest – are set out to assist in the process of determining whether an individual is or is not deprived of their liberty, a process which ultimately relies upon the application of judgment by the professional(s) concerned.

D: Limits of the guidance

1.16 In addition to the limitations set out immediately above, we make clear that:

- 1.16.1 The guidance does not provide detailed answers to the question of what should happen where a deprivation of liberty has been identified. A short answer is set out at paragraphs 2.41 to 2.43, but it is outside the scope of this guidance to provide detailed answers, which will depend upon the precise circumstances in which the deprivation of liberty has arisen. Professionals should note that the Law Commission is currently examining the question of how deprivation of liberty in the context of the delivery of care and treatment should best be regulated and authorised. It is anticipated that a consultation paper will be forthcoming in the summer of 2015 and a final report (and draft legislation) in the summer of 2017;⁸
- 1.16.2 This guidance is primarily addressed to the position in England and Wales: the considerations that arise in respect of Northern Ireland and Scotland, in particular in relation to the authorisation of deprivation of liberty,⁹ are sufficiently different that space precludes consideration of these jurisdictions. It may nonetheless be useful for frontline professionals confronted with the same questions as their counterparts in England and Wales;
- 1.16.3 For the reasons discussed at the start of chapter 9, this guidance is deliberately limited in respect of those under 18 to 16 and 17 years olds lacking capacity to take the material decisions;
- 1.16.4 This guidance does not constitute legal advice, which must be sought – if necessary – on the facts of any specific individual case.

⁸ For more detail, see <http://lawcommission.justice.gov.uk/areas/capacity-and-detention.htm>

⁹ For an overview in the context of proposals to amend the relevant legislation in Scotland, see <http://www.scotlawcom.gov.uk/law-reform-projects/adults-with-incapacity/>

E: The bigger picture

1.17 There are three crucial ways in which this guidance needs to be seen as part of the bigger picture.

Why are we concerned about deprivation of liberty?

1.18 In order to understand why deprivation of liberty is only part of a bigger picture, it is important to stop and ask **why** we are concerned about whether a person is deprived of their liberty?

1.19 As important as the procedural steps required to authorise a deprivation of liberty are (including the right to challenge that deprivation of liberty¹⁰), it is almost more important in this context to remember that professionals are working with individuals who cannot take decisions about some of the most fundamental issues in their lives. Because such decisions are taken by others, these individuals are extremely vulnerable.¹¹ Therefore professionals must focus on whether the **whole care and/or treatment package** is in the best interests of the person who cannot consent to it because they lack the capacity to do so. In other words, the starting point must be a consideration of whether the arrangements made for them – their placement and the care and/or treatment plan around them – are in their best interests having regard to less restrictive alternatives. This represents – or should represent – no change to the normal approach adopted by health and social care professionals to the delivery of care and treatment of those without capacity.

1.20 In some circumstances that placement and those arrangements may amount to a deprivation of the person's liberty. If so, then professionals must seek authority for that deprivation. That they must do so – we emphasise – is not a reflection of anything 'wrong' being done by the professionals in terms of the delivery of care or treatment, but rather the proper operation of the law.

Deprivation of liberty is not the only issue

1.21 Many individuals whose situations may amount to a deprivation of liberty will also have decisions made for them by professionals about important aspects of their lives. Those decisions may or may not relate to steps amounting to a deprivation of liberty but are very likely to involve decisions that relate to the person's private and family life.

1.22 Respect for private and family life, one's home and correspondence, is a right guaranteed by Article 8 ECHR. Where the decisions do interfere with Article 8, (contact with family being the most obvious example), they can only be justified if they are necessary and proportionate and addressed to the individual's specific situation rather than – for instance – to assist the easier management of the placement.

1.23 Professionals must also appreciate that decisions as to whether to prevent or control a person's contact with others have a greater impact on that person when they are also deprived of their liberty. The European Court of Human Rights ('ECtHR') has emphasised how much more personal autonomy means for those who are the subject of 'authorised' deprivations of liberty.¹²

¹⁰ See further paragraph 2.10.

¹¹ See paragraph 57 of the judgment in *Cheshire West*.

¹² See *Munjaz v United Kingdom* [2012] ECHR 1704 at paragraph 80, in the context of detention under the Mental Health Act 1983.



- 1.24 Further, professionals should always remember that authority to deprive someone of their liberty does not, itself, provide authority to provide care and treatment to them. If a person does not have capacity to consent to take decisions in this regard, then it will always be necessary to consider the basis upon which those decisions are being taken by others and their authority for doing so which, will, in general terms, be:
- 1.24.1 On the basis of the provisions of ss.5-6 MCA 2005¹³, in terms of the delivery of ‘routine’ care and treatment;
 - 1.24.2 On the basis of a court order, where the care and treatment goes beyond the ‘routine;’
 - 1.24.3 In some circumstances, on the basis of the provisions of Part IV of the Mental Health Act 1983 (but only ever in relation to the provision of medical treatment related to the individual’s mental disorder).
- 1.25 In other words, no one should assume that just because the deprivation of liberty is authorised that this is the end of the story for that individual.

The need for a plan

- 1.26 As noted above, this guidance does not seek to answer the question of what individuals, organisations and public bodies are to do when there is a deprivation of liberty. However, we conclude this introductory chapter by emphasising the importance of organisations and public bodies having in place proper policies and procedures both to enable staff to identify when a deprivation of liberty may arise¹⁴ and what they are meant to do if it does. Only if such policies are in place can front-line professionals get on with their primary task of making arrangements and caring for individuals, confident that they know what to do if those arrangements and that care amount to a deprivation of liberty.

13 Which serve – in essence – to protect those delivering care and treatment from legal liability if they reasonably consider that the person in question lacks the capacity in relation to the relevant matter and that they are acting in the person’s best interests

14 Which may well include a specific indication as to what the particular organisation considers amounts to a ‘non-negligible’ period of time: see further paragraphs 3.29-3.32.

A: Introduction

- 2.1 This chapter will be of use to professionals who need to have a detailed understanding of the legal framework that governs deprivation of liberty. It is likely to contain more detail than is required for professionals who need to decide on a day to day basis whether those to whom they are delivering (or arranging) care and treatment are deprived of their liberty; such professionals are likely to find it more useful to go straight to Chapter 3 which specifically addresses the ‘acid test’ identified in *Cheshire West* and its application.
- 2.2 In this chapter, we outline, first, the central principles of Article 5 ECHR; then summarise the key elements of the *Cheshire West* decision; outline (briefly) the authorisation of deprivation of liberty and the consequences of **not** getting appropriate authorisation; address the somewhat different legal issues that arise in the case of ‘private’ deprivations of liberty; and, finally, conclude with a short note on the status of the Code of Practice accompanying Schedule A1 to the MCA 2005 (often called the ‘DOLS Code’¹).
- 2.3 Since its amendment by the Mental Health Act 2007², the MCA 2005 provides the primary vehicle through which the deprivation of liberty of those lacking capacity to consent to their care and treatment is authorised³. This is done primarily by the introduction of the Deprivation of Liberty Safeguards regime which is contained in Schedule A1 of the MCA 2005 as amended.⁴
- 2.4 At this juncture it is worth referring to ss.5-6 MCA 2005 with which professionals should be familiar. In almost every case, there will be a continuum from:
- 2.4.1 *‘routine’ decisions or interventions in an individual’s life to provide them with care and treatment.* These will be taken on the basis of a reasonable belief that the individual lacks capacity to take the material decision and that the professional is acting in the individual’s best interests: these can be carried out safe in the knowledge that the professional is protected from liability under s.5 MCA 2005;
- moving through to:*
- 2.4.2 *Interventions that constitute restraint.* Restraint does not merely mean the use of force, but can include the threat of the use of force or restriction of the individual’s liberty, whether or not they resist.⁵ By operation of s.6 MCA 2005, a professional restraining an individual will be protected from liability provided the restraint is proportionate to the risk of and likelihood of harm and is only used where the professional reasonably believes it to be necessary to prevent harm to the person;
- moving through to:*
- 2.4.3 *Interventions that go beyond ‘mere’ restraint to a deprivation of liberty.* The professional at that point cannot rely upon the provisions of ss.5-6 MCA 2005, but authority will be required from one of the sources identified at paragraph 2.41 below.

1 Available at http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/en/documents/digitalasset/dh_087309.pdf

2 To respond to the decision of the European Court of Human Rights in *HL v United Kingdom* (the ‘Bournewood case’) *HL v United Kingdom* (2004) 40 EHRR 761.

3 Save where that is for purposes of providing them with treatment for their mental disorder, in which case the Mental Health Act 1983 will be as – if not more – important.

4 Schedule 1A deals with the interface between the MCA DOLS regime and the Mental Health Act 1983.

5 Section 6(4) MCA 2005.

- 2.5 It is identifying precisely where the measures lie on the continuum that can sometimes prove so difficult. This difficulty is not helped by the fact that the MCA 2005 does not contain a detailed statutory definition of what constitutes a deprivation of liberty. Rather, it provides in s.64(5) that “[i]n this Act, references to deprivation of a person’s liberty have the same meaning as in Article 5(1) of the Human Rights Convention.” This means that when the courts are asked to decide whether a particular set of circumstances amounts to a deprivation of liberty, they have had to try to work out what the ECtHR – which has ultimate responsibility for interpreting the Convention - would say.
- 2.6 Authoritative guidance as to the broad approach to adopt has now been given by the Supreme Court in *P v Cheshire West and Chester Council; P & Q v Surrey County Council* [2014] UKSC 19, commonly known as ‘Cheshire West.’ As set out in more detail at paragraphs 2.23 to 2.38 below, the court decided that a person lacking the relevant capacity met the ‘acid test’ of being deprived of their liberty in any setting where they were under continuous (or complete) supervision and control and not free to leave.
- 2.7 This chapter concentrates on Article 5 ECHR because it underpins both Schedule A1 to the MCA 2005 and it creates the requirement for applications to be made to the Court of Protection for judicial authorisation of deprivations of liberty in settings outside care homes and hospitals.⁶
- 2.8 However, as outlined in Chapter 1, it is important to remember that determining the care and treatment arrangements for someone lacking capacity to consent to them may give rise to the need to consider other ECHR rights, most obviously the Article 8 right to respect for private and family life. It may also, in some circumstances, require attention to other legal issues such as criminal liability or liability for false imprisonment. This chapter does not, and cannot, contain a detailed discussion of all the legal issues that might arise; for more reading, see the resources in Chapter 11.

B: Article 5 ECHR

- 2.9 The most relevant parts of Article 5 ECHR are:

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

[...]

(e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants;

- 2.10 Article 5 also carries with it an express procedural protection, set out in Article 5(4) which provides that:

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

⁶ I.e. in settings for which it is not possible to seek authorisation under Schedule A1 to the MCA 2005.

- 2.11 Alone amongst the provisions of the ECHR, Article 5 also provides a guarantee in Article 5(5) that those who have had their rights under this Article breached have an enforceable right to compensation. As discussed further at paragraph 2.46, this does not necessarily mean that they are entitled to money, but this guarantee emphasises the importance of the rights enshrined in Article 5.
- 2.12 As interpreted by the European Court of Human Rights and by the courts in this country, Article 5(1) has been identified as having three elements, all of which need to be satisfied before a particular set of circumstances will amount to a deprivation of liberty falling within the scope of the Article:
- 2.12.1 The **objective element**: i.e. that the person is confined to a particular restricted place for a non-negligible period of time;
 - 2.12.2 The **subjective element**, i.e. that the person does not consent (or cannot, because they do not have the capacity to do so) to that confinement;
 - 2.12.3 **State imputability**: i.e. that the deprivation of liberty can be said to be one for which the State is responsible.
- 2.13 Each of these will be examined briefly below, but it is always important to remember that there is a legal difference between a **restriction** upon a person's liberty and a **deprivation** of their liberty. Although the United Kingdom has not ratified Protocol 4 to the ECHR, which enshrines⁷ the right to liberty of movement and freedom to choose one's residence, the ECtHR has made reference to this Protocol on several occasions in seeking to highlight the distinction between restriction and deprivation,⁸ along with the points that:
- 2.13.1 The difference between deprivation of liberty and restrictions on liberty of movement is merely one of degree or intensity, and not one of nature or substance;⁹ and
 - 2.13.2 Although the process of classification into whether it is a deprivation or a restriction will sometimes prove to be no easy task, in that some borderline cases are a matter of pure opinion, a decision¹⁰ has to be taken as to which side of the line the circumstances fall.¹¹

C: The objective element

- 2.14 In deciding whether someone has been deprived of their liberty, the ECtHR has decided that the starting point must be their concrete situation and account must be taken of a range of criteria such as the type, duration, effects and manner of implementation of the restrictive measure in question.¹²

7 In Article 2.

8 Perhaps the most relevant decision being [Stanev v Bulgaria](#) (2012) 55 EHRR 22 at paragraph 115. Lady Hale in *Cheshire West* set out the key propositions from *Stanev* at paragraphs 19-25.

9 *Cheshire West* at paragraph 20 citing *Stanev* at paragraph 115.

10 Ultimately by the ECtHR.

11 *Cheshire West* at paragraph 20 citing *Stanev* at paragraph 115.

12 *Cheshire West* at paragraph 20 citing *Stanev* at paragraph 117.

- 2.15 For a person to be deprived of their liberty for the purposes of Article 5 ECHR, it is clear from the ECtHR case law that they must be confined to a particular restricted place for a non-negligible period of time.¹³ Exactly what will constitute a ‘non-negligible’ period of time appears from the case-law to vary according to the particular circumstances under consideration. We discuss this in more detail at paragraphs 3.29-3.32.
- 2.16 The objective element (but not the time element) was considered in detail by the Supreme Court in the decision in *Cheshire West*, and is discussed further in Chapter 3 below.

D: The subjective element

- 2.17 Even if a person is objectively confined, their circumstances will not fall within the scope of Article 5 ECHR if they have validly consented to the confinement.¹⁴ A person can only give valid consent to being subject to circumstances amounting to a deprivation of their liberty if they have the mental capacity to do so.¹⁵
- 2.18 There have been very few decisions identifying what is required to have capacity to consent to what would otherwise be a deprivation of liberty. In *M v Ukraine*,¹⁶ a case concerning deprivation of liberty in a psychiatric facility, the ECtHR held that:
- “ 77. ... [T]he Court takes the view that a person’s consent to admission to a mental health facility for in-patient treatment can be regarded as valid for the purpose of the Convention only where there is sufficient and reliable evidence suggesting that the person’s mental ability to consent and comprehend the consequences thereof has been objectively established in the course of a fair and proper procedure and that all the necessary information concerning placement and intended treatment has been adequately provided to him.”¹⁷*
- 2.19 In the English (and Welsh) setting, in *A PCT v LDV & Ors*¹⁸ – a case concerning deprivation of liberty in a psychiatric hospital – Baker J held that:
- 2.19.1 The relevant question to ask is that set out in the “mental capacity requirement” in paragraph 15 of Schedule A1, i.e. “*whether or not he should be accommodated in the relevant hospital or care home for the purpose of being given relevant care or treatment;*”¹⁹ and
- 2.19.2 The information relevant to that question goes beyond simply the information relating to the placement to include information about the care and treatment and, broadly, the nature of the restrictions that will amount to an objective deprivation of their liberty.²⁰

13 *Cheshire West* at paragraph 20 citing *Stanev* at paragraph 117.

14 *Cheshire West* at paragraph 20 citing *Stanev* at paragraph 117.

15 *Cheshire West* at paragraph 23 citing *Stanev* at paragraph 118 and, in turn, *HL v United Kingdom* (2004) 40 EHRR 761 at paragraph 90.

16 [2012] ECHR 732.

17 On the facts of the case, the Court held that there was no evidence suggesting that M’s “mental ability to consent was established, that the consequences of the consent were explained to her or that the relevant information on placement and treatment was provided to her,” such that she could not be said to have given valid and lawful consent to what was objectively a deprivation of her liberty.

18 [2013] EWHC 272 (Fam).

19 See paragraph 29.

20 See paragraphs 39 and 40 which set out a list of factors that amounted to a deprivation of liberty in LDV’s case.

- 2.20 We suggest that the same broad approach will apply in other settings, i.e. that the material information will include the outlines – even if not the minute detail – of the circumstances (in many cases, the contents of the care plan) which give rise to the deprivation of liberty. Most obviously, the information will include the circumstances establishing that the person is under continuous supervision and control and not free to leave (addressed further below).

E: Imputable to the State

- 2.21 The final requirement contained in Article 5 ECHR is that the deprivation of liberty must be imputable to the State. The ECtHR has held that this can arise in one of three ways,²¹ two of which are relevant for present purposes:²²
- 2.21.1 Direct involvement of public authorities in the individual’s detention, which will be the case in the majority of the scenarios discussed in this guidance;
- 2.21.2 By violating the state’s positive obligation under Article 5(1) to protect individuals against deprivation of their liberty carried out by private persons. This positive obligation is discussed further at paragraphs 2.50-2.58 below.

F: *Cheshire West*

- 2.22 In March 2014, the Supreme Court handed down a judgment holding that three individuals, ‘P’, ‘MIG’ and ‘MEG,’ were deprived of their liberty in three different settings.²³ This case is more commonly known as the “*Cheshire West*” judgment. The general principles established by the majority of the Supreme Court²⁴ are ones that are of wide application in both the social and healthcare settings. Those principles are discussed in this section, after the background to the decision is summarised.
- 2.23 One preliminary point should be made: no one at any stage suggested that the arrangements for each of P, MIG and MEG were not in their best interests. The question was solely whether the arrangements amounted to a deprivation of their liberty. This emphasises the extent to which there is a difference between the **neutral** question of whether a person is deprived of their liberty and the **evaluative** question of whether those arrangements are in their best interests.

Mr P

- 2.24 Mr P was an adult born with cerebral palsy and Down’s syndrome who required 24 hour care. Until he was 37 he lived with his mother but when her health deteriorated the local social services authority obtained orders from the Court of Protection that it was in P’s best interests to live in accommodation arranged by it. Since November 2009 he had lived in a staffed bungalow with two other residents near his mother’s home, in which there were normally two members of staff on duty during the day and one ‘waking’ member of staff overnight. Mr P required prompting and help with all activities of daily living, getting about, eating, personal hygiene and continence. He sometimes required intervention when he exhibited challenging

²¹ *Storck v Germany* (2006) 43 EHRR 6 at paragraph 89.

²² The third way that the ECtHR has held that a deprivation of liberty could be imputable to the State is where the courts have failed to interpret the law governing any claim for compensation for unlawful deprivation of liberty “in the spirit of Art. 5” (*Storck* at paragraph 89).

²³ Parts of this section draw (with permission) upon summaries produced by the 39 Essex Chambers Mental Capacity Law Newsletter editors, available at www.copcasesonline.com

²⁴ The lead judgment was given by Lady Hale, with whom Lord Sumption agreed. Lords Neuberger and Kerr expressly agreed with Lady Hale in their separate concurring judgments. Lords Carnwath and Hodge gave a joint dissenting judgment in the cases of P and Q.

behaviour (including attempting to eat his continence pads), but was not prescribed any tranquilising medication. He was unable to go anywhere or do anything without one to one support; such one to one support was provided at such a level (98 hours a week) as to enable him to leave the home frequently for activities and visits.

- 2.25 Baker J held²⁵ that these arrangements did deprive him of his liberty but that it was in P's best interests for them to continue. On the Council's appeal, the Court of Appeal substituted a declaration that the arrangements did not involve a deprivation of liberty, after comparing his circumstances with another person of the same age and disabilities as P.²⁶ The Official Solicitor appealed to the Supreme Court.

MIG (known also as 'P' before the Court of Appeal) and MEG (known as 'Q')

- 2.26 MIG was an 18 year old girl with a moderate to severe learning disability and problems with her sight and hearing, who required assistance crossing the road because she was unaware of danger, and who was living with a foster mother whom she regarded as 'Mummy.' Her foster mother provided her with intensive support in most aspects of daily living. She was not on any medication. She had never attempted to leave the home by herself and showed no wish to do so, but if she did, her foster mother would restrain her. She attended a further education college daily during term time and was taken on trips and holidays by her foster mother.
- 2.27 MIG's sister, MEG, was a 17 year old with mild learning disabilities living with three others in an NHS residential home for learning disabled adolescents with complex needs. She had occasional outbursts of challenging behaviour towards the other three residents and sometimes required physical restraint. She was prescribed (and administered) tranquilising medication to control her anxiety. She had one to one and sometimes two to one support. Continuous supervision and control was exercised so as to meet her care needs. She was accompanied by staff whenever she left. She attended the same further education college as her sister daily during term time, and had a full social life. She showed no wish to go out on her own, and so there was no need to prevent her from doing so.
- 2.28 When the care proceedings were transferred to the Court of Protection in 2009, Parker J held²⁷ that these living arrangements were in the sisters' best interests and did not amount to a deprivation of liberty. This finding was upheld by the Court of Appeal.²⁸ The Official Solicitor appealed to the Supreme Court.

The decision of the Supreme Court²⁹

- 2.29 The Supreme Court held (unanimously) that Mr P was deprived of his liberty, and (by a majority of 4 to 3) that P and Q were also deprived of their liberty. Despite the unanimity of the decision³⁰ in relation to Mr P, the Supreme Court justices were also divided 4 to 3 as to the governing questions of principle.

25 [\[2011\] EWHC 1330 \(COP\)](#).

26 [\[2011\] EWCA Civ 1257](#).

27 [\[2010\] EWHC 785 \(COP\)](#).

28 [\[2011\] EWCA Civ 190](#).

29 The decision is discussed in more detail in the [April 2014 edition](#) of the 39 Essex Chambers Mental Capacity Law Newsletter.

30 Although the minority made it clear that it was a 'marginal' case, which, had they been considering the question for themselves, they might have concluded differently: paragraph 103.



- 2.30 All the Supreme Court justices agreed that the ECtHR had never considered the precise combination of factors that arose in the context of the cases before them (and which prevail also in many cases involving the DOLS regime). The division between the minority and the majority was whether it was possible to distil a clear test from the principles in decided cases; the minority considered that it was not possible to derive a universal test, and that the approach had to be case-specific. Lady Hale, for the majority, held that there was an ‘acid test’ that could be applied, at least in the circumstances of the cases before them, namely to ask whether the individual in question was subject to continuous (or – elsewhere³¹ – complete) supervision and control and was not free to leave.³² In reaching this conclusion, Lady Hale cited the decision of the ECtHR in *HL v United Kingdom* in which these same phrases had been used.³³
- 2.31 The majority also held that irrelevant to the determination of whether a person is deprived of their liberty is: (1) the person’s compliance or lack of objection; (2) the relative normality of the placement (whatever the comparison made); and (3) the reason or purpose behind a particular placement.
- 2.32 It was uncontroversial before the Supreme Court that, in order for a deprivation of liberty to fall within the scope of Article 5(1) ECHR, it will also be necessary for the person not to have given valid consent to the arrangements, and that the deprivation of liberty must be imputable to the State. As Lady Hale noted in respect of the latter, the positive obligation identified in Article 5(1) to protect the liberty of those within its jurisdiction may make the State on occasions “*accountable even for arrangements which it has not itself made.*”³⁴
- 2.33 Lady Hale was also at pains to emphasise that the fact that the arrangements made for an individual who cannot consent to them may be the best that can be made for them is irrelevant in determining the question of whether they amount to a deprivation of their liberty: in other words “*a gilded cage is still a cage.*”³⁵
- 2.34 Speaking extra-judicially in a speech in October 2014, Lady Hale summarised the judgment of the Supreme Court thus:³⁶

“We all held that the man had been deprived of his liberty, but three members of the court held that the sisters had not been deprived of their liberty, while the majority held that they had. The acid test was whether they were under the complete control and supervision of the staff and not free to leave. Their situation had to be compared, not with the situation of someone with their disabilities, but with the situation of an ordinary, normal person of their age. This is because the right to liberty is the same for everyone. The whole point about human rights is their universal quality, based as they are upon the ringing declaration in article 1 of the Universal Declaration of Human Rights, that ‘All human beings are born free and equal in dignity and rights’.”

31 Paragraph 53.

32 Paragraphs 48-49.

33 At paragraph 49, citing [HL v United Kingdom](#) (2004) 40 EHRR 761 at paragraph 91.

34 Paragraph 26.

35 Paragraph 46.

36 “Psychiatry and the Law: An enduring interest for Lord Rodger”: The Lord Rodger Memorial Lecture 2014, available at <https://www.supremecourt.uk/docs/speech-141031.pdf>

2.35 This statement does not, of course, represent a judicially endorsed summary of the decision, but it does represent a useful insight into the reasoning of the majority. As Lady Hale recognised in the next paragraph in her lecture:

“The decision has alarming practical consequences. It means that a great many elderly and mentally disabled people, wherever they are living, must have the benefit of safeguards and reviews, to ensure that their living arrangements are indeed in their best interests.”

2.36 The practical consequences of the decision are outside the scope of this guidance, but it is important to note that in the lecture, as in the judgment itself,³⁷ that Lady Hale was concerned to emphasise that the **purpose** of the scrutiny is to ensure that the arrangements made for vulnerable individuals such as P, MIG and MEG are in their best interests.

2.37 It is important to note that the local authorities involved in the case could not appeal to the European Court of Human Rights. Until and unless either the Supreme Court holds that a deprivation of liberty in the context of Article 5(1)(e) ECHR means something different to that determined in *Cheshire West* or the European Court of Human Rights holds either expressly or implicitly that the Supreme Court was incorrect, the approach set down by the majority represents the current law of the land in England and Wales and must be respected by professionals and their legal advisers.³⁸

2.38 We address the elements of the ‘acid test’ in more detail in Chapter 3.

G: The need for authority to deprive a person of their liberty

2.39 If the three key elements of the Article 5(1) ‘trinity’ are met – i.e. the person is confined to a particular place for more than a non-negligible period of time, they cannot consent to that confinement, and the deprivation of liberty is imputable to the State – then it is necessary for authorisation to be obtained. The public body depriving the person of their liberty is otherwise acting unlawfully by virtue of s.6(1) Human Rights Act 1998, as they will be breaching their Article 5 ECHR rights.

2.40 It is beyond the scope of this guidance to outline the steps required to authorise the deprivation of liberty of a person unable to consent to the same.³⁹ In broad terms, the person will either have to be the subject of a DOLS authorisation issued under Schedule A1 to the MCA 2005 (if they are in a hospital or care home),⁴⁰ or detained under the Mental Health Act 1983,⁴¹ or made the subject of a court order (most usually the Court of Protection, but in some circumstances potentially an order of the High Court under the inherent jurisdiction). Reference should be made to the Code of Practice accompanying Schedule A1 to the MCA

³⁷ At paragraph 57.

³⁸ And, whilst not formally binding, is at a minimum highly influential in Scotland. Whilst this guidance does not purport to address the legal position in Scotland, we note the extensive reference to the decision in the Scottish Law Commission’s report on Adults with Incapacity (setting out a draft statutory scheme to be the functional equivalent of Schedule A1 to the MCA 2005, available at <http://www.scotlawcom.gov.uk/law-reform-projects/adults-with-incapacity/>).

³⁹ If the person can consent (i.e. they have the capacity to do so) but does not do so, then there may be circumstances under which a deprivation of liberty will be lawful – most obviously where the person can be the subject of compulsory detention (‘sectioning’) under the Mental Health Act 1983. We do not discuss these situations in this guidance.

⁴⁰ The process for doing so will differ whether the person is in England or in Wales because of the different arrangements made for supervisory bodies in the two areas.

⁴¹ Section 4B MCA 2005 also gives authority to deprive a person of their liberty if this is necessary to provide life-sustaining treatment or to prevent a serious deterioration in the person’s condition pending determining of an application relating to that person by the Court of Protection.



2005 (often called the ‘DOLS Code’⁴²), as well as the new Code of Practice accompanying the Mental Health Act 1983.⁴³ Where a person is deprived of their liberty other than in a care home or hospital and an order of the Court of Protection is required, reference should also be made to Practice Direction 10AA,⁴⁴ which provides more detail as to the steps that are required.⁴⁵

H: The effect of authorisation

- 2.41 It is important to understand that the grant of authority to deprive an individual of their liberty under the MCA 2005 (whether by way of a DOLS authorisation or an order of the Court of Protection) does not require the individual to be deprived of their liberty. In other words, it is not an order that the person must be detained. Rather, it means that a person or body can rely upon that authority to deprive the individual of their liberty secure in the knowledge that they are acting lawfully.
- 2.42 This means – for instance – that we consider that there is nothing wrong in having in place a standard authorisation to cover a regular deprivation of liberty in a respite placement⁴⁶ if the individual goes into that respite placement (say) for a week every month. It would not then be necessary for the managing authority of the respite placement to seek (and the relevant supervisory body to grant) a separate authorisation for each respite stay. As a matter of law, the authorisation would – in essence, cover those periods each month when the individual was a detained resident at the respite placement, and could be relied upon for those periods to provide authority to detain them (assuming that all the other conditions are met).
- 2.43 We should emphasise that we consider that this route⁴⁷ will be lawful only if the respite placement is a regular one because it would only be proper to construe the individual as being a ‘detained resident’ at the placement for purposes of paragraph 19(2) of Schedule A1⁴⁸ if there is such a degree of regularity.⁴⁹

I: Consequences of a failure to obtain an authorisation

- 2.44 As noted above, if a public body does not have authority to deprive an individual of their liberty, they will be acting unlawfully contrary to s.6 Human Rights Act 1998.⁵⁰ The individual in question will be entitled to a declaration that their rights have been breached. The question

42 Available at http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087309.pdf

43 Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/396918/Code_of_Practice.pdf: this will come into force in April 2015 subject to Parliamentary approval.

44 <http://www.judiciary.gov.uk/publications/10aa-deprivation-of-liberty/>

45 Following the decision of the President of the Court of Protection in *Re X & Ors (Deprivation of Liberty)* (Nos 1 and 2) [2014] EWCOP 25 and [2014] EWCOP 37. Note that the judgment of the Court of Appeal in appeals made against these decisions was awaited at the time of writing this guidance.

46 If it is a hospital or care home falling within the scope of Schedule A1.

47 Which we accept is not provided for expressly in either Schedule A1 or the DOLS Code, but which we consider is not inconsistent with either (and, most importantly, Schedule A1).

48 I.e. the first condition that must be satisfied for them to meet the best interests requirement under Schedule A1.

49 There is also a question mark as to whether it is necessary that the person be present at the placement at least once every 28 days, or whether the requirement in paragraph 24(2) of Schedule A1 that the person is ‘likely – at some time within the next 28 days – to be a detained resident’ only applies in relation to the initial deprivation of liberty. In the absence of any case-law, we consider that it is legitimate to take the view that the requirement only applies to the initial deprivation of liberty, such that an authorisation can be granted even in the case of more infrequent (but still regular) periods of respite.

50 They may also be liable to a claim for false imprisonment: in other words, a claim at common law that they imprisoned the individual without lawful authority to justify such imprisonment. In practice, claims in this context are usually brought on the basis of the Human Rights Act 1998, in part because the legal framework relating to such claims is rather more straightforward.



that is often asked, however, is whether they will be entitled to more – and, in particular, whether they will be entitled to financial compensation.

2.45 The question of when damages are payable for breaches of rights under Article 5 ECHR is a complicated one that lies outside the scope of this guidance to discuss in detail. However, we think it important to highlight the – limited – number of cases in which judges have considered damages awards in the Court of Protection:⁵¹

2.45.1 In *London Borough of Hillingdon v Neary*⁵², a period of a year’s detention resulted in an award of £35,000 (no judgment being made public to accompany the consent order approved by the High Court);

2.45.2 In *A Local Authority v Mr and Mrs D*,⁵³ District Judge Mainwaring-Taylor approved an award of £15,000 (plus costs) to Mrs D for a period of 4 months unlawful detention (together with £12,500 to her husband and his costs). In *Mr and Mrs D*, District Judge Mainwaring-Taylor had noted that this was towards the lower end of the range if the award in the Neary case was taken as the bench mark;

2.45.3 In *Essex County Council v RF*,⁵⁴ District Judge Mort noted the important difference between ‘procedural’ breaches, where the authority’s failure to secure authorisation for the deprivation of liberty or provide a review of the detention would have made no difference to P’s living or care arrangements and ‘substantive’ breaches occur where P would not have been detained if the authority had acted lawfully. As the judge noted, such breaches have more serious consequences for P. He further noted that two decisions above suggested that the level of damages for the substantive breaches of the right to liberty is between £3000 and £4000 per month. In the case before him, the judge was clear that the Council’s practice was substandard – indeed that their conduct had been reprehensible, with “*very sad and disturbing consequences for P.*” The judge ultimately approved an award of £60,000 to reflect the unlawful deprivation of RF’s liberty in a care home for a period of approximately 13 months.⁵⁵

2.46 By contrast, in *A County Council v MB, JB and a Residential Home*,⁵⁶ Charles J granted a declaration that a woman had been unlawfully deprived of her liberty at a care home from 29 March 2010 to 13 April 2010, but made no award of damages, noting – in his view correctly – that no such award had been sought. It is clear from the judgment in that case that this was a case where the breach was ‘procedural’ rather than ‘substantive,’ and indeed that the local authority had made attempts to ensure that the appropriate authorisation was obtained, albeit unsuccessful.

51 It is perhaps important to note that none of these decisions actually stand formally as a precedent, the first because it was a consent order with no accompanying judgment, and the second and third because they are decisions of District Judges. They nonetheless stand as a useful guide to the approach that may be adopted.

52 [2011] EWCOP 1377.

53 [2013] EWCOP B34.

54 [2015] EWCOP 1.

55 The other elements of the compromise agreement he approved included: a declaration that the Council unlawfully deprived P of his liberty for period of approximately 13 months; the Council would waive any fees payable by P to the care home in which he was detained for the period of his detention (a sum of between £23,000 and £25,000); the Council to exclude P’s damages award from means testing in relation to P being required to pay a contribution to his community care costs; the payment of all P’s costs, to be assessed on the standard basis.

56 [2010] EWHC 2508 (COP).



- 2.47 The distinction between ‘procedural’ and ‘substantive’ breaches has also been highlighted – in the context of detention under the Mental Health Act 1983 – by the decision of the Court of Appeal in *Bostridge v Oxleas Foundation NHS Trust*,⁵⁷ in which the Court of Appeal held that a person unlawfully deprived of their liberty cannot claim any more than nominal damages (usually £1) if they have suffered no loss in consequence.⁵⁸ In other words, if the public body could show⁵⁹ that they would have been detained in any event if they had followed the correct procedures (there, those provided for under the Mental Health Act 1983), the claimant could not claim more than nominal damages. We suggest that a similar approach is likely to be followed in cases involving unlawful deprivation of liberty in the context of the MCA 2005.
- 2.48 The cases discussed above therefore suggest that the courts will take a very different view as to whether damages should be awarded depending on whether:
- 2.48.1 The public authority in question has sought to comply with its statutory obligations and – above all – properly to direct themselves by reference to the best interests of the individual, in which case there is a good argument that only declarations and nominal damages should be awarded;
- 2.48.2 The public authority has in its actions fallen below the standards expected of it, especially where it has failed to have appropriate regard to the impact of its actions upon the individual’s best interests. It is clear in this latter regard that the courts are increasingly unwilling to accept ignorance of the MCA 2005 as an excuse given that the length of time since the Act came into force.
- 2.49 It should, finally, be noted that a failure to obtain an authorisation may expose the relevant body not only to a claim before the courts but also to sanction from regulators⁶⁰ and/or the relevant Ombudsman.⁶¹ Regulatory sanctions will be much more likely to be imposed where the failures are systemic.

J: ‘Private’ deprivations of liberty and the positive obligation under Article 5(1) ECHR

- 2.50 As noted at paragraph 2.39 above, a deprivation of liberty only falls within the scope of Article 5(1) ECHR if it is ‘imputable’ to the State.
- 2.51 There has been a level of concern expressed following the *Cheshire West* judgment as to the extent to which the ‘acid test’ applies to ‘private’ deprivations of liberty – i.e. circumstances under which an individual lacking the relevant capacity is subject to continuous (or complete) supervision and control by a private individual (or body), they are not free to leave, but the arrangements are not made by the State.

57 [2015] EWCA Civ 79.

58 The case was also framed by reference to the common law tort of false imprisonment, but the Court of Appeal appeared to approach the question on the basis that the approach to the assessment of damages was identical.

59 It is for the public body to show this on the balance of probabilities: see, by analogy *R(EO & Ors) v SSHD* [2013] EWHC 1236 (Admin) at paragraph 74.

60 The CQC now includes compliance with the MCA 2005 – including (where relevant) with provisions relating to deprivation of liberty – as one of its Key Lines of Enquiry; details of enforcement actions taken for failures to comply with the requirements of Schedule A1 in 2013/4 are discussed in its most recent report upon DOLS, available at <http://www.cqc.org.uk/content/deprivation-liberty-safeguards-201314>

61 See for a recent example, the investigation of the Local Government Ombudsman into the case of Mr N, available at <http://www.lgo.org.uk/downloads/CO%20Adult%20social%20care/2014-2015/2111-13-016-935-Cambridgeshire-CC-20.1.2015.pdf>, in which the Ombudsman was, in particular, critical of the failure of Cambridgeshire County Council properly to consider the question of Mr N’s capacity and where his best interests lay in the decision-making process leading to his placement at a care home in circumstances that – it is clear – undoubtedly amounted to a deprivation of liberty but where no lawful authority was obtained.



- 2.52 As a starting point, we note that, whilst, strictly, those who are ‘self-funding’ in private care homes and hospitals (i.e. who have had arrangements made for them by family members and who are not reliant on State funding to pay for those arrangements) are outside the scope of Article 5(1) ECHR, they are to be treated **as if** they were within its scope, such that managing authorities of such institutions are required to apply for authorisations if they meet the acid test. The precise rationale for this is not explained in the DOLS Code⁶² but we would suggest that it is because private care home and hospitals are institutions regulated by the State. As such, any notionally ‘private’ deprivations of liberty taking place in such institutions are – or should – be ones of which the State is aware. This, in turn, triggers the State’s positive obligations to secure the Article 5 ECHR rights of the individuals concerned, which are discharged by operation of the authorisation procedure under Schedule A1.
- 2.53 Further, there will be many circumstances in which the person is cared for in their own home (or in some other living arrangement), where they are predominantly cared for privately, but where there is some State involvement. That State involvement can vary from – for instance – the payment of direct payments to an appropriate person on the individual’s behalf for the purposes of arranging their care down to much more limited involvement, such as visits by a nurse on a monthly basis. The precise point on this spectrum at which the arrangements will cease to be the direct responsibility of the State and be a matter for which private individuals are responsible (and hence which trigger the positive, rather than negative obligations of the State bodies concerned) is something that has yet to be decided by the courts. It will tentatively be discussed in the different settings in which it arises in the relevant chapters below.
- 2.54 Where a deprivation of liberty can truly be said to arise out of arrangements that the State has had no part in making, the obligation on the State bodies is to take measures “*providing effective protection*” of the individual.⁶³ In *Re A and Re C*⁶⁴ Munby LJ held that:

“Where the State – here, a local authority – knows or ought to know that a vulnerable child or adult is subject to restrictions on their liberty by a private individual that arguably give rise to a deprivation of liberty, then its positive obligations under Article 5 will be triggered.

- i *These will include the duty to investigate, so as to determine whether there is, in fact, a deprivation of liberty. In this context the local authority will need to consider all the factors relevant to the objective and subjective elements [of the test for deprivation of liberty discussed above];*
- ii *If, having carried out its investigation, the local authority is satisfied that the objective element is not present, so there is no deprivation of liberty, the local authority will have discharged its immediate obligations. However, its positive obligations may in an appropriate case require the local authority to continue to monitor the situation in the event that circumstances should change.*

62 Self-funders are – surprisingly – touched on only in passing in the DOLS Code at paragraph 5.23. That private care homes and hospitals fall within the scope of Schedule A1 is also supported by the confirmation in s.64(6) MCA 2005 that it does not matter for purposes of references to deprivation of liberty in the Act whether the person is deprived of his liberty by a public authority or not.

63 *Stanev* at paragraph 120.

64 [2010] EWHC 978 (Fam), at paragraph 95.



- iii *If, however, the local authority concludes that the measures imposed do or may constitute a deprivation of liberty, then it will be under a positive obligation, both under Article 5 alone and taken together with Article 14, to take reasonable and proportionate measures to bring that state of affairs to an end. What is reasonable and proportionate in the circumstances will, of course, depend upon the context, but it might for example, Mr Bowen suggests, require the local authority to exercise its statutory powers and duties so as to provide support services for the carers that will enable inappropriate restrictions to be ended, or at least minimised.*
- iv *If, however, there are no reasonable measures that the local authority can take to bring the deprivation of liberty to an end, or if the measures it proposes are objected to by the individual or his family, then it may be necessary for the local authority to seek the assistance of the court in determining whether there is, in fact, a deprivation of liberty and, if there is, obtaining authorisation for its continuance.”*

- 2.55 It is likely that the precise scope of the obligations on local authorities (and/or NHS bodies) who are – or should be – aware of ‘private’ deprivations of liberty will be the subject of further judicial scrutiny in due course, not least as certain of the Strasbourg cases on the subject have never been the subject of consideration by the English courts.⁶⁵
- 2.56 It is perhaps important also to note that a private individual who is depriving an incapacitated individual of their liberty in a purely private setting may also, depending upon the context, be liable for false imprisonment. This is a common law tort (i.e. ‘wrong’), the key elements of which are that the individual is imprisoned, and the person or body doing the imprisoning does not have authority to justify that imprisonment. A person who has been falsely imprisoned can seek damages from the responsible person or body. They do not need to show that they have suffered loss or damage (such as any form of injury) to be able to sue for damages, but if they cannot show that they have suffered any loss or damage they will not be entitled to more than nominal damages.⁶⁶ False imprisonment is also a common law criminal offence involving the unlawful and intentional or reckless detention of the victim.⁶⁷
- 2.57 The interaction between false imprisonment and unlawful deprivation of liberty contrary to Article 5 ECHR is not straightforward,⁶⁸ in particular because issues arise as to whether the person/body doing the detaining can rely upon the defence of necessity to defend themselves against a claim or charge of false imprisonment (in a way that cannot be done in relation to a claim brought under Article 5 ECHR⁶⁹). These are matters that lie outside the scope of this guidance.

65 Most obviously *Riera Blume v Spain* (2000) 32 EHRR 632 and *Rantsev v Cyprus and Russia* (2010) 51 EHRR 1 and *Rantsev v Cyprus and Russia*, as well as the more recent admissibility decision in *Chosta v Ukraine* (Application no. 35807/05, decision of 14 January 2014).

66 See most recently *Bostridge v Oxleas Foundation NHS Trust* [2015] EWCA Civ 79.

67 For a review of the complicated law in this area, see the Law Commission’s project on simplification of the law relating to kidnapping and related offences: <http://lawcommission.justice.gov.uk/areas/kidnapping.htm>

68 And a breach of Article 5 ECHR does not necessarily involve false imprisonment: see *Zenati v (1) Cmr of the Police for the Metropolis; (2) CPS* [2015] EWCA 80 at paragraphs 49-55.

69 This was the clear conclusion of the ECtHR in the *Bournewood* case, but the same court did not have to decide whether necessity could still play any part in relation to the common law.



2.58 It should, finally, be noted that, depending upon the circumstances, a private individual depriving an incapacitated individual in a purely private setting may also potentially be guilty of an offence under s.44 MCA 2005 if the conditions under which the individual was kept amount to ill-treatment or wilful neglect by the person doing the detaining if they had care of them, or were an attorney under a lasting or enduring power of attorney or a court appointed deputy.

K: The DOLS Code

2.59 The DOLS Code is a statutory one, to which all professionals providing care and treatment to individuals lacking capacity must have regard.⁷⁰ The Code itself provides that it must be read subject to subsequent legal developments⁷¹ so it is absolutely clear that Chapter 2 – entitled “*What is deprivation of liberty?*” – must now be read subject to the judgments of the courts handed down since it was written in 2008.

2.60 This means that care must be taken when considering the factors outlined at paragraph 2.5 of the DOLS Code as potentially identifying whether steps taken involve more than restraint and amount to a deprivation of liberty. The factors identified there may well be valuable in indicating whether a particular person is under continuous (or complete) supervision and control and not free to leave, but they go no further than that. In particular, we would advise caution before a conclusion is drawn solely from the basis that a person’s contact with others is restricted that they are deprived of their liberty. Imposing restrictions on contact with others is a significant interference with rights under Article 8 ECHR, but we suggest that they do not, in and of themselves, necessarily give rise to issues under Article 5 ECHR. It is further also extremely important to note that the DOLS regime (and also the procedure for judicial authorisation of deprivation of liberty) cannot be used to authorise restrictions on contact: if such are sought in the best interests of the individual concerned, it is likely that an application to the Court of Protection will be necessary.

2.61 We should emphasise that this guidance does not – and cannot – in any way intend to replace the DOLS Code insofar as it relates to the steps that must be taken if a person is deprived of their liberty.

⁷⁰ Section 42(4) MCA 2005.

⁷¹ Chapter 2, introduction.

- 3.1 The formulation of the ‘acid test’ in the *Cheshire West* decision has led to an intense focus on the concepts of the practical meaning of ‘**continuous/complete supervision and control**’ and ‘**freedom to leave,**’ as well as of what may be a ‘**non-negligible**’ period of time.
- 3.2 The majority of the rest of this guidance represents an attempt to reflect what these concepts may mean in particular settings. In this chapter some initial and generally applicable observations are given. The obvious caution has to be given that these concepts may ultimately have to be given a judicial definition which will override anything within this guidance.
- 3.3 The approach taken by this guidance is also predicated upon the warning of Lady Hale that: “[b]ecause of the extreme vulnerability of people like P, MIG and MEG, [...] we should err on the side of caution in deciding what constitutes a deprivation of liberty in their case.”¹

A: Continuous / complete supervision and control – what is continuous/complete?

- 3.4 The phrase “continuous supervision and control” was taken by Lady Hale from the European Court of Human Rights’ judgment in *HL v United Kingdom*.² This concept or variations of it has been used in the major ECtHR cases subsequently,³ and in seeking to interpret the phrase, we consider that it is of use to have regard to the ECtHR case-law.
- 3.5 The ECtHR case-law indicates strongly that the requirement for continuous / complete supervision and control cannot and should not be interpreted as requiring 24 hour monitoring and/or that the person is to be physically accompanied over a continuous 24 hour period. In other words, if the individual is subject to such monitoring or such degree of accompaniment,⁴ then the necessary degree of continuity or completeness will be satisfied. But it is capable of being satisfied even if the supervision and control is ‘lighter touch.’
- 3.6 Perhaps the two most significant ECtHR cases here are:
 - 3.6.1 *Ashingdane v the United Kingdom*,⁵ in which the ECtHR held that a person could be regarded as having been “detained” even during a period when he was in an open hospital ward with regular unescorted access to the unsecured hospital grounds and the possibility of unescorted leave outside the hospital; and
 - 3.6.2 *Stanev v Bulgaria*,⁶ in which Mr Stanev was able to leave the building where he resided and to go to the nearest village (and indeed had been encouraged to work in the restaurant in the village where his care home was located “to the best of his abilities”) and had also been on “leaves of absence.” However, he needed to have permission to leave the care home, and his visits outside were subject to controls and restrictions; his

1 Paragraph 57.

2 [2004] ECHR 471 at paragraph 91.

3 In *Stanev*, the term was “constant supervision” (paragraph 128).

4 As would be the case, for example, in a maternity unit where a woman lacking capacity (i.e. called P before the Court of Protection) to take decisions as to her own medical treatment is imminently to give birth, where

“It will commonly be the case that when at the acute hospital P:

i) will have obstetric and midwifery staff constantly present throughout her labour and delivery;

ii) will be under the continuous control of obstetric and midwifery staff who, because she lacks capacity to make decisions about her medical care, will take decisions on her behalf in her best interests” (NHS Trust v FG [2014] EWCOP 30.

5 (1985) 7 EHRR 528.

6 (2012) 55 EHRR 22



leaves of absence were entirely at the discretion of the home's management, who kept his identity papers and administered his finances. When he did not return from a leave of absence, the home asked the police to search for and return him and he was returned to the home against his wishes. He was, in consequence, the Grand Chamber held, "*under constant supervision and was not free to leave the home whenever he wished,*"⁷ and was therefore deprived of his liberty.

- 3.7 These two cases suggest that the ECtHR would take a relatively broad-brush approach to deciding whether supervision and control was sufficiently 'continuous' or 'complete' to satisfy this element of the test.
- 3.8 A pragmatic way of answering the question is to ask whether the person(s) or body responsible for the individual have a plan in place which means that they need always broadly to know:
 - 3.8.1 where the individual is; and
 - 3.8.2 what they are doing at any one time.
- 3.9 If the answer to both questions is 'yes,' then we suggest that this is a strong pointer that the individual is under continuous / complete supervision and control. This is particularly so if the plan sets out what the person(s) or body responsible for the individual will do in the event that they are not satisfied that they know where the individual is and what they are up to.
- 3.10 We also suggest that it is clear that the test for completeness / continuity will also be met without **every** decision being taken for the individual. In other words, the individual may well be able to take quite a number of decisions as to their own activities (for instance what they would like to have for breakfast) but still be subject to complete or continuous supervision and control if the individual is in an overall structure in which aspects of decision-making are being allowed to them at the discretion of those in control of their care.

B: Continuous / complete supervision and control – what is supervision and control?

- 3.11 What of 'supervision and control'? The terms are likely in due course to be the subject of further scrutiny by the courts. However, in our view, the ECtHR, if asked, would focus primarily on the fact that the arrangements have been made for an individual who lacks the capacity to consent to them. Even if these arrangements are conscientiously considered to be in their best interests, there is in all such situations a power imbalance between those providing the care and treatment and the person to whom it is being provided.
- 3.12 We suggest that caution must be exercised before concluding that arrangements amount to "mere" care, support or enablement rather than shading into supervision and control. MIG's case makes this clear, because she was provided with what was described as "*intensive support*" by a woman she regarded as her mother, and was not subject to overtly controlling measures. She was nonetheless held by the majority in the Supreme Court to be under continuous supervision and control.

⁷ *Stanev* at paragraph 128.

C: Freedom to leave

- 3.13 It is vitally important not to conflate “*freedom to leave*” with “*ability to leave*” or “*attempts to leave*.” Doing so would lead to the reduction in the universality of the right to liberty upon which the Supreme Court placed such emphasis. As Lord Kerr noted, liberty is “*predominantly an objective state. It does not depend on one’s disposition to exploit one’s freedom.*” Reflecting this, it was clear that P, MIG or MEG would not – of their own accord – attempt to leave, but all of them were found not to be free to leave.⁸
- 3.14 In this context the focus should be upon the actions (or potential actions) of those around the individual, rather than the individual themselves. In other words, the question may well be a hypothetical one – if the person manifested a desire to leave (or a family member properly interested in their care sought to assist them to leave), what would happen?
- 3.15 If the answer is that steps would be taken to enable them to leave, then that points in one direction; if the answer is that steps would be taken to prevent them leaving that points in the other. Crucially, it would not matter in this regard if the steps to prevent the person leaving were said to be in their best interests.
- 3.16 Approaching matters on that basis helps make clear that, for example, whether not there are locks or keypads on the doors is not the answer.⁹ It is what would be done by the staff with the ability to unlock the door if the individual were to seek to open that door that is important. It also helps make clear that compliance or lack of objection is irrelevant to the question of whether a person is deprived of their liberty,¹⁰ and hence does not lead to the understandable but incorrect approach that questions of deprivation of liberty are only raised when the individual is continuously resisting personal care, subject to hands-on restraint or attempting to leave.
- 3.17 One important question that arises here is whether freedom to leave is:
- 3.17.1 ‘Micro’ – i.e. the freedom to come and go from the premises in question temporarily; or
- 3.17.2 ‘Macro’ – i.e. freedom to move from those premises to another one on a permanent basis (or simply to leave those premises permanently, even if they do not have a clear destination¹¹).
- 3.18 As at the point of preparing this guidance, the answer to this question is not absolutely clear. Some have suggested that the focus should solely be on the ‘macro’ question, and that questions of whether or not the individual is temporarily able to come and go from the place in question are essentially not relevant.¹² However, we suggest that this is doubtful:

8 In the case of *Rochdale MBC v KW* [2014] EWCOP 45, Mostyn J held that (in the context of a deprivation of liberty at home) a person who is not physically capable of leaving cannot be deprived of their liberty for the purposes of Article 5 ECHR. KW’s appeal against the decision was allowed by consent by the Court of Appeal in February 2015 (without any accompanying judgment; see also Mostyn J’s subsequent judgment [2015] EWCOP 13). We suggest that the decision is so clearly incompatible with the *Cheshire West* decision and with the Strasbourg case law that it should not be followed. We address this further below in Chapter 8.

9 Indeed, this is also clear from the Strasbourg case-law: see *HL* at paragraph 92.

10 Paragraph 50. Their compliance/lack of objection is very relevant to the question of whether the deprivation of liberty can be said to be in their best interests.

11 It is not necessary that a person has somewhere else to go for them to be deprived of their liberty: Mr Stanev had nowhere else to live (see paragraph 153 of the decision in his case).

12 In *Rochdale MBC v KW* [2014] EWCOP 45 Mostyn J held (at paragraph 20) that Lady Hale had in *Cheshire West* “*implicitly approved*” this earlier finding, and that this was the “*required sense*” of the second part of the acid test. The phrase quoted was the conclusion reached by Munby J (as he then was) in *JE v DE & Ors* [2006] EWHC 3459 (*Fam*) (at paragraph 115). However, as noted above, KW’s appeal was allowed by consent in February 2015.



- 3.18.1 In the speech given by Lady Hale referred to at paragraph 2.35 above and in the course of discussing the situations of P, MIG and MEG, she noted that:
- “they were under the complete control of the people looking after them and were certainly not free to go, either for a short time or to go and live somewhere else”* (emphasis added).
- 3.18.2 Even though Lady Hale was not speaking in a judicial capacity, this statement suggests that she does not consider that the majority of the court held that freedom to leave was only relevant in the ‘macro’ sense.
- 3.18.3 The Grand Chamber of the ECtHR placed considerable emphasis in *Stanev* on the fact that Mr Stanev was not able to leave the care home for such purposes as visiting the nearby village “*whenever he wished*” (i.e. not merely for purposes of permanent relocation) in finding that he was deprived of his liberty.¹³
- 3.19 Despite what has been said above, it may be that a higher court looking at the question of “freedom to leave” might conclude that the question of whether a person is able to come and go as they like may more naturally fall to be considered when dealing with the question of whether they are under continuous/complete supervision and control. However, it would be unlikely if no account were to be taken of such restrictions being imposed. Taking a step back, and applying Lady Hale’s approach from *Cheshire West*, it would appear clear that a person of unimpaired health and capacity who was prevented from being able to come and go as they see fit from a particular location would consider themselves to be deprived of an important right even if it was said that they would be able to relocate permanently whenever they wished. Indeed, it is not immediately obvious that there will be many situations in which a person will be prevented from coming and going as they wish but those in charge of the placement would be entirely happy for them simply to ‘up sticks’ and leave altogether.
- 3.20 Until and unless further clarification is given by the Court of Appeal (or Supreme Court), this guidance offers the following as a set of broad propositions:
- 3.20.1 If a person is not free to come and go as they wish (with or without help) from a placement or place of treatment save with the permission of the decision-makers around them, then this is, at a minimum, a pointer to the individual being subject to restrictions upon their liberty. This may – depending upon the other measures imposed upon them – amount to a deprivation of their liberty or it may be that they amount solely to a restriction upon their liberty and the body imposing the restrictions can rely upon the provisions of ss.5-6 MCA 2005;
- 3.20.2 A person will clearly not be ‘free to leave’ if they are able permanently to relocate from the place only with the permission of the person(s) or bodies responsible for their care and treatment; **and** if they do seek to leave that location permanently, and not to return, steps will be taken to locate and bring about their return if they do not do so of their own accord;

13 Paragraph 128.



3.20.3 Both aspects of the test set out immediately above will need to be satisfied. If the reality is that **no steps at all** would be taken in the event that the person simply walked out one afternoon from a care home announcing their intention to move elsewhere – or simply to leave permanently - and did not come back, then they would clearly be free to leave.

3.21 Four further broad points should be made here:

3.21.1 There may well be circumstances in which a person is not free to leave one specific place at the times when they are there, but they are not otherwise subject to restrictions. An obvious example of such a situation is a person who is cared for at home, but then receives regular respite care at a facility, from which they are not allowed to leave, but are not otherwise under similar restrictions when they are at home. It would, in such circumstances, be logically possible for the person to be deprived of their liberty whilst at the facility but not deprived of their liberty whilst at home. However, it is possible to produce absurd results by over-analysing such situations. We suggest that the better approach in such a case is to have regard to the individual's care plan and to identify whether – **taken as a whole** – it amounts to a plan in which their movements are sufficiently circumscribed and they are under a sufficient degree of supervision and control that it amounts to a deprivation of their liberty. We address the specific question of respite in Chapter 6 (and in relation to children, in Chapter 10);

3.21.2 If those who are making the decisions on the ground (especially if they are public bodies) would be content for the individual to live anywhere that they might be able to choose¹⁴ other than one specific location, then this may indicate that they are not “free to leave” for the purposes of the acid test.¹⁵ It will, in any event, give rise to significant issues in relation to their rights under Article 8 ECHR¹⁶ and would probably require an application to the Court of Protection so as to ensure that the necessity and proportionality of the actions could be subject to proper judicial scrutiny;

3.21.3 We reiterate that it is not necessary that a person has somewhere else to go for them to be deprived of their liberty: this is clear from the decision of the Grand Chamber in Mr Stanev's case: he had nowhere else to live (see paragraph 153 of the decision in his case) but this did not prevent him being held to be deprived of his liberty;

3.21.4 For the purposes of testing what steps professionals making decisions would take in the event that the person attempted to leave, it is appropriate to take into account that a person properly interested in their welfare¹⁷ may request that they be allowed to leave. So, if a person is unable to express any wishes or feelings and would therefore be unable even to suggest leaving, it would be appropriate to consider what the decision makers would do if such a person (most obviously a family member) said that they wished to move them from the placement. Professionals should note [HL v United](#)

14 I.e. the place that they chose is actually available.

15 See *JE v DE & Ors* [2006] EWHC 3459 (Fam) at paragraphs 115-117. Surrey County Council would also have moved MIG to a different foster placement had she wished, but this did not prevent her from being held to be deprived of her liberty.

16 See also in this regard the decision of Peter Jackson J in *Hillingdon LBC v Neary* [2011] EWHC 1377 (COP) and that of Baker J in *AJ (Deprivation of Liberty Safeguards)* [2015] EWCOP 5.

17 We deliberately use this broad phrase, and intend it to encompass more than those who would have authority to take decisions regarding the individual's care and residence under the MCA 2005 (i.e. attorneys under a health and welfare Lasting Power of Attorney or health and welfare deputies).

Kingdom, in which the European Court of Human Rights took note of the fact that Mr L would only be released from the hospital to his carers as and when those professionals considered it appropriate.¹⁸ More broadly, taking this approach ensures that the proper distinction between “freedom to leave” and “ability to leave” is maintained in the case of those who are least able to exercise any freedom that would be afforded to those who did not have their level of disability.

D: Both elements of the acid test must be satisfied

3.22 Lady Hale in *Cheshire West* was clear that it was necessary that both elements of the acid test needed to be satisfied. The Official Solicitor (on behalf of P, MIG and MEG) had argued that supervision and control was relevant only as it demonstrated that the person was not free to leave. Lady Hale was not prepared to go so far, and held that:

“A person might be under constant supervision and control but still be free to leave should he express the desire so to do. Conversely, it is possible to imagine situations in which a person is not free to leave but is not under such continuous supervision and control as to lead to the conclusion that he was deprived of his liberty.”¹⁹

3.23 However, the second limb causes some difficulty in the case of a person who is locked in a room (or within a facility that is itself locked) but is not subject to continuous supervision and control. We suggest that this is not the situation that Lady Hale had in mind,²⁰ and it would be unwise to proceed on the basis that this kind of situation would not be capable of amounting to a deprivation of liberty. The situation that Lady Hale had in mind was much closer – we suggest – to the situation where a person is required to live in a particular place but is not subject to any additional controls upon them at that place.

3.24 Therefore, professionals should note that wherever a person is subject to a residence requirement imposed under the Mental Health Act 1983 (‘MHA 1983’),²¹ it should not be assumed that such requirement will, itself, give rise to a deprivation of that person’s liberty. That is because: (1) it is strongly arguable that the power to impose such requirements do not, themselves, amount to power to prevent the person leaving; and (2) a requirement that a person does not leave a particular place does not, itself, amount to a deprivation of liberty unless the care and treatment package contains the necessary elements of supervision and control.²²

18 Paragraph 91.

19 Paragraph 49.

20 This is clear from the fact that Lady Hale then explained in the next sentence that the possibility of someone not being free to leave but not being subject to sufficient control and supervision as to be deprived of their liberty “*could be the explanation for the doubts expressed in [Haidn v Germany](#),”* (Application no 6587/04), where the court expressed “*serious doubts*” whether instructing the applicant to live in an old people’s home which he was not to leave without his custodian’s permission amounted to a deprivation rather than a restriction of liberty. It is clear that this was not a case relating to physical steps being taken to prevent a person leaving a place.

21 E.g. by a guardian.

22 See the decision of the Upper Tribunal in *NL v Hampshire County Council (Mental health: All)* [2014] UKUT 475 (AAC) at paragraphs 14-19. The Upper Tribunal held that, even if the power that could be exercised by the guardian could have the effect of meaning that Mr L was not free to leave the place where he was required to reside, he could not be considered to be deprived of his liberty because the requisite additional elements of continuous supervision and control were contained within the care plan. As the local authority was not imposing those elements of supervision and control upon Mr L, he was therefore not considered to be deprived of his liberty.

E: Irrelevant factors

3.25 In *Cheshire West*, Lady Hale acceded to the suggestion of the National Autistic Society and Mind to indicate certain factors that would not be relevant to the assessment of whether a person is objectively deprived of their liberty. These are:

3.25.1 **The person's compliance or lack of objection;**

3.25.2 **The relative normality of the placement (whatever the comparison made); and**

3.25.3 **The reason or purpose behind a particular placement.**²³

3.26 In relation to the first of these factors, something of a working presumption had been established prior to the *Cheshire West* decision that it was only necessary to consider questions of deprivation of liberty where the individual was non-compliant (or their family were agitating for their departure from the facility). Whilst, as noted below, staff must be on alert if the person is non-compliant, the converse was not, and never has been true. In other words, the mere fact that the person was sitting quietly in the corner of the care home and apparently acquiescing to the arrangements made for them never meant that they could not be deprived of their liberty. Indeed, the irrelevance of compliance had long been acknowledged by the ECtHR.²⁴ A focus not just on the individual but upon the nature of the arrangements in place around them can assist in avoiding this trap.

3.27 However, whilst compliance is irrelevant, non-compliance, or resistance, is highly relevant. In particular, where a person strongly resists the arrangements (for instance an individual in a hospital setting has to be forcibly restrained to prevent them from absconding), this is highly significant. If they strongly resist, then it is clear that the measures will have a greater effect upon them. Further, the greater the resistance, the more intensive the measures will be. The more intense the measures, the shorter the period of time before the imposition of those measures will stop being 'merely' a restriction upon the person's liberty and become a deprivation of it. See further in this regard paragraphs 3.33-3.40 below.

3.28 The second of these factors is self-explanatory, and makes clear that the decisions of the Court of Appeal in (then) MIG and MEG and in *Cheshire West* were incorrect. If there is to be any comparison drawn, it is not between the nature of the setting but between the arrangements made for the individual in question and those that would be applied to an individual of unimpaired health and capacity.²⁵ In other words, and recognising the potentially (if inadvertently) pejorative nature of this exercise, if such a person would consider the arrangements in place to amount to a deprivation of their liberty, they will amount to a deprivation of liberty even for a person who, because of their disabilities, is unable either to recognise it as such or take advantage of the liberty of which they are deprived.²⁶

²³ See paragraph 50.

²⁴ Mr L was compliant, and never tried to leave Bournemouth Hospital.

²⁵ See Lady Hale in the speech quoted at paragraph 2.34 above.

²⁶ See *Cheshire West* at paragraph 46.

F: Non-negligible period of time

- 3.29 As noted at paragraph 2.15, in order for a person to be deprived of their liberty for the purposes of Article 5 ECHR, it is clear from the ECtHR case law that they must be confined to a particular restricted place for a non-negligible period of time.²⁷ Exactly what will constitute a ‘non-negligible’ period of time appears from the case-law to vary according to the particular circumstances under consideration, including their nature and consequences.²⁸
- 3.30 By way of two examples from English decisions (which consider ECtHR cases):
- 3.30.1 The total and “intense” restraint by police officers of a 16 year old with autism for a period of 40 minutes was held to amount to a deprivation of his liberty;²⁹
- 3.30.2 By contrast, it was held that in the ‘ordinary case’ it would be unlikely that a person required to remain in the s.136 MHA 1983 suite of a hospital during the processing of an application for admission under the MHA 1983 would be deprived of their liberty even if they are required to remain there for up to 8 hours.³⁰
- 3.31 In the absence of clear guidance from the courts as to the precise period of time that may constitute a non-negligible period, we suggest that it is open for individual public bodies to set down what they consider to be such a period for their own operational purposes where such may be necessary. An obvious example of this is in the hospital setting where a decision will have to be taken as to the length of time that – in general – a patient is in (say) an acute ward before they are considered to be deprived of their liberty. It would clearly make sense in such a setting for the relevant hospital Trust to have a policy as to the length of time considered to be ‘non-negligible’ for these purposes. That policy should allow for calibration to individual circumstances: in other words, to make clear that, the more intense the measures of control the person is subject to, and/or the more the person resents the control to which they are subject, the shorter the period of time that can be considered ‘non-negligible.’
- 3.32 Because the period will vary from setting to setting, we have deliberately avoided in this guidance giving a period of time that can be considered ‘safe.’ Our clear view is that it is unlikely under any of the circumstances considered in this guidance to extend beyond a few (2-3) days and is likely to be substantially less in settings in which particularly intense measures of control are imposed. We would **strongly** suggest that it is not safe to use the rule of thumb that some public bodies have adopted that a deprivation of liberty is unlikely to arise where a person is confined for less than 7 days. We understand that this may have been taken from a reading of certain paragraphs of the DOLS Code as to the circumstances under which it is appropriate to grant an urgent authorisation.³¹ However, this is to conflate the question of **whether** there is a deprivation of liberty with the quite separate question of **how** such deprivation of liberty may be authorised.

27 *Cheshire West* at paragraph 20 citing *Stanev* at paragraph 117.

28 See, for instance, *Rantsev v Cyprus and Russia* (App. No. 25965/04) [2010] ECHR 22: “In all, the alleged detention lasted about two hours. Although of short duration, the Court emphasises the serious nature and consequences of the detention and recalls that where the facts indicate a deprivation of liberty within the meaning of Article 5 § 1, the relatively short duration of the detention does not affect this conclusion” (paragraph 317, emphasis added).

29 *ZH v Commissioner of the Police for the Metropolis* [2013] EWCA Civ 69 at paragraph 83.

30 *Sessay v South London & Maudsley NHS Foundation Trust & The Commissioner of Police for the Metropolis* [2011] EWHC 2617 (QB).

31 Most obviously paragraphs 6.3 and 6.4.

G: *Cheshire West*: a test of universal application?

3.33 It is clear that the Supreme Court was not expressly addressing the situation of all persons to whom the acid test might apply: for instance, those in hospices or intensive care units in hospitals.

3.34 Understandable concern has been expressed by many professionals and providers that applying the test in some of these contexts will lead to a diversion of clinical and social work professionals from their ‘real’ tasks in favour of the completion of DOLS paperwork that are perceived as serving no useful function for the protection of the rights of the individuals

concerned.³² Further concern has been expressed that the application of the test (for instance in the context of those in the last days or hours of their lives) leads to undue distress on the part of families and others concerned with the care and treatment of the individual.

3.35 It is proper to acknowledge these concerns. It is also proper to acknowledge the strong concern that many front line professionals feel that, although the Law Commission has been asked to review deprivation of liberty in the health and social care context,³³ the Commission will not produce draft legislation until the summer of 2017, and there is – at present – no plans for any legislative amendments in the meantime.

3.36 However, these wider concerns are beyond the scope of this guidance which focuses upon the question of **when** a deprivation of liberty may arise. Professionals must be careful not to let their concerns as to the consequences of the application of the acid test drive how the test is interpreted. Unless it is possible to identify a legal basis upon which the test does not apply in a particular set of circumstances, we suggest that it is necessary to proceed on the basis that it does. Even if Lord Neuberger’s judgment in *Cheshire West* might be read as indicating that he considered that the test is not necessarily universal,³⁴ Lord Neuberger nonetheless indicated that it should be adopted “*unless there is good reason not to.*”³⁵

3.37 This guidance highlights points at which it might properly be considered that there is good reason (founded upon the case-law) to suggest that the acid test might not apply. Indeed, we highlight points where we consider it is very likely that a judge, asked to decide whether a particular individual was deprived of their liberty, would be very sympathetic to arguments that they were not.

3.38 It is perhaps helpful to highlight one overarching factor. Lady Hale’s judgment can be read as suggesting that context is still a factor that may be of relevance – in line with the decision of the Grand Chamber in *Austin v United Kingdom*.³⁶ The judgment in *Austin* is a frustratingly

32 Especially where there is no realistic prospect that the necessary assessments can be completed so as to allow, e.g. for a DOLS authorisation to be granted in an Intensive Care Unit prior to the patient’s departure from that unit.

33 <http://lawcommission.justice.gov.uk/areas/capacity-and-detention.htm>. That review may give an opportunity to consider the philosophical objections to the test voiced by those who consider that the Supreme Court placed too much store on an abstract concept of physical liberty: see the judgment of Mostyn J in *Rochdale MBC v KW* [2014] EWCOP 45.

34 At paragraph 61, he held that “*at least in principle, the approach proposed by Lady Hale appears to me to be attractive, and should be adopted unless there is good reason not to do so.*” Whether this actually represents the view of the majority is questionable, given that Lord Sumption expressly agreed with Lady Hale, and Lord Kerr agreed with both Lady Hale and Lord Neuberger.

35 It is questionable whether Lord Neuberger was doing more than setting up his analysis of why the reasons advanced by Lords Carnwath and Hodge were **not** good reasons to adopt the approach. This point and that made in the footnote above will no doubt be the subject of legal argument in due course.

36 *Austin v United Kingdom* (2012) 55 EHRR 14. See paragraph 44 of the judgment in *Cheshire West* in particular, where Lady Hale expressly noted that it may be “*most helpful*” to consider how the question before the Supreme Court “*has been approached in the particular context, in this case the placement of mentally incapacitated people, whose lawful detention in any setting designed for their care is always potentially justifiable under article 5(1)(e)*” (emphasis added).



ambiguous one, but suggests that it remains properly open to those on the ground to consider the context in which the deprivation of liberty is said to arise. The further away that any particular circumstances are from those of P, MIG and MEG, the more that it might be said that the court could properly find grounds upon which to apply the objective element of the Article 5 test in a different fashion to that set down in *Cheshire West*. In other words, the more likely we consider it is that the courts will find principled reasons for saying that the ‘acid test’ does not apply in exactly the same fashion as it did to P, MIG and MEG.

- 3.39 We emphasise, however, that the matters set out above are ultimately legal questions upon which only a court is capable of deciding.
- 3.40 Finally, we reiterate that, until the courts have considered the questions set out above (as well as others that will no doubt emerge), it is important that we should not abandon attempts to identify the dividing line between a restriction upon freedom of movement and a deprivation of liberty.³⁷ Throughout the ‘setting-specific’ chapters of this guidance, therefore, we outline situations in which we consider it can be properly said that the individuals in question are not deprived of their liberty but ‘merely’ subject to restrictions upon their freedom of movement.

³⁷ As Lady Hale noted in *Cheshire West*, the cases before the Supreme Court were “not about the distinction between a restriction on freedom of movement and the deprivation of liberty. P, MIG and MEG are, for perfectly understandable reasons, not free to go anywhere without permission and close supervision.” Paragraph 48.

A: Introduction

- 4.1 This chapter focuses on deprivation of liberty of those lacking the capacity to consent to care, treatment and confinement in a hospital setting for purposes of treatment of physical disorders. This includes NHS hospitals and treatment by the independent sector / private hospitals, but also transfer to hospital in the first instance by ambulance, and care in the hospice setting. Questions relating to deprivation of liberty in the psychiatric setting are dealt with in Chapter 6. In line with the other chapters, it does not provide detailed answers to the questions of what should happen where a deprivation of liberty has been identified.
- 4.2 The majority of patients who lack capacity to make decisions about their care and treatment and admission to or discharge from hospital can be treated in their best interests under s.5 MCA 2005. Restraint may be used provided that the person using restraint reasonably believes that it is necessary to restrain the patient in order to prevent harm to the patient, and that the act is a proportionate response to the likelihood of the patient suffering harm, and the seriousness of the harm.¹ The difficult issue to identify is the point at which the level and intensity of the restraint used amounts to a deprivation of liberty.
- 4.3 As a starting point, we should emphasise that emergency life-sustaining interventions and the provision of emergency care to a patient lacking consent to such treatment **should always be given** as clinically required and **there should never be any delay** for prior deprivation of liberty authorisation to be sought. We acknowledge that this means that there may – in some cases – be situations in which the question of whether a person is deprived of their liberty (and if so, how that deprivation of liberty is to be authorised) cannot be resolved prior to the administration of such treatment.
- 4.4 As noted at paragraph 3.33 above, the acid test set out in the Supreme Court in *Cheshire West*, i.e. continuous (or complete) supervision and control’ and ‘lack of freedom to leave, did not address the situations of those in Accident and Emergency (‘A&E’) departments, hospices or intensive care units. There is no case-law at the time of writing this guidance that deals specifically with deprivation of liberty in these settings,² and it is not absolutely clear how the courts will approach these questions.
- 4.5 However, in very broad terms, and although this has not been tested before the courts, we consider that:
- 4.5.1 It is likely that the immediate provision of life-sustaining treatment to an incapacitated patient in a true emergency situation will not be considered to be a deprivation of liberty (either in the ambulance or in the A&E setting);³
- But that:
- 4.5.2 As the patient transitions from the initial emergency treatment to on-going care the risk of deprivation of liberty increases with the increasing duration of such treatment (or other such treatment as identified as clinically necessary).

1 Sections 6(1)-(3) MCA 2005.

2 Although the case of *NHS Trust & Ors v FG* [2014] EWCOP 30 suggests that the ‘acid test’ may well be satisfied in the context of the delivery of obstetric care to a person incapable of consenting to it.

3 For a fuller discussion on this see M. Crews et al, *Deprivation of Liberty in Intensive Care*, Journal of the Intensive Care Society, October 2014.

- 4.6 As soon as a deprivation of liberty has been identified, appropriate steps should be taken to obtain authorisation, either under Schedule A1 to the MCA 2005 (a ‘DOLS authorisation’⁴), under the MHA 1983, or from the Court of Protection.⁵ We should highlight here that, in the event that a person suffering from a mental disorder within the meaning of the MHA 1983 requires assessment and treatment for that disorder and wishes to leave the hospital before the assessment has been carried out, consideration should be given to the use of the powers of detention contained in the MHA 1983 to ensure that the person does not leave the hospital (see Chapter 5) before that assessment has been carried out.⁶

B: The acid test and the hospital setting

- 4.7 When considering whether a patient is ‘free to leave’ for the purpose of the acid test the focus should not be on whether a patient is actually physically capable of leaving, but rather upon what actions hospital staff would take if for example family members, properly interested in their care, sought to remove them from the hospital.
- 4.8 In addressing the ‘acid test’ it is also particularly important in a hospital setting to consider the following:
- 4.8.1 Whether the deprivation of liberty is likely to last for more than a negligible period of time;
 - 4.8.2 Whether the person is able to give consent to what amounts to the ‘objective’ deprivation of their liberty; and
 - 4.8.3 Whether the deprivation is imputable to the State.
- 4.9 The scenarios below attempt to distinguish those situations:
- In which we consider the individuals in question to be deprived of their liberty;
 - Where there may be a potential deprivation of liberty; and
 - Where individuals are subject to restrictions in their freedom of movement not amounting to a deprivation of liberty.
- 4.10 Because, as set out above, the legal position regarding what amounts to a deprivation of liberty in hospital settings is unclear, it is essential that Trusts put in place policies which define for their purposes who they consider to be deprived of their liberty; and how they propose to authorise the same.

C: ‘Imputable to the state’

- 4.11 A deprivation of liberty only falls within the scope of Article 5(1) ECHR if it is ‘imputable’ to the state. This will inevitably be satisfied in an NHS hospital setting. Care may also be arranged or commissioned by a Clinical Commissioning Group (‘CCG’) or Local Health Board to be

⁴ Most likely an urgent authorisation in the first instance, although note that an urgent authorisations should only be granted if the situation giving rise to the deprivation of liberty could not have been anticipated in sufficient time to enable a standard authorisation to be sought: see *NHS Trust & Ors v FG*, footnote 2 above, at paragraph 101.

⁵ For further discussion, see the paper entitled: *Deprivation of Liberty in a Hospital Setting* by Alex Ruck Keene and Catherine Dobson: http://www.39essex.com/docs/articles/deprivation_of_liberty_in_the_hospital_settingv3.pdf

⁶ See ss.136, 5(2) and 5(4) of MHA 1983. Section 5 of the MHA 1983 only applies to patients who have been admitted to hospital. The Accident and Emergency Department waiting area of a hospital is considered a public place for the purpose of section 136 MHA 1983 - *R (Sessay) v (1) South London & Maudsley NHS Foundation Trust (2) The Commissioner of Police for the Metropolis* [2011] EWHC 2617 (QB) at paragraph 39.



provided by an independent healthcare provider⁷ and in these circumstances, except for situations where the person is being cared for in the community, the Deprivation of Liberty Safeguards will also apply. There will also be circumstances where a patient is being cared for in a hospital and receiving treatment from a private provider and the arrangements are privately funded and not made by the State. The DOLS Code makes it clear that even though these situations are outside the scope of Article 5(1) ECHR, they are to be treated as if they were within its scope, such that managing authorities of such institutions are required to apply for an authorisation if the care and treatment of their patient meets the acid test.⁸

- 4.12 It is therefore necessary to consider whether the totality of the care and treatment arrangements amount to a deprivation of liberty, whether the person is being treated in an NHS hospital or by an independent healthcare provider and whether the care is arranged and commissioned by a CCG or privately.

D: Conveyance by ambulance to or from hospital

- 4.13 Transporting a person who lacks capacity from their home, or another location to a hospital by ambulance in an emergency will not usually amount to a deprivation of liberty. In almost all cases, it is likely that a person can be lawfully taken to a hospital or care home by ambulance under the wider provisions of the Act, as long as it is considered that being in the hospital or care home will be in their best interests.⁹
- 4.14 The DOLS Code suggests¹⁰ that there may be exceptional circumstances where taking a person to a hospital or a care home amounts to a deprivation of liberty. We suggest that the following situations which include, but go beyond those discussed in the Code, may give rise to the need to seek authorisation to ensure that the measures taken are lawful:
- Where it is or may be necessary to arrange for the assistance of the police and/or other statutory services to gain entry into the person's home and assist in the removal of the person from their home and into the ambulance;
 - Where it is or may be necessary to do more than persuade or provide transient forcible physical restraint of the person during the transportation;
 - Where the person may have to be sedated for the purpose of transportation; or
 - Where the journey is exceptionally long.

7 See paragraph 2.50. Independent healthcare providers are private, voluntary or non-profit individuals or organisations that are not owned or managed by the NHS. Their services may be contracted by the NHS, may be paid for by an individual or funded through healthcare insurance schemes. Some providers deliver services both privately and for the NHS. Independent providers deliver a wide range of services to both adults and children. There are 276 independent acute hospitals and 47 independent treatment centres registered with the Care Quality Commission. The Care Quality Commission does not currently oversee the regulation of the independent healthcare services that deliver secondary and tertiary care, but proposes to begin doing so in 2015.

8 Paragraph 1.21 of the DOLS Code, available at http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087309.pdf

9 Paragraph 2.14 of the DOLS Code.

10 Paragraph 2.15.

- 4.15 Whilst we do not in general in this guidance address how authority is to be sought for deprivation of liberty in particular cases, we consider that we should make clear that, as the law stands, an authorisation under Schedule A1 cannot be used to authorise a deprivation of liberty on the way to the place where the patient will be treated.¹¹ If there is a real risk that cannot be sensibly ignored that the transport of the patient will amount to a deprivation of their liberty, it will be necessary to obtain an order from the Court of Protection.¹² It is less clear whether an authorisation granted in respect of one hospital can be used to authorise a deprivation of liberty that may arise in respect of a patient being transferred from that hospital to another,¹³ and legal advice should be sought where it appears clear that there will be a deprivation of liberty in such a case. We would also emphasise that, in such a case, it will be necessary to ensure in advance that there is a standard authorisation in place in the second hospital (assuming that the circumstances in which the patient will be treated will also amount to a deprivation of liberty).¹⁴

Transportation by Ambulance: a deprivation of liberty

- 4.16 The measures in the following scenario are likely to amount to a deprivation of liberty:

Jane is 35 years old and lives alone in a rented property. Jane has moderate learning difficulties and can be uncooperative and violent. Jane has given birth to 2 children. They have both been taken into care shortly after birth. By chance Jane's social worker, Alice, meets Jane at the local shopping centre. Alice notices that Jane appears to be about 7 months pregnant. Alice is very concerned because Jane has not been engaging with social services, and has not to her knowledge received any antenatal care. Jane denies that she is pregnant and tells Alice that she is buying new clothes because she 'is getting fat', and that 'anyway they will take the baby away'. Jane had experienced difficulties with her last pregnancy that resulted in an emergency admission to hospital and the baby being delivered by caesarean section. Despite all attempts by the statutory services, Jane refuses to engage and does not attend appointments aimed at monitoring the pregnancy and providing obstetric care. Both social services, and the acute trust that will provide obstetric care to Jane and deliver her child, wish to make arrangements for Jane to be brought into hospital for an ante-natal assessment, blood tests and placental location ultrasound scan and to plan the delivery of her child. The Trust has taken advice and if Jane is not compliant a plan has been devised that provides for the police to assist in gaining entry to Jane's property and for Jane to be transferred from home by ambulance accompanied by professionals employed by the Trust and an anaesthetist. In the event that Jane cannot be persuaded to get into the ambulance she will be given mild sedation and taken from her home using physical restraint. The journey to hospital will take over an hour and during this time both physical and chemical restraint (as appropriate) may be used.

11 *GJ v The Foundation Trust* [2009] EWHC 2972 (Fam) at paragraph 9: "The new provisions in the MCA [i.e. in Schedule A1] do not cover taking a person to a care home or a hospital. But they can be given before the relevant person arrives there so that they take effect on arrival (see for example paragraph 52 of Schedule A1 to the MCA)."

12 Court of Protection judges are available, in suitably urgent cases, to hear cases 24 hours a day 365 days a year. The guidance at paragraph 23(a) of the Annex to the judgment in *NHS Trust & Ors v FG* [2014] EWCOP 30 contains details of as to matters to be considered when arranging ambulance transfers, relevant beyond the context with which that case is concerned.

13 The question is as to the point at which it can properly be said that the patient ceases to be a 'detained resident' in the first hospital. Up until that point, it appears that an authorisation granted in respect of that first hospital may provide authority to deprive the patient whilst they are on 'leave' from the hospital: *Re P (Scope of Schedule A1)* (30 June 2010) (Unreported) (Mostyn J). Once the patient ceases to be a detained resident

14 See *NHS Trust & Ors v FG* [2014] EWCOP 30 at paragraph 101.



Key factors pointing to a deprivation of liberty:

- *the potential involvement of the police and that Jane may be taken to hospital against her will*
- *the potential use of sedation and physical restraint to get Jane into the ambulance*
- *the potential use of physical and chemical restraint for a period lasting potentially over an hour.*

Transportation by ambulance: potential deprivation of liberty

4.17 We suggest that the measures in the following scenario may give rise to a deprivation of liberty:

Ahmed has a serious head injury caused by a road traffic accident. He has been assessed as lacking capacity to make decisions about his care and treatment. He has been admitted to a local Trauma Unit for stabilisation but then requires transfer to the regional Trauma Centre at a hospital 100 miles away. Ahmed is heavily sedated, intubated and ventilated. Because of poor visibility it is not possible for Ahmed to be airlifted to the Trauma Centre. The journey will therefore have to be undertaken by ambulance which will have to travel slowly because of the severity of Ahmed's head injuries and may take up to 5 hours to complete the journey. Ahmed will require continuous care, monitoring and supervision during the course of the journey.

Key factors pointing to a potential deprivation of liberty:

- *the length of the ambulance journey (which is significantly longer than usual for such a transfer)*
- *the degree of monitoring and supervision required.*

Note: we accept that this scenario is one that may provoke discussion amongst practitioners, and have deliberately included it so that specific consideration can be given by Trusts in the formulation of policies as to the potential for a deprivation of liberty to arise in such cases.

Transportation by ambulance: not a deprivation of liberty

4.18 We suggest that the following scenario is unlikely to amount to a deprivation of liberty:

Trisha lives at home with support. She suffers from dementia which has recently become worse. While making a cup of tea she knocks over a kettle of boiling water that scalds her leg. The care team do their best to treat her leg but it is quite clear that the burn will require medical attention. An ambulance is called by her care worker. Trisha is in a great deal of pain and is reluctant to get into the ambulance. After some coaxing she gets into the ambulance. The ambulance crew with the assistance of her care worker persuade her to take some medication to ease the pain while she is transported to a nearby hospital Accident and Emergency Department. Trisha becomes agitated during the journey and the ambulance crew have to restrain her briefly during the short journey to avoid her injuring herself further.



Key factor pointing away from deprivation of liberty:

- *the short length of the journey and the short duration of the restraint*

E: Accident and Emergency ('A&E')

- 4.19 It is of paramount importance that clinicians and hospital staff act in the best interests of their incapacitated patient and that the patient concerned receives appropriate and timely care and treatment.
- 4.20 As set out at paragraph 4.2 above the majority of people who lack capacity to make decisions about their care, treatment and admission to or discharge from hospital can be treated in their best interests under s.5 MCA 2005.
- 4.21 Although most people's stay in A&E is of short duration, as the scenarios below show, this does not of itself mean that a deprivation of liberty cannot occur during such a stay.¹⁵ The more intensive the restraint upon the person (whether physical or chemical) and the more the person is able to perceive what is happening and become distressed or resistant, the shorter will be the period of time before liberty-restricting measures taken in relation to the patient amount to a deprivation of liberty.
- 4.22 There may be circumstances in which staff consider that there may be a deprivation of liberty but that there is, in fact, nothing that can be done about it by way of obtaining authorisation within a sufficiently short period of time. We note in this regard that caution should be adopted in relation to paragraph 6.4 of the Deprivation of Liberty Safeguards Code of Practice which suggests that an urgent deprivation of liberty authorisation should not be granted if a person is in A&E "*and it is anticipated that within a matter of a few hours or a few days the person will no longer be within that environment.*" As set out in paragraphs 3.29-3.32, there may well be cases in which a person is in fact deprived of their liberty within that period of time.
- 4.23 We recognise that the situation set out above is not a happy state of affairs. It is particularly important that Trusts put in place policies that address such situations so that staff are not distracted from the delivery of care to patients but can instead have a clear indication of what they should be doing, parallel to the delivery of that care, to obtain authorisation where such is properly possible.
- 4.24 The following are examples of potentially liberty-restricting measures that may be found in an A&E Department:
- Physical restraint and the duration of any restraint;
 - The use of sedation;
 - The use of catheters and/or intravenous drips;
 - The observation and monitoring levels;
 - The requirement for a person to remain in a certain area of the A&E department and restricting the person to that area;
 - The requirement that the person does not leave the A&E department pending further tests or transfer.

¹⁵ The legal reasons why this is so are set out at paragraphs 3.29-3.32.

A&E: a deprivation of liberty

4.25 The measures in the following scenario are likely to amount to a deprivation of liberty:

Dan is brought into the A&E department having taken an overdose of paracetamol. Dan is vomiting, confused and very anxious. He resists attempts by staff to take a blood test and start N-acetylcysteine treatment. He has to be restrained and sedated by members of the hospital staff in order for treatment to be carried out. The treatment will take 24 hours to complete. He tells staff that at the earliest opportunity he will leave the hospital to complete his suicide. Dan is placed in a side room watched by a member of staff while his treatment is carried out and he is forcibly restrained and prevented from leaving during the 24 hour period.

Key factors pointing to a deprivation of liberty:

- *the monitoring of Dan whilst in the A&E department (in his clinical interests)*
- *the use of restraint and sedation to carry out the treatment*
- *the use of forcible restraint to prevent him leaving.*
- *that Dan is aware of and is resistant to the measures being carried out upon him which will, in combination with the use of forcible restraint, compress the relevant time-frame for a deprivation of liberty to occur*

Note: this situation is one in which consideration should undoubtedly be given to admitting Dan for admission for assessment under the provisions of the MHA 1983.

A&E: potential deprivation of liberty

4.26 We suggest that the measures in the following scenario may give rise to a deprivation of liberty:

John is a 19 year old, who has gone out with his friends on a Friday night. At 3am, his parents find him showering fully dressed singing at the top of his voice. He has a large bruise and laceration to the left side of his head. His parents take him to hospital. In the A&E Department, John is initially willing to have a skull X-ray and some blood tests. These show a very elevated blood alcohol level and a fracture of the left temporal region of his skull. John then starts getting very argumentative and tells everyone that he is leaving to take a train to the beach. He cannot explain why he has to go to the beach. Clinically, he should have a CT of his brain and probable transfer to a neuro-sciences unit. John is assessed as lacking capacity to make decisions about his care and treatment. The team plans to sedate and ventilate him in order to carry out the transfer. It will take a number of hours for the CT scan to be carried out and thereafter for John to be transferred to the neuro-sciences unit. During this time, John has on one occasion forcibly to be restrained to prevent him assaulting a nurse, he is then administered sedatives and, whilst continuing to be argumentative, he has to be verbally dissuaded from leaving the ward.

Key factors pointing to a potential deprivation of liberty:

- *the monitoring of John whilst in the A&E department (in his clinical interests),*
- *the use of physical restraint and sedation*
- *the key factors in determining whether this is a restriction or a deprivation of John's liberty will be the length of time that they are imposed for and the frequency and intensity of the restrictions.*

A&E – not a deprivation of liberty

4.27 The following scenario is unlikely to amount to a deprivation of liberty:

Olga lives in a rented flat. She has learning difficulties. Her care worker, Sarah, visits her twice daily to support her. On arriving in the morning she finds Olga sitting dazed on the kitchen floor. It appears that she has fallen and knocked her head on the kitchen unit. Sarah asks Olga what happened, but Olga cannot remember. Sarah calls an ambulance and Olga is taken to the A&E Department of the local general hospital. Once at the hospital Olga becomes very agitated because she does not know where she is and she vomits on the floor. She tells Sarah that she wants to go home now. A casualty doctor examines Olga and carries out a basic neurological examination. She explains to Sarah that she would like to keep Olga under observation for a couple of hours in the A&E Department before deciding whether further tests are necessary or sending her back home. Olga does not have capacity to consent to remain in the A&E Department. Sarah and the nursing staff explain to Olga that she needs to stay in hospital for a little longer and that Sarah will stay with her. Olga is pleased that Sarah will stay with her. After 2 hours she is sent home without any further assessments or treatment being necessary.

Key factors pointing away from deprivation of liberty:

- *The short length of the stay in the A&E Department*
- *The absence of physical restraint or the use of medication used to manage or modify her behaviour*

F: Intensive Care Units ('ICU')

4.28 The majority of patients in ICU lack capacity to make decisions about their care and treatment during some or all of their stay in ICU, due to the nature of their injuries, or disease, or level of sedation. Physical, mechanical or chemical restraint is often used to facilitate the care of patients in ICU and their care is closely monitored. The circumstances of patients lacking capacity who are in ICU for more than a negligible period of time may meet the 'acid test' criteria, although further judicial consideration is likely to be required in due course.¹⁶

4.29 We suggest that patients who have capacity to consent to their intensive care arrangements before being admitted to intensive care or whilst on the unit and prior to losing capacity are not considered to be deprived of their liberty because they do not satisfy the subjective

¹⁶ See also here M. Crews et al *Deprivation of Liberty in Intensive Care*, Journal of the Intensive Care Society, October 2014.

element of Article 5(1) of the ECHR.¹⁷ We should emphasise that this will only be the case so long as the circumstances in which they are treated and the length of their stay remain as anticipated at the point at which the patient gave their consent.

- 4.30 It is also important to bear in mind in this care setting that aside from mental incapacity, a patient's deprivation of liberty can only be authorised if they are also 'of unsound mind.'¹⁸ For the purposes of seeking authorisation under Schedule A1 to the MCA 2005, this requires the patient to have a mental disorder within the meaning of the MHA 1983, that is, 'any disorder or disability of the mind.'
- 4.31 The state of unconsciousness, caused by a variety of disorders and injuries, presents a particular problem in the context of deprivation of liberty. The Department of Health has recently advised that it does not consider a state of unconsciousness in itself as being a mental disorder for purposes of Schedule A1 to the MCA 2005.¹⁹
- 4.32 It may be that a patient who is unconscious, but is not otherwise suffering from a mental disorder within the meaning of the MHA 1983, can be the subject of an application to the Court of Protection for an order authorising the deprivation of their liberty,²⁰ but legal advice will be required in such cases and/or Trusts will have to set out a policy (on the basis of such advice) as to how they intend to proceed in relation to such patients.
- 4.33 This is a difficult area and we anticipate that there is likely to be case-law clarifying the position in due course. **However, we reiterate that any questions that may arise in this context of deprivation of liberty should not prevent the delivery of such immediately necessary life-sustaining treatment as continues to be required (and we reiterate again that those delivering such care and treatment will be protected from liability by s.5 MCA 2005 in relation to the delivery of treatment if they reasonably believe that the patient lacks capacity to consent, and that they are acting in the patient's best interests).**
- 4.34 Factors that are likely to be taken into account when considering whether a deprivation of liberty is taking place include:
- Continuous monitoring (almost a certainty in ICU);
 - Length of time sedated and/ or ventilated and/or intubated;
 - The use of restraint to bring about admission;
 - The use of restraint /medication being used forcibly during admission;
 - Staff taking decisions on a person's behalf regarding treatments and contact with visitors;
 - Duration of the restrictions
 - The patient not being free to leave the ICU;
 - The amount of time it is likely to take for the patient to recover capacity once they are extubated/taken off ventilation/ sedation;

¹⁷ The subjective element is discussed at paragraphs 2.27-2.20.

¹⁸ The requirement imposed by Article 5(1)(e) ECHR.

¹⁹ Department of Health Letter to DOLS Leads, 14 January 2015 at <http://www.mentalcapacitylawandpolicy.org.uk/wp-content/uploads/2014/04/DH-Letter-to-MCA-DOLS-Leads-14-January-2015-FINAL.pdf>

²⁰ Because the Court of Protection does not have to apply the requirement that the individual suffers a mental disorder within the meaning of the MHA 1983, but instead may be able to take a broader approach to the meaning of the phrase 'of unsound mind.'

- The amount of time the patient is likely to remain in the ICU before moving from the ICU to an acute ward, or a rehabilitation ward;
- The package of care taken as a whole

ICU: a deprivation of liberty

4.35 The measures in the following scenario are likely to amount to a deprivation of liberty:

Mr. Smith is a 45 year old man, who had no significant past medical history. While out jogging, he collapsed in front of an off duty nurse. She called for help and started basic life support until the ambulance arrived. The paramedics found that he was in VF and he was shocked back into sinus rhythm. The total downtime was around 12 minutes. On arrival in the Emergency Department his GCS was 3/15. Primary coronary intervention (PCI) demonstrated a lesion of his circumflex artery, which was stented. Following PCI, he has a CT scan of his brain which was reported as normal. Following this, he is admitted to ICU and intubated and ventilated for temperature management. After 24 hours, his temperature is allowed to normalise, and he is ventilated for a further 48 hours (72 in total), after which time it is noted that he had a flexion response to pain, but that he did not localise. The ICU team in consultation with his family decide to perform a tracheostomy to allow early weaning from ventilation and accurate assessment of his neurological function. Following the tracheostomy, his neurology has not changed, but the longer-term prognosis is unclear. A repeat CT does not show any evidence of significant brain injury. A neurological opinion is that there could be significant, possibly complete, recovery, however, any recovery will occur over weeks to months. In the meantime he will have to stay in a hospital environment to optimise his rehabilitation. Mr Smith's family are unhappy that he has to remain in hospital and would like him to return home as soon as possible where they will care for him.

Key factors pointing to deprivation of liberty:

- *the degree of monitoring of Mr Smith's condition*
- *the length of the potential stay in hospital*
- *Mr Smith's family would like him to return home in circumstances where the hospital team consider it necessary that he stay in hospital (if the hospital team, in fact, agreed that he could return home, then there would be no deprivation of liberty)*

ICU: Potential deprivation of liberty

4.36 We suggest that the measures in the following scenario may give rise to a deprivation of liberty:

Tony is 56 years old. He is in an acute ward recovering from the removal of a large meningioma that has left him with some persistent but minor cognitive impairment. While there he suffers a pulmonary embolism and is brought to ICU for monitoring. He wants to leave the ward to have a cigarette and when advised he will have to stay for his own safety, declares he wants to discharge himself. It is anticipated that he will require some form of sedative medication to ensure his compliance with treatment over the next few days.

Key factors pointing to a deprivation of liberty:

- *The degree of supervision and monitoring*
- *That Tony may not be free to leave the ICU: the key question will be what staff will do if he does, in fact, seek to discharge himself*
- *The potential use of sedation*

Note – it is (deliberately) not clear from this scenario whether Tony’s decision-making capacity is impaired (and, if so, how): if the circumstances amount to an objective deprivation of his liberty, an assessment of this will be crucial

ICU: not a deprivation of liberty:

4.37 The following scenario is unlikely to amount to a deprivation of liberty:

Mr Dillett is a 55 year old man, who has been diagnosed with oesophageal cancer. He is suitable for an oesophagectomy and receives adjuvant chemotherapy prior to his operation. He attends a pre-operative clinic and receives information about the operative procedure and his peri-operative management. Included in the information provided are details about the 2 - 3 days he is expected to stay on ICU post-operatively. On admission he signs the consent form for the operation. The operation goes well, and post-operatively he is sedated and ventilated on ICU and his treatment is going according to plan. The consultant expects Mr Dillett to be extubated in a day or two.

Key factors pointing away from a deprivation of liberty:

- *Mr Dillett gave consent to the operation which, by extension, included consent to the consequential treatment plan*
- *the circumstances have not gone beyond those under contemplation at the time of Mr Dillett’s consent*

G: Acute ward

4.38 The following are examples of potentially liberty-restricting measures that may be found in an acute ward:

- Physical restraint;
- Baffle-locks on ward doors;
- Mittens, or forms of restraint used to prevent a patient removing or interfering with a nasogastric feeding tube, or intravenous drip;
- Raised bedrails;
- Catheter bag attached to bed;
- A patient being placed in a chair and being unable to move from the chair without assistance;
- Frequency and intensity of observation and monitoring levels;

- The requirement for a patient to remain in a certain area of the ward;
- The requirement that a patient does not leave the ward, accompanied by a plan that, if he does he will be returned to the ward.

Acute ward: a deprivation of liberty

4.39 The measures in the following scenarios are likely to amount to a deprivation of liberty:

Mrs Jones is an 80 year old lady, who lives on her own in a semi-detached house. One evening her neighbours notice the smell of burning. Not finding anything in their house, they go next door. They find Mrs Jones slumped in her kitchen with the toaster on and a piece of burned charcoal in the toaster. Mrs Jones is admitted to hospital with a diagnosis of severe community acquired pneumonia. She responds well to antibiotics and after a week tells the treating team that she wants to go home. She has been assessed during her admission by the physiotherapy and occupational therapy team, who feel that she has significant problems with her activities of daily living. Their professional opinion is that it would be unsafe for her to return home. The doctors treating her note that she is slightly confused, and she scores 8/10 repeatedly on a mini-mental test. Mrs Jones is adamant that she will not consider anything other than returning home. Her neighbours, who have visited her daily in hospital, are very concerned about her returning home. The treating team considers that she should stay in hospital for further assessment and thereafter a suitable care home should be found for her. She will have to remain on the acute ward until then, and there is no immediate prospect of her returning home.

Key factors pointing towards a deprivation of liberty:

- *the monitoring and supervision of Mrs Jones on the ward,*
- *the decision of the treating team not to let her leave to return home*
- *the potential that Mrs Jones will have to remain on the ward for a significant period of time.*

Acute Ward: potential deprivation of liberty

4.40 We suggest that the measures in the following scenario may give rise to a deprivation of liberty:

Alex suffered a serious cerebrovascular accident several years ago. He has been diagnosed as being in a minimally conscious state with little chance of recovering any further function. Although he vocalises and can track with his right eye he is inconsistent in his responses but shows some awareness. He is unable to carry out any activities for himself, he receives CANH via a PEG feeding tube. He required 24 hour nursing care and his care and treatment are constantly monitored. Alex is looked after in a long stay ward of a hospital that specialises in neuro-rehabilitation. He receives excellent care and his wife, Rose and children visit him regularly. Rose recalls Alex telling her before his accident that if at any time in the future he was unable to look after himself, he would want to be looked after at home. Rose has informed those treating Alex that she would like to make arrangements for Alex to be cared for at home. Rose has recently been told that such a move would not be in Alex's best interests and is due to have a further meeting with the treating team to discuss his future.

Key factors pointing towards a potential deprivation of liberty:

- *the monitoring of Alex on the ward and the length of his stay*
- *whether he is free to leave will depend upon whether hospital would, in fact, prevent Rose taking him to care for him at home which will depend upon the outcome of the discussions with the treating team*

Acute Ward: not a deprivation of liberty

4.41 The following scenario is unlikely to amount to a deprivation of liberty:

Cheryl brings her brother Daryl into A&E at 2 o'clock in the morning. Daryl is 19 years old and has mild learning difficulties. He has been involved in a fight with a bouncer at a local club. He is examined by the casualty doctor and sent for an X-Ray. He has a broken jaw and a number of broken teeth. Daryl is referred to a maxillofacial surgeon. He needs to operate on him as soon as possible. The operation will take 3 or 4 hours and during that time Daryl will be anaesthetised. After the operation his face will be very sore and his jaw will be held in place by bands in such a way that he will not be able to eat solid food for up to a week after the operation. He will not be able to go home for at least 2 days during which time he will be kept under observation. Daryl is admitted to a surgical ward. The surgeon assesses Daryl as having capacity to make decisions about his medical treatment and care. Daryl gives his consent to the operation. The operation goes as planned and Daryl goes home 2 days after the operation..

Key factors pointing away from deprivation of liberty:

- *that Daryl had capacity to give consent to the operation and the consequential treatment arrangements, including the requirement to stay in hospital for up to 2 days post-operation.*
- *If however Daryl did not have capacity to give consent to the operation and the consequential treatment arrangements, the facts of this scenario may point to a potential deprivation of liberty*

H: Hospices

4.42 Hospice or palliative care is available in a range of settings, for example as a hospital in-patient, as a hospice in-patient, as a patient attending a hospice daily or at home. This part of the guidance concentrates on care provided in a hospice to a person as an in-patient for a terminal illness.

4.43 Provided the proposed treatment and treatment plan is explained to the person on admission and the person consents to the treatment plan when admitted to the hospice then we consider that the subjective element of Article 5(1) ECHR may not be met and the circumstances will not amount to a deprivation of liberty falling within the scope of the Article 5(1).²¹This, however, must be kept under review during the person's stay at the hospice and consideration given as to whether the care and treatment provided to the patient differs from

²¹ The subjective element is discussed further at paragraphs 2.17-2.19.



the agreed treatment plan (because of changes to the patient's condition) to such an extent that the consent given on admission is no longer valid and the person is deprived of their liberty.²²

- 4.44 If the person lacked capacity to make decisions about his care and treatment at the time they were admitted then staff will need to look closely at the factual situation to see if the person's circumstances objectively amount to a deprivation of their liberty.
- 4.45 Most people suffering from a terminal illness are usually only admitted to a hospice for periods of respite or towards the end of their life. Therefore the length of time that a person is subject to constraint is likely to be a factor in whether or not the person is deprived of their liberty within the meaning of Article 5(1) ECHR. Hospices work together with the patient and the family to provide palliative care and do not usually admit people who are resisting admission. A hospice is also unlikely to insist on a person remaining in the hospice if the family wanted him to return home with care provided for the person at home.
- 4.46 There may, still, however, be circumstances that will meet the 'acid test.'
- 4.47 Factors that are likely to be taken into account when considering whether a deprivation of liberty is taking place include:
- That the circumstances are no longer covered by a consent given on admission;
 - Administering sedatives to decrease anxiety and agitation;
 - Chemical restraint;
 - Constant supervision in case of terminal agitation; and
 - Restricting movement of patients who are mobile, so that they are not free to leave the hospice grounds because they may be a danger to themselves
- 4.48 Because we consider that, in very many cases, whether a person is deprived of their liberty will turn on (1) whether, in fact they are free to leave; and (2) whether they have given consent in advance, we offer here only one scenario that amounts to a deprivation of liberty and one that we suggest does not amount to such a deprivation.

Hospice: a deprivation of liberty

- 4.49 The measures in the following scenarios are likely to amount to a deprivation of liberty:

Mariam is 34 years old. She has a 4 year old daughter and 2 year old son. She has an inoperable primary brain tumour. Some time before admission she had discussed her end of life plan in a general way with her GP, family and staff of the Hope Hospice. She chose Hope Hospice because of its location near to her family home and beautiful gardens. She has agreed with her partner that she will spend weekdays at the Hospice and weekends at home. She had been receiving care at home so that she could spend as much time as possible with her young children, but she has deteriorated more rapidly than had been anticipated. She is now very confused, has become doubly incontinent and suffers from acute headaches that require constant pain relief. In accordance with her previously known wishes she is brought to the hospice by her partner and is admitted to the hospice. At the point of admission she is

²² See also the Department of Health letter to MCA DOLS leads, 14 January 2015, available at <http://www.mentalcapacitylawandpolicy.org.uk/wp-content/uploads/2014/04/DH-Letter-to-MCA-DoLS-Leads-14-January-2015-FINAL.pdf>.



assessed as lacking capacity to consent to her admission and the proposed treatment plan. Although confused she is still mobile. She requires constant supervision because she wanders out of the hospice into the road where she is at risk of injury. At times she becomes very agitated and wishes to go home to be with her children and has to be restrained by staff to ensure that she remains at the hospice to receive care. Mariam's partner has told Hospice staff that he is unable to cope with Mariam's care at home during the weekends as well as looking after their children. The hospice does not consider it in Mariam's best interests to go home. Mariam is in receipt of palliative care and she is likely to remain at the hospice until her death, which may be some weeks away.

Key factors pointing towards a deprivation of liberty:

- *Mariam is under constant supervision; she is not free to leave (and, additionally, must be restrained to prevent her acting upon her desire to leave)*
- *Mariam is likely to remain at the hospice for a number of weeks.*

Hospice: not a deprivation of liberty

4.50 The following scenario is unlikely to amount to a deprivation of liberty:

Mandeep has stage 4 ovarian cancer which has reached a terminal phase. During most of her illness she has been cared for at home by her mother and sister. Once she became aware that her illness was terminal she visited her local hospice with her sister and agreed that she would go there for care within the next week or two. While there she discussed and agreed an advance care plan that detailed her end of life care wishes and preferences. This plan includes pain relief and the use of sedative medication to manage the symptoms of the terminal phase of her illness and the use of a nurse call system that will activate if she starts to wander. She was told that her family could visit her at any time. When she was admitted to the hospice she gave her agreement to a care package which reflected the terms of the advance care plan. Not long after Mandeep is admitted she loses capacity to make care and treatment decisions. The Hospice continues to care and treat her in accordance with the agreed care package.

Key factors pointing away from a deprivation of liberty:

- *Mandeep gave advanced consent to the care and treatment arrangements that are now in place.*

I: Questions for front-line practitioners

4.51 These questions may help establish whether an individual is deprived of their liberty in this context:

- What liberty-restricting measures are being taken?
- When are they required?
- For what period will they endure?
- What are the effects of any restraint or restrictions?
- What are the views of the person, their family or carers?
- How are any restraints or restrictions to be applied?
- Are there less restrictive options available?
- Is force or restraint (including sedation) being used to admit the patient to a hospital to which the person is resisting admission?
- Is force being used to prevent a patient leaving the hospital, hospice, or ambulance where the person is persistently trying to leave?
- Is the patient prevented from leaving by distraction locked doors, restraint, or because they are led to believe that they would be prevented from leaving if they tried?
- Is access to the patient by relatives or carers being severely restricted?
- Is the decision to admit the patient being opposed by relatives or carers who live with the patient?
- Has a relative or carer asked for the person to be discharged to their care and is the request opposed or has it been denied?
- Are the patient's movements restricted within the care setting?
- Are family, friends or carers, prevented from moving the patient to another care setting or prevented from taking them out at all?
- Is the patient prevented from going outside the hospital or hospice (escorted or otherwise)?
- Is the patient's behaviour and movements being controlled through the regular use of medication or, for example, seating from which the patient cannot get up, or by raised bed rails that prevent the patient leaving their bed?
- Does staff exercise complete control over the care and movement of the person for a significant period?
- Is the patient constantly monitored and observed throughout the day and night?

A: Introduction

- 5.1 This chapter considers how to identify deprivation of liberty in psychiatric hospitals. These vary greatly depending on the level of security and the client group.
- 5.2 Please also see Chapters 6 and 7 which consider two different types of community settings where residents may be subject to powers under the MHA 1983, such as conditional discharges, Community Treatment Orders (CTOs) and Guardianship.

B: Hospitals

- 5.3 A “hospital” is defined in s.275 National Health Service Act 2006 as:
 - (a) *any institution for the reception and treatment of persons suffering from illness,*
 - (b) *any maternity home, and*
 - (c) *any institution for the reception and treatment of persons during convalescence or persons requiring medical rehabilitation,*

and includes clinics, dispensaries and out-patient departments maintained in connection with any such home or institution, and “hospital accommodation” must be construed accordingly.
- 5.4 The same definition appears in s.206 National Health Service (Wales) Act 2006. This is also the definition used by the MHA 1983.
- 5.5 Within this broad definition, there is a huge range of hospitals for the care and treatment of people with mental disorders which we will refer to as “psychiatric hospitals.” Secure Mental Health Services comprise the three High Secure Hospitals (Broadmoor, Rampton and Ashworth), medium secure services and low secure services. These are not considered further in this chapter as those cared for in such secure settings will always be liable to detention under the MHA 1983, which provides authority to deprive the patient of his or her liberty for assessment and psychiatric treatment. We consider that the nature of secure settings is such that they will almost inevitably involve a deprivation of liberty.
- 5.6 Identification of deprivation of liberty, or of a risk that cannot be ignored that a particular patient may be deprived of his or her liberty, will be important in settings where the MHA 1983 may or may not be used. These will include:
 - 5.6.1 Acute wards;
 - 5.6.2 Rehabilitation wards or “stepdown” placements;
 - 5.6.3 CAMHS (Children and Adolescent Mental Health Services) wards;
 - 5.6.4 Assessment and Treatment Units (ATUs); and
 - 5.6.5 Dementia specialist units
- 5.7 These settings are provided both by the NHS and the independent sector. In the great majority of cases the patient’s care will have been commissioned by the relevant Clinical Commissioning Group (‘CCG’).¹ In all these settings patients may be treated for their mental

¹ There will be a few occasions where the state is not involved in the patient’s admission, care or treatment but we do not deal with these in the balance of this guidance, largely because any private hospital would still have to seek authorisation for the deprivation of the patient’s liberty under Schedule A1 to the MCA 2005. See further paragraph 2.49.



disorder informally (where the patient is described as an “informal” or “voluntary” patient), provided (1) the care and treatment regime does not amount to a deprivation of liberty; or (2) if it does, they can consent to the restrictions amounting to a deprivation of their liberty.²

- 5.8 If the patient either cannot or does not consent to their admission, assessment and/or treatment for mental disorder in the psychiatric setting, and that admission, assessment and/or treatment will involve a deprivation of their liberty, then authority will be required under one of four routes:
 - 5.8.1 the provisions of the MHA 1983;
 - 5.8.2 DOLS, i.e. the provisions of Schedule A1 Mental Capacity Act 2005 (“DOLS”);
 - 5.8.3 (unusually) by way of an order made under the inherent jurisdiction of the High Court;
 - 5.8.4 (unusually) by way of an order made by the Court of Protection.
- 5.9 The decision as to which legal framework to use is outside the scope of this document but will first require an assessment of:
 - 5.9.1 whether the arrangements made for the patient’s care and treatment deprives them of their liberty, or whether there is “a possibility that cannot sensibly be ignored”³ that they may do so;
 - 5.9.2 if so, whether the patient can, and does, consent to those arrangements.
- 5.10 In addition to the availability of legal frameworks to authorise deprivation of liberty, practitioners must apply the provisions of the MHA Code of Practice (the ‘MHA Code’), whether or not the compulsory powers of the MHA 1983 are being used. This is because – in addition to giving guidance about the use of the MHA 1983 – the Code provides guidance for “medical practitioners and members of other professions in relation to the medical treatment of patients suffering from mental disorder.”⁴ This also includes treatment in the community.
- 5.11 This guidance looks at the settings set out in paragraph 5.6 and considers how a deprivation of liberty can be identified in each setting. It is worth remembering that all hospitals – whether treating physical or mental disorder – need to run on the basis of a structured timetable. Anyone who has received inpatient treatment in a busy surgical ward will know this can involve surrendering control over many aspects of life, in ways that may not have been anticipated before the admission begins. We stress that the fact that we identify measures that restrict liberty is not a criticism of the care provided: some restrictions are unavoidable. Similarly, where we identify risks that a particular scenario involves a deprivation of a patient’s liberty, this simply means that the patient is entitled to the legal safeguards, in the form of independent checks, required by Article 5. Lady Hale summed this up in the Supreme Court judgment in *Cheshire West*: thus “[n]or should we regard the need for such checks as in any way stigmatising of them or of their carers. Rather, they are a recognition of their equal dignity and status as human beings like the rest of us” (paragraph 57).

2 A patient can only be an ‘informal’ or ‘voluntary’ patient in such circumstances if they have capacity to consent to their admission and treatment and to the restrictions inherent in that admission and treatment, and give that consent freely: see [A PCT v LDV](#) [2013] EWHC 272 (Fam) and paragraph 2.19.

3 [AM v South London and Maudsley NHS Foundation Trust](#) [2013] UKUT 365 AAC

4 S118 (1) (b).



5.12 It should be noted that the Care Quality Commission ('CQC') which inspects mental health services and monitors the use of the MHA has expressed the view that any incapacitated patient who requires psychiatric admission is likely to satisfy the "acid test" for deprivation of liberty.⁵

C: Psychiatric hospitals generally: measures which restrict liberty

5.13 The following are examples of potentially liberty-restricting measures that apply in psychiatric hospitals generally:

- Wards are busy places where there may be a high turnover of patients and significant pressure on staff time. This can result in blanket restrictions. These include: limited access to bedrooms during the day; restrictions on access to parts of the ward such as kitchen areas;
- Setting of observation and monitoring levels;
- Requirements for patients to be escorted in certain parts of the ward or site;
- The physical environment (e.g. wards not on ground level) may limit patients' access to the outdoors;
- The prescription and administration of medication to a patient who lacks capacity to consent to it, in particular medication to sedate and/or to control the behaviour of the patient;
- The extent to which the patient is required to adhere to a timetable;
- Locked doors, or use of "baffle locks", unless patients have the code and are able to come and go as they please⁶;
- The concept of "protected time" is a valuable means of ensuring that patients have quiet periods during the day but also represents control over the activities of patients;
- Limited visiting time;
- Lack of easy access to telephones, internet, equipment for hobbies and interests such as art or music materials, possibly on safety or availability grounds;
- Use of seclusion⁷, especially where such seclusion is regular and/or prolonged;
- Use of physical restraint, especially where such restraint is regular;
- Sanctions, such as time out, for behaviour that causes concern;
- Restriction of access to finances.

5 "Monitoring the Mental Health Act 2013/4" (page 47), available at <http://www.cqc.org.uk/content/mental-health-act-annual-report-201314>.

6 The CQC has noted an increase in the use of locked wards, finding that 86 % of the wards visited in 2013/14 were locked: see page 47 of its report: [Monitoring the Mental Health Act in 2013/4](#)

7 Seclusion is defined in the 2015 MHA [Code of Practice](#) (available at <https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>) at 26.103 as "the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others."

D: An Acute Ward

5.14 Many patients admitted to psychiatric hospitals will be treated in acute wards. These wards can be very busy depending on the pressure on admissions at the time. Acute wards are not usually intended to be long-stay settings and as such the make-up of the client group will change and may at times be volatile, with patients presenting with a range of different disorders, at an early stage in their recovery.

Acute Ward: a deprivation of liberty

5.15 The measures in the following scenarios are likely to amount to a deprivation of liberty:

Miss Sara Wong, aged 59, has had mental health issues for many years and has a diagnosis of schizophrenia. She lives on her own now that she has retired and neglects her personal care and her diabetes is not well managed. She is non-compliant with diet guidance and does not like taking her anti-psychotic medication. It is winter and her central heating boiler is no longer working. She is reluctant to spend money on a new boiler.

Due to her increased paranoia, and threats to neighbours who she accuses of spying on her, a decision is made to admit her to hospital under s.2 MHA 1983 for assessment. She is admitted to the acute ward of the local psychiatric hospital. She becomes cooperative with taking medication and after some weeks, as she agrees to stay on the ward, she is not made the subject of an application under s.3 MHA 1983 at the end of the 28 day period of her initial section, but remains on as an informal patient.

Miss Wong thinks that she is on the ward for treatment of her diabetes and her bad foot. She has agreed to stay on until her foot is better and states that when the doctors tell her she is ready for discharge, she will return home. A formal capacity assessment as to whether she can consent to informal admission has been conducted and Miss Wong is considered to lack such capacity.

A discharge planning meeting takes place attended by the hospital's social worker. The psychiatrist is concerned about Miss Wong's ability to cope on her own, and suggests that she may also have dementia but is awaiting scan results. The psychiatrist recommends that Miss Wong be placed in residential care. No relatives in England have been identified.. The social worker agrees with the psychiatrist that Miss Wong lacks capacity to make a residence decision as she cannot weigh up the risks of returning home and it is feared that once home, she will revert to her habits of not letting the district nurses visit to check her foot and diabetes and also that she will not allow the CPN to check that she is taking her medication. She has also refused a key safe, as she fears that it will include a spy camera and that neighbours will use it to enter her home.

Miss Wong has not asked to go out. However, the hospital is on a very busy road and staff consider it would not be safe for her to go out without staff. She could go out with family but no family have been found. If Miss Wong wanders into the male ward, she is redirected to her own ward. There is a key pad on the door and no one can leave, even visitors, without staff entering the code.

Key factors pointing to a deprivation of liberty:

- *The level of supervision and control on the ward*
- *Miss Wong is not free to leave temporarily without staff present or to go home.*

Acute Ward: potential deprivation of liberty

5.16 We suggest the measures in the following scenario may give rise to a deprivation of liberty:

Mr Nicholas James has treatment resistant schizophrenia with co-morbid physical problems. He is to be started on clozapine (a drug that needs considerable physical monitoring). Although this can be done in the community, the team consider it would be preferable and more efficient to do this in hospital, because of concern that Mr James will not attend appointments for monitoring on time. Mr James lacks capacity to consent to treatment as he believes the treatment offered is for an alien infection not a mental disorder. He is happy to come into hospital as an inpatient and receive tablets as this is, he thinks, appropriate treatment for an infection. He thinks it irrelevant that this is a psychiatric hospital as he states that as there are doctors and nurses there who can help him. When on the ward, the staff would be concerned were he to seek to leave while the treatment gets under way and would have to consider invoking s.5 MHA 1983 to prevent him leaving pending assessment for admission under the Act.

Key factors pointing to a potential deprivation of liberty:

- *The level of supervision and control on the ward*
- *the level of monitoring required in relation to clozapine and the need for staff to consider invoking s.5 MHA 1983*
- *that Mr James may be on the acute ward for a number of days;*
- *whether Mr James would in fact be deprived of his liberty would depend in large part upon exactly what plan the staff would have if he sought to leave and the planned length of his admission.*

Acute Ward: not a deprivation of liberty

5.17 We suggest that the following scenario is unlikely to amount to a deprivation of liberty:

Ms Razia Ahmed has sought help for feelings of depression and hopelessness. She has capacity to consent to admission to hospital for assessment and treatment and has and continues to consent. The consent includes an understanding and agreement that there will inevitably be some restrictions on her movements and that she will be asked to follow the advice of staff about when to leave the ward, and for how long. Ms Ahmed recognises that meals and visits are at set times. She is aware that she may be offered medication, as well as other treatment such as talking therapies, but is not obliged to accept it.

Key factors pointing away from a deprivation of liberty:

- *Ms Ahmed has capacity to consent to the admission and the attendant restrictions upon her liberty.*

E: A rehabilitation or “step down” ward

5.18 This setting will share some of the features of the acute ward, and many of the measures outlined at paragraph 5.13 are likely to be present. The nature of such placements is that for therapeutic reasons a very structured timetable may be present, which patients are expected to adhere to. Patients are likely to move to these placements at a relatively advanced stage in their recovery and the client base will be more stable as patients are likely to remain for longer.

Rehabilitation ward: a deprivation of liberty

5.19 We suggest the measures in the following scenario are likely to amount to a deprivation of liberty:

Mr Alfred Smith has a long history of mental illness. He has a diagnosis of schizophrenia. He has been detained many times under section 3 MHA and has relapsed between admissions. He has held a tenancy in supported living but has neglected himself and his flat is a health hazard. He uses drugs and this is said to compound his problems. He is very pleasant when well but when ill can be aggressive and unpredictable. He has a number of negative symptoms and although it is suspected that his cognitive functioning is impaired. A referral has been made for neuropsychological testing. He always holds residual delusional beliefs and lacks capacity to make decisions about where to live and his care arrangements. He was moved to a locked rehabilitation unit as he has lost many of the skills relating to Activities of Daily Living. He is complying with the timetable but has not yet got escorted leave.

Alfred was detained under s.3 MHA 1983 and applied to the Tribunal. Somewhat to the surprise of the clinical team the Tribunal discharged him on the basis that he would remain informally and he has in fact continued on the ward with the current care plan, which involves a significant degree of oversight over his activities because he is not safe to carry out many Activities of Daily Living unaccompanied. Staff are aware they may need to review this in view of the lifting of the section.

Key factors pointing to a deprivation of liberty:

- *Alfred is not free to leave the locked ward (and when he gets leave, it will be under escort).*
- *Alfred is under supervision and control on the ward, particularly whilst carrying out activities of daily life.*
- *Rehabilitation or “step down” ward: potential deprivation of liberty*

5.20 We suggest that the measures in the following scenario may give rise to a deprivation of liberty:

Ms Mary Smith is in her 60s with chronic schizophrenia and has been in a cycle of admissions and relapses for many years. She has lived a chaotic life in the community and is street-homeless. She has been in hospital for the past twelve months and has recently moved from an acute ward to a rehabilitation ward. Her psychotic symptoms are controlled by medication but she has significant negative symptoms. Her consultant thinks she may additionally have some cognitive defects. She has lost many of the skills related to the Activities of Daily Living. The aim of the placement is to help her rebuild these and the plan – which she supports – is for her to move into supported accommodation for those with severe and enduring mental health problems. She is compliant with medication which is administered partly orally and partly via depot. However, she needs to be prompted as she would forget otherwise. The ward has a structured timetable: Ms Smith is expected to get up at 8am and is prompted to attend to her personal hygiene which she tends otherwise to neglect. She is encouraged to choose healthy options for breakfast which she helps to prepare and tidy up. She is then encouraged to tidy her bedroom, do her laundry and attend a community meeting with other patients. Each weekday she has a timetable which could involve going to a day centre, attending a cooking class, doing some shopping, or attending a keep fit class. At the end of the day she is encouraged to go to bed no later than midnight. There are limited facilities on the ward for cooking but she is expected to prepare simple meals and snacks. She is discouraged from reliance on takeaways but there is a weekly pizza or curry evening for everyone. There are also organised activities such as trips to the cinema with other patients. The majority of the time Ms Smith accepts and appears to welcome the structured timetable on the ward as part her rehabilitation. Ms Smith would not be allowed to leave the ward unaccompanied without the permission of the clinical team, but can go out with permission when the staff know where she is going.

Key factors pointing to a potential deprivation of liberty:

- *Ms Smith is not free to leave and there is a degree of supervision and control over her on the ward and when she leaves the ward.*
- *A key factor will be the extent to which it can be said that this represents ‘support’ as opposed to supervision and control. In light of MIG’s case (discussed further at paragraph 2.26), we suggest that caution would need to be exercised before such a conclusion is reached.*

Rehabilitation ward: not a deprivation of liberty

5.21 The following scenario is unlikely to amount to a deprivation of liberty:

Ms Naomi Archer is 66 and has schizophrenia. She has a history of alcohol abuse. She has been detained under s.3 MHA 1983 for the last year. Prior to her admission to hospital she had been living in a hostel but was evicted as a result of her behaviour when drinking. Her mental health had deteriorated and she was thought-disordered, aggressive and delusional when she was admitted.



Ms Archer spent 6 months on an acute ward and her section was renewed. She has made good progress and her psychotic symptoms have receded significantly. She has managed to remain abstinent from alcohol. She continues to hold a number of delusional beliefs including that she has been abducted and an impostor put in her place. She does not believe that the hospital is a real hospital. When she was admitted to hospital she found these beliefs frightening and distressing but now can tolerate them. She has been assessed as lacking capacity to decide where to live. She has been on the rehabilitation ward for the last six months. The plan is for Naomi to move to highly supported accommodation when she leaves hospital and she is on the waiting list for a particular place she has visited and liked very much. The clinical team have made plans for Naomi to be discharged from the hospital as soon as a place is available. If she were to insist on leaving her care co-ordinator would make an urgent referral to the local authority's homelessness team to secure bed and breakfast for Naomi until her care home place comes up and would arrange support in the community for her until then.

Naomi takes part in the ward programme and at one stage had four hours' unescorted leave a day which she used to visit the library, or spend time with her cousin who lives nearby. She appealed to the Tribunal and at the hearing said she was willing to stay in "this place, whatever it is" until she was allocated a room at the new placement. The Tribunal discharged her on the basis of her agreement to remain. Naomi's responsible clinician has made it clear to her that she can come and go from the ward as she pleases and is no longer restricted to four hours unescorted leave. She appears to enjoy taking part in ward activities and rarely spends more than four hours off the ward.

Key factors pointing away from a deprivation of liberty:

- *Naomi is free to leave*
- *Careful examination of whether the arrangements on the ward amount to continuous supervision and control will be necessary to reach a decision.*

F: A CAMHS ward

5.22 The Child and Adolescent Mental Health Services ('CAMHS') setting will share some of the features of the acute ward, and many of the measures outlined at paragraph 5.13 are likely to be present. However, the environment should be suitable for their age which allows for their personal, social and educational development and with access to age appropriate leisure activities and facilities for visits from family and carers.⁸

5.23 Where a 16 or 17 year old with capacity refuses admission, consent from those with parental responsibility cannot be relied upon: s.131(4) MHA 1983. Nor can such consent be relied upon where someone under 18 lacks capacity or competence to consent or refuse care arrangements which amount to a deprivation of liberty: *RK v BCC, YB and AK*.⁹ For further details regarding the 'nuanced' acid test for those under 18, see chapter 9.

⁸ See generally chapter 19 of the *Mental Health Act 1983 Code of Practice* (2015), available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/395494/mh-code.pdf, due to come into force in April 2015 subject to Parliamentary approval.

⁹ [2011] EWCA Civ 1305.

A CAMHS ward: a deprivation of liberty

5.24 The measures in the following scenario are likely to amount to a deprivation of liberty:

Anna is 16 years old and suffers with severe anorexia. She is admitted to a locked CAMHS ward with a very low body mass index and is refusing food. As she lacks capacity to make dietary decisions or her care and treatment arrangements more generally, given the risk of damage to her organs it is decided with her parents that she will require nasogastric feeding or PEG feeding through her stomach wall which, it is anticipated, she is likely to resist. Physical or chemical sedation will therefore be required to minimise risk of harm and she will not be able to leave her hospital bed for a number of weeks during the re-feeding process.

Key factors pointing to a deprivation of liberty:

- *the use of physical/chemical sedation during the course of her stay on the ward*
- *her lack of freedom to leave*
- *It is important to also note that if Anna is deprived of her liberty, this falls outside the scope of parental responsibility: see further paragraph 9.5. The use of the MHA 1983 will be required to authorise her detention and psychiatric treatment.*

A CAMHS ward: potential deprivation of liberty

5.25 We suggest that the measures in the following scenario may give rise to a deprivation of liberty:

Jon is 16 years old and his concerned mother organised his admission to the locked ward. He suffers from a nervous condition and a chronically neurotic state of mind. The conditions on the ward are as similar as possible to a real home and, whilst there he is regularly observed by staff. He needs permission from staff to use his phone, receives no medication but is engaged in talking and environmental therapies. He is allowed to leave the ward with staff permission, for example to attend the hospital library. He also goes outside to playgrounds and museums with other children, always accompanied by staff. He is able to visit his parents and school friends regularly and, towards the end of his 5?-month hospital stay, starts going to school during the day. On one occasion he absconded and was returned by the police. The restrictions are being relaxed as his treatment progresses.

Key factors pointing to a potential deprivation of liberty:

- *The degree of control over his activities exercised by the staff on the ward and the extent to which they control his ability to leave the ward.*
- *As discussed further in chapter 9, a key factor will be the extent to which it can be said that the conditions imposed upon Jon are akin to those which would be imposed upon any 16 year old young person admitted to hospital.*



Note: this case is based upon the facts of the case in *Nielsen v Denmark*,¹⁰ although the child in question in that case was 12 years old. The ECtHR considered that the circumstances did not amount to a deprivation of liberty because any restrictions upon the liberty of the child arose out of the proper exercise of parental responsibility. We suggest that the logic of this case, which has been criticised, is not necessarily applicable to a young person of 16.

A CAMHS ward: not a deprivation of liberty

5.26 The following scenario is unlikely to amount to a deprivation of liberty:

Debbie is 16 years old and lacking the relevant capacity was admitted in her best interests with obsessive compulsive traits concerning keeping herself and her environment immaculately clean. She has a skin rash from scrubbing herself so hard and her hand have become itchy as a result. Every morning her mother attends the ward to collect her for school and returns her in the afternoon. If the family decide to have dinner at home it is expected that she will come back before 8pm. Often her mother returns her at 4pm. Sometimes Debbie will spend the night with her parents, about which the hospital will be informed. Debbie enjoys school greatly and has excellent grades. She engages with psychological therapy at weekends and staff are available during the weekday evenings to learn to tolerate the idea of germs and also to the risks to her physical and mental health arising from her obsessive compulsive traits. Debbie rarely chooses to go out alone and does not wish to go out without her mother or father.

Key factors pointing away from a deprivation of liberty:

- *Debbie's age and maturity and the involvement of her parents, and the reality that the hospital does not have the degree of control to require her to be on the ward: see further chapter 9 for the application of the 'nuanced' acid test in relation to relatively young children*

G: An Assessment and Treatment Unit (ATU)

5.27 ATUs are specialist in-patient settings for patients with learning disabilities. The level of security of such settings varies. In addition to the features set out at paragraph 5.13 above, some or all of which may be present in ATUs, the CQC has found evidence of a number of restrictive practices in learning disability services.¹¹ These include:

- physical restraint;
- seclusion (often described in misleading terms, not recognized as such and thus not reviewed in accordance with the MHA 1983 Code of Practice);
- blanket rules which were rarely justified by the needs of the individual patient. This can be exacerbated by pressure on staff through low numbers;
- routine and clear boundaries, which can be beneficial and a source of reassurance, but can also entail assuming control over what the individual does with their time.

¹⁰ (1989) 11 EHRR 175.

¹¹ <http://www.cqc.org.uk/content/cqc/s-symposium-restrictive-practices>.

- 5.28 It is difficult to identify scenarios in this setting that would not give rise to a real risk of deprivation of liberty (where the individual lacks the material capacity to consent to the restrictions imposed upon them).

ATU: a deprivation of liberty

- 5.29 The measures in the following scenario are likely to amount to a deprivation of liberty:

Mr Jaswant Singh has epilepsy, severe autism and learning disabilities and has a history of failed placements. He is twenty years old. He can display challenging behaviour and this can involve self-harm in the form of banging his head against walls, assaulting others, and causing serious damage to property. A community placement broke down 18 months ago and he was admitted to an ATU informally in the absence of any other available alternative. It has however proved very difficult to arrange an alternative placement partly due to a dispute as to who is responsible for funding his care and partly due to the complexity of his needs. He therefore remains in hospital. He has been classified as a delayed discharge for the past year. He lacks capacity to consent to admission or treatment.

Mr Singh finds it hard to tolerate others. He is able to live in a small self-contained bungalow on the hospital site. This is usually occupied by 2 people but is currently used for Mr Singh alone. Some adaptations have been made, for example handles have been removed from cupboard doors and there are no pictures or ornaments on the walls because Mr Singh would pull them down.

Mr Singh's treatment consists of medication for epilepsy and nursing care. He is encouraged to wear a helmet because of the risk of injury due to head banging. Otherwise, staff attempt to engage him in a programme of activities inside and outside the ward. His day is very structured and tends to follow a very similar pattern as he finds this easy to cope with. Mr Singh is not allowed out of the unit without staff support.

Key factors pointing towards a deprivation of liberty:

- *The degree of supervision and control over Mr Singh's day to day activities at the ATU*
- *The lack of freedom to leave*
- *The indefinite nature of the placement*

H: A dementia specialist unit

- 5.30 Many of the liberty-restricting measures identified above will be present in such settings. In addition the following features may be present:

- The need for restraint and other physical interventions, in the patient's best interests, to deliver personal care;
- Blanket restrictions to avoid risks such as falls

5.31 As such, we consider it highly unlikely that a patient in this setting who lacks capacity to consent to admission will not be considered to be deprived of his or her liberty. A typical example of an incapacitated compliant patient, who is receiving appropriate care and treatment in his best interests but who satisfies the ‘acid test’ is set out below.

Mr James Henry has severe dementia and does not understand why he is in hospital, does not know he is in hospital and is calm and settled following treatment with an antidepressant which has reduced his irritability and resistance to care. He does not try to leave and walks with assistance, though his key risk when walking is that he may fall over. Therefore he is often (though not always) accompanied when he walks.

Personal care is provided by nurses so that he can enjoy cleanliness and comfort. At times he resists them and sometimes this is dealt with by the staff leaving and coming back half an hour later. At other times, care is occasionally imposed by using mild restraint so as to assure his cleanliness.

Mr Henry does not try to leave the ward, accepts care and support and accepts food and drink. If he did try to leave he would be stopped, but in fact he is not trying to leave. If he refused medication and his behaviours and distress returned, he would be treated but he is willingly taking medication although he does not understand the purpose.

Mr James regularly has visitors. His wife holds a health and welfare LPA for him; she regularly attends ward rounds and is fully supportive of his care and treatment.

Key factors pointing to a deprivation of liberty:

- *Mr Henry is not free to leave in that if he attempted to do so, he would not be allowed to do so (in fact he has not made such attempts).*
- *The level of intervention needed to provide safe care for him.*

I. Summary of questions for front-line staff

5.32 These questions may help establish whether an individual is deprived of their liberty in this context:

- Is the door to the ward or unit locked? Does the patient either know the code or have a swipe, and is he or she able to make use of it to come and go as he or she pleases?
- Can the patient leave the ward at any time or are there any conditions the person is required to adhere to?
- How easy is it for the patient to go outside and get access to fresh air?
- What if any steps would be taken by staff if the patient were to announce their intention to leave the ward a) temporarily or b) permanently?
- Is the patient able to access all areas of the ward when they wish to?
- Can the patient prepare any refreshments for themselves?
- Is the patient able to access items for leisure activities when they wish, such as: games consoles, books, means of listening to music, art, craft or writing equipment, the internet?



- What observation levels is the patient on and how are they monitored?
- Is the patient prescribed medication? If so, can they consent to such medication, and what is its purpose? Is it to control their behaviour?
- To what extent is the patient required to adhere to a timetable?
- Does the ward have a period of “protected time” when visitors cannot come onto the ward?
- How easy is it for the patient to use the phone in private?
- What are the visiting hours?
- Is the patient ever nursed alone and if so in what circumstances?
- Is the patient ever secluded? If so, why and for how long on each occasion? Is seclusion regularly used?
- Is restraint ever used and in what circumstances? How often is it used?
- Are there any sanctions used if the patient’s behaviour is cause for concern? If so what are they and why?
- Does the patient manage his or her own finances? If not, who does, why, and under what authority?
- Could any of the liberty- restricting measures be dispensed with and if so how?

A: Introduction

6.1 By far the highest number of applications for authorisations under the Deprivation of Liberty Safeguards (“DOLS”) are made by care homes¹. Care homes are defined by s.3 Care Standards Act 2000 as follows:

Care homes.

- (1) *For the purposes of this Act, an establishment is a care home if it provides accommodation, together with nursing or personal care, for any of the following persons.*
- (2) *They are—*
 - (a) *persons who are or have been ill;*
 - (b) *persons who have or have had a mental disorder;*
 - (c) *persons who are disabled or infirm;*
 - (d) *persons who are or have been dependent on alcohol or drugs.*

6.2 All care homes in England must be registered with and inspected by the Care Quality Commission (‘CQC’). Care homes in Wales are inspected by the Care and Social Services Inspectorate Wales (CSSIW). There are two types of care home: residential care homes and care homes with nursing, but there is of course a wide variety within these types.

6.3 The CQC explains on its website² that residential care homes range in size from very small homes with few beds to large-scale facilities. They offer care and support throughout the day and night. Staff may help with washing, dressing, at meal times and with using the toilet. Care homes with nursing will normally offer the same type of care but with the addition of 24-hour medical care from a qualified nurse. Within these two however there will be a wide variety of provision, because care homes may have different specialisms. These will include dementia, alcohol or drug dependency, mental health or learning disability. This chapter looks at the type of liberty-restricting measures which could be present in the following settings which come within the definition of a care home:

6.3.1 A residential care home for older adults;

6.3.2 A care home with nursing;

6.3.3 A care home for people with severe and enduring mental health problems, including mentally disordered offenders;

6.3.4 A care home for adults with physical and learning disabilities.

6.3.5 An arrangement for respite.

6.4 This chapter will summarise the legal frameworks which may apply to care home residents. It will then consider the settings listed above and provide scenarios which describe a regime in each setting which amounts to a deprivation of liberty; and, where appropriate, regimes which may be a deprivation of liberty or which we do not consider will amount to a deprivation of

¹ Around 70% of all applications in 2013-14: see [Care Quality Commission's report "Monitoring the Use of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards at <http://www.cqc.org.uk/content/deprivation-liberty-safeguards-201314>](http://www.cqc.org.uk/content/deprivation-liberty-safeguards-201314).

² <http://www.cqc.org.uk/content/care-homes>

liberty. Following the scenarios we set out are questions which can usefully be asked by front-line staff attempting to ascertain where on the spectrum a particular care arrangement may fall. An appendix deals with specific issues that arise in relation to the use of care homes for respite.

B: The Legal Framework

- 6.5 In very general terms, people live in care homes so that their care and support needs can be met. This may be on a short term basis, such as for respite, or for long periods, in some cases for the rest of the resident's life. Residents may or may not contribute financially to the costs of their care. Statutory bodies have various duties under legislation such as the Care Act 2014 (in force as of 1 April 2015) to provide care and support. It is important to keep in mind that the provision of care and support does not, itself, compel the adult concerned to accept it or provide authority to deprive the adult of their liberty in order to receive it. As Munby LJ noted in *Re A and Re C*³ (in relation to the various community care obligations then imposed upon local authorities): “[t]he essential point for present purposes is that none of these sources of local authority engagement with someone like C confers on the local authority any power to regulate, control, compel, restrain, confine or coerce. They are concerned with the provision of services and support.”
- 6.6 Some care home residents will have full capacity to consent to their care and support arrangements, including restrictions that follow on from these arrangements, and will have consented to them. As explained at paragraph 2.12, case law provides that the question of whether a person is deprived of their liberty requiring an authorisation only arises in the case of those who have not consented or cannot consent to such restrictions.
- 6.7 Some care home residents may be subject to one or more of a range of legal measures which have different effects. These are summarised briefly below:
- 6.7.1 A DOLS authorisation under Schedule A1 to the MCA 2005. If the requirements are met, an authorisation granted by the relevant supervisory body permits the care home (‘the managing authority’) to deprive the resident of his or her liberty in the care home for the purpose of being given care or treatment.⁴ This framework cannot be used to resolve a dispute about whether the resident should be in the care home in the first place. One reason for this is that decisions about where a person should live will engage their right under Article 8 of the European Convention on Human Rights to respect for private and family life. See *London Borough of Hillingdon v Neary*,⁵ and also *Re AJ (Deprivation of Liberty Safeguards)*.⁶ If in fact it becomes clear that Schedule A1 has been used in this way, legal advice should be sought as soon as possible as to whether an application to the Court of Protection is required;
- 6.7.2 A welfare order made by the Court of Protection under s.16(2)(a) MCA 2005. Such an order can only be made where: (1) a Court of Protection judge has concluded that the resident lacks capacity to decide where to live and to make decisions in relation to their care arrangements; (2) that the resident is of ‘unsound mind’ for purposes of Article

3 [\[2010\] EWHC 978 \(Fam\).](#)

4 Schedule A1 to the MCA 2005, Paragraphs 1(2) and 2.

5 [\[2011\] EWCOP 1377.](#)

6 [\[2015\] EWCOP 5.](#)

5(1)(e);⁷ (3) that it is in the resident's best interests to live and receive care at the care home; and (4) that deprivation of the person's liberty is necessary and proportionate to the risk that they would face otherwise. The order may include other provisions, for example, limits on contact with family members. When such orders are made the court nearly always directs that a copy is retained on the resident's file at the care home. The order may, itself, authorise deprivation of liberty or the Court may direct that a DOLS authorisation should be used in addition to the welfare order;

- 6.7.3** Leave granted to a mental health patient under s.17 MHA 1983, probably for a limited trial period to see how he or she settles into the home. The resident is liable to recall back to hospital whilst on leave. A DOLS authorisation can be used alongside s.17 leave if certain conditions are met: see Schedule 1A to the MCA 2005. Section 17 MHA 1983 does not, itself, give authority to deprive the patient of their liberty at the care home;
- 6.7.4** A guardianship order under s.7 MHA 1983. This gives the guardian (usually an Approved Mental Health Professional ('AMHP') acting on behalf of the local authority) the following powers:⁸
- i the power to require the patient to reside at a place specified by the guardian
 - ii the power to require the patient to attend at specified places and times for medical treatment, occupation, education or training
 - iii the power to require access to the patient to be given, at any place where they are residing, to any registered medical practitioner, AMHP or any other specified person
 - iv if certain conditions are met, guardianship can be used alongside DOLS: see Schedule 1A to the MCA 2005. Our view, based on case law, is that guardianship alone does not authorise deprivation of liberty, but also that the mere exercise of the power of the guardian to require a patient to live at a specific place does not itself give rise to a deprivation of liberty;⁹
- 6.7.5** A Community Treatment Order ('CTO') under s.17A MHA 1983. This will only arise in the cases of residents who have previously been detained in hospital under ss.3 or 37 MHA 1983. A CTO must always contain conditions which require the resident to make themselves available for examination to the patient's Responsible Clinician ('RC') to assess if the order should be renewed and to a doctor appointed by the CQC to give a second opinion on treatment. If the resident does not comply with either of these conditions, the RC may recall the resident. Other conditions may be imposed by the RC but a resident on a CTO cannot be recalled simply because they have breached one of these conditions so this does not itself mean that the person is not free to leave.¹⁰ A CTO does not provide authority to deprive people of their liberty but a DOLS authorisation may be used together with a CTO: see Schedule 1A to the MCA 2005;

⁷ This is clear, we suggest, from *Re X (No 1)* [2014] EWCOP 25 at paragraph 14. In *G v E* [2010] EWCA Civ 822, the Court of Appeal suggested that medical evidence would not always be required. However, we suggest that – as with applications for authorisations under Schedule A1 – medical evidence of unsoundness of mind must always be obtained. It may be that there are cases where the person is unsound in mind but does not have a mental disorder for purposes of the Mental Health Act 1983 (the requirement under Schedule A1), in which case the Court of Protection would be able to make an order even if an authorisation under Schedule A1 cannot be granted.

⁸ Section 8(1)(a) MHA 1983.

⁹ See *NL v Hampshire County Council* [2014] UKUT 475 (AAC).

¹⁰ By analogy also with the NL case discussed immediately above.

- 6.7.6 A Conditional Discharge. Offender patients who have been detained under “restricted” sections of the MHA 1983 (for example ss.37 and 41) may be discharged by the Secretary of State for Justice or the Mental Health Tribunal subject to conditions with which they must comply. Such patients will remain liable to recall by their RC or the Secretary of State. A conditional discharge does not authorise deprivation of liberty (see *Secretary of State for Justice v RB*)¹¹ but where the person lacks capacity to consent to admission to a care home, a conditional discharge order can be used together with a DOLS authorisation when certain conditions are met: see Schedule 1A to the MCA 2005;
- 6.7.7 An order made under the inherent jurisdiction of the High Court. These cases are so rare that they are not discussed further in this chapter.

C: A residential care home for older adults: liberty restricting measures

- 6.8 As with all care settings, there is a huge variety in the way in which each establishment will seek to provide safe and appropriate care for its residents. What follows is not an attempt to stereotype this kind of provision, but recognition of the challenges that can arise in providing such care in the least restrictive environment. These challenges include:
- 6.8.1 how to promote choice: for example if a resident does not want to eat the meal offered on a particular day how easy is it for them to go out to eat?
- 6.8.2 the physical environment and the impact of a structured timetable: in many care homes of this type residents may be expected to spend at least part of the day seated in a lounge, perhaps with a television or music. How can residents be given as much autonomy as possible in how they spend their time and where?
- 6.8.3 promoting family and private life: how can care settings promote important intimate (which may include sexual) relations between residents?
- 6.9 The following are examples of potentially liberty-restricting measures that apply in a residential care home for older adults:
- A keypad entry system;
 - Assistive technology such as sensors or surveillance;¹²
 - Observation and monitoring;
 - An expectation that all residents will spend most of their days in the same way and in the same place;
 - A care plan providing that the person will only access the community with an escort;
 - Restricted opportunities for access to fresh air and activities (including as a result of staff shortages);
 - Set times for access to refreshment or activities;

¹¹ [\[2011\] EWCA Civ 1608](#).

¹² The CQC consider this to be a relevant factor in their document “[Using Surveillance](#),” December 2014, <http://www.cqc.org.uk/content/using-surveillance-information-service-providers>.



- Limited choice of meals and where to eat them (including restrictions on residents' ability to go out for meals).
- Set times for visits;
- Use of restraint in the event of objections or resistance to personal care. (In [Re AJ](#),¹³ Baker J agreed that in any case where physical restraint is used in the care of an incapacitated adult, all physical intervention should be recorded in the care plan and documented in any DOLS process);
- Mechanical restraints such as lapstraps on wheelchairs;
- Restricted ability to form or express intimate relationships;
- Assessments of risk that are not based on the specific individual; for example, assumptions that all elderly residents are at a high risk of falls, leading to restrictions in their access to the community

Care home for older adults: a deprivation of liberty

6.10 The measures in the following scenario are likely to amount to a deprivation of liberty:

Peter is 78. He had a stroke last year, which left him blind and with significant short-term memory impairment. He can get disorientated needs assistance with all the activities of daily living. He needs a guide when walking. He is married but his wife Jackie has struggled to care for Peter and with her agreement Peter has been admitted into a residential care home. Peter has his own room at the home. He can summon staff by bell if he needs help. He tends to prefer to spend time in his room rather than with other residents in the communal areas. He can leave his room unaccompanied at any time he wishes. Due to his visual and cognitive impairments, he does not feel safe doing this. He has access to the communal garden, the dining room, the lounge area and any other resident's room. He is able to use the telephone when he wants. It is in a communal area of the home. He is unable to remember a number and dial it himself. He rarely asks to make phone calls. He is visited regularly by Jackie. She has asked to be allowed to stay overnight with Peter in his room but this request has been refused. The home has a key pad entry system, so service users would need to be able to use the key pad to open the doors to get out into the local area. Peter has been taken out by staff after prompting and does not ask to go out. He would not be allowed to go out unaccompanied. Most of the time Peter is content but on occasions he becomes distressed saying that he wishes to leave. Members of staff reassure and distract Peter when this happens.

Key factors pointing to a deprivation of liberty:

- *the extent to which Peter requires assistance with all activities of daily living and the consequent degree of supervision and control this entails.*
- *Peter is not free to leave either permanently or temporarily.*

13 [\[2015\] EWCOP 5.](#)

Care home for older adults: potential deprivation of liberty

6.11 The measures in the following scenario may give rise to a deprivation of liberty:

Mr Ghauri is 88. His wife of 60 years died last year and he has lived alone since then. He has no children. He is generally in good physical health but is in the early stages of dementia. After a fall he decided to move into a local residential care home. At the time he had capacity to make the decision to move. However, his dementia has progressed, and staff consider he may be less able to make more complex decisions. He has his own room. He enjoys the meals at the home in the dining room but otherwise spends most of his time in his room where he listens to music and reads. He has a regular routine whereby he leaves the home for a walk after breakfast. He normally buys a paper and returns before lunch but sometimes eats in a local café and returns in the early afternoon. If he did not return from the café the staff would contact the police to take steps to locate and return him.

Key factors pointing towards a potential deprivation of liberty:

- the potential degree of supervision and control within the home – although more information would be required in order to assess whether this satisfied the acid test;
- Mr Ghauri is not free to leave the home. However, it is not clear from the information available whether he has or lacks the capacity to consent to these care arrangements, which would have to be examined carefully.

Care home for older adults: not a deprivation of liberty

6.12 The following scenario is unlikely to amount to a deprivation of liberty:

Mrs Banotti is a widow and is also an alcoholic. She does not have the capacity to decide where to live. She lives in rented social housing unit for older adults, which has a warden. She was found collapsed on the street a few weeks ago and was admitted to hospital. She was persuaded to go into respite from hospital to give Environmental Health staff from the local District Council time to clean up and renovate her flat. She leaves the respite residential care unit every day after breakfast to see friends. In fact she sees a male friend who also has a drink problem. Staff report to the social worker that they are worried whether her male friend is financially exploiting her and whether she is having a proper lunch or whether she is drinking. She comes back every evening about 7pm when meals are finished for the evening and does not have a smell of drink on her. Mrs Banotti has made clear that once her flat is fixed up, she will return to live there but that she is willing to stay in respite in the interim provided that she is allowed to continue to stay out all day every day. Staff are unhappy about the risks to her of her drinking. However, their policies do not allow for physical restraint so the staff have not attempted to stop her leaving and have not followed her or asked her to return. Mrs Banotti has made clear that if staff try to insist on her staying in all day, or only going out with staff, she will stop the respite and go and stay with her male friend. The staff would not take any steps to prevent her doing so if she did do so.

Key factors pointing away from a deprivation of liberty:

- Mrs Banotti is free to leave, whatever the level of supervision and control to which she may be subjected.

D: A care home with nursing

6.13 The challenges to providing care in the least restrictive way identified in paragraph 6.8 will be present here. The liberty-restricting measures described in paragraph 6.9 above are also likely to be present in a care home with nursing; the following features may also be present:

- Use of medication for mental health problems
- The need for restraint in the event of objections to personal care (which must be recorded in the resident's care plan: see note in 6.9).
- The need for interventions to protect staff: for example, removal of residents' false teeth to prevent biting.

It is difficult to identify scenarios in this setting that would not give rise to a real risk of deprivation of liberty (where the individual in question lacks the material capacity to consent to the restrictions imposed upon them).

Care home with nursing: a deprivation of liberty

6.14 The measures in the following scenarios are likely to amount to a deprivation of liberty:

Mr Lopez is an older man with dementia, who lacks capacity to take decisions relating to his residence and care arrangements. He had previously been estranged from his older son as he had disliked his son's wife. The son is now divorced and has visited Mr Lopez once a week at the care home where he resides for the last month. Due to Mr Lopez co-existing physical and other mental health difficulties, including schizo-affective disorder, he has a fully funded continuing healthcare package. Mr Lopez has been quite paranoid and threatening and abusive to staff, and very demanding and engaged in what they call challenging behaviours. There are not enough staff to take Mr Lopez out every day as he has requested and the care package does not include any one to one care. Mr Lopez used to be a long distance walker and loses his temper and expresses frustration at not being allowed out on his own. As the home is near a main road, the manager has taken the view that concern for his health and safety demand that he should not be allowed out without one to one care.

Key factors pointing to a deprivation of liberty:

- *the extent to which staff are required to monitor, control and supervise Mr Lopez to control his 'challenging behaviour;*
- *his lack of freedom to leave the care home whenever he wishes.*

Mrs Neville is eighty-five. She lives in a care home with nursing and has Alzheimer's dementia which is now advanced. She is very confused and disorientated, and can now only manage very simple conversations. She is physically fit and mobile. She spends much of the day wandering in the corridors of the nursing home. The doors are locked and there is a sensor on the doormat at each entry to the home. On one occasion Mrs Neville found her way out of the back door of the home, which had been left open in warm weather. She was spotted walking towards the main road and immediately escorted back. Mrs Neville frequently shouts and screams and is gently escorted from the communal areas when she is

making a noise, to reduce disturbance to other residents. Mrs Neville is resistant to personal care and can lash out at staff. All her personal care is delivered by two members of staff.

Key factors pointing towards a deprivation of liberty:

- *Mrs Neville is plainly not free to leave.*
- *The nature of her care needs and the interventions required make it clear that she is under continuous supervision and control.*

Care home with nursing: potential deprivation of liberty

6.15 We suggest that the measures in the following scenario may give rise to a deprivation of liberty:

Mr Alexander is in his 70s and has a long history of mental health problems going back to his twenties. He has lived for the last thirty years in a housing association flat where he has a tenancy support worker. He is subject to a guardianship order and the local authority is his guardian. He also has a CPN. Last year he began to disengage from his CPN and tenancy support worker. He started to neglect himself and would not allow the district nurses to visit to dress an ulcer on his leg. Eventually he allowed access to the district nurses who were concerned about his physical health and he was admitted to the general hospital where he spent a few days. Professionals at the hospital considered he needed a period of convalescence and the guardianship order was then varied to require him to reside at a local nursing home. He has been assessed as lacking capacity to decide where to live, but he has expressed willingness to remain in the nursing home for a few weeks until he feels stronger. In the meantime plans are being made to reinstate a home care package. Mr Alexander is not allowed to visit his home during this period as there is concern that he may not return to the nursing home.

Key factors pointing to a potential deprivation of liberty:

- *That Mr Alexander is not free to leave (N.B. this lack of freedom to leave does not derive from the guardianship order per se – see paragraph 6.7.4). Whether he will be deprived of his liberty will depend upon the extent to which he is under a sufficient degree of supervision and control at the care home, which requires more investigation on the facts available, but which would appear likely given the nature of the placement.*

E: Care homes for those with severe and enduring mental health problems

6.16 Residents in care homes with this specialism may have lower needs for personal care but there will be restrictions in place, some of which may be geared towards managing risk to the public. These will need to be factored into the consideration of whether a resident is deprived of his liberty or not. In addition to some of the measures set out at paragraph 6.9 above, specific liberty-restricting measures may include:

- Having to take part in specified programmes (e.g. sex offender treatments) as a condition of a conditional discharge or CTO;

- Being required to comply with medication as a term of a conditional discharge or CTO;
- Having to avoid certain settings (such as playgrounds);
- Being required to live in the care home as a term of a conditional discharge;
- A requirement to be escorted when going out (whatever the risk being guarded against);
- A curfew;
- Having to observe an exclusion zone;
- Restrictions on contact with victims or other persons.

Care home for those with mental health problems: a deprivation of liberty

6.17 The measures in the following scenario are likely to amount to a deprivation of liberty:

Mr Harry Hall is subject to a conditional discharge order made under ss. 37/41 MHA 1983 made 5 years ago for sex offences against female children. He has a delusional disorder and more recently has been diagnosed with vascular dementia. He has lived in a care home since his conditional discharge with conditions which include:

- i to reside at the care home;
- ii to take treatment as prescribed by his RC;
- iii to maintain contact with his social supervisor.

Harry's dementia is getting worse and he is now talking about returning home to London. He has no home in London and last lived there 5 years ago. He has left the care home several times recently heading for the train station but was brought back by staff. The care plan provides for monitoring within the home so that he does not place vulnerable women at risk. He is only allowed community contact accompanied by a worker which includes going to the local pub two nights a week.

Key factors pointing to a deprivation of liberty:

- *the specific monitoring of Harry required within the home*
- *the controls placed upon his ability to leave the home when he wishes.*

Care home for those with mental health problems: potential deprivation of liberty

6.18 We suggest that measures in the following scenario may give rise to a deprivation of liberty:

Milon is twenty-five years old. He has a diagnosis of schizophrenia which is complicated by his use of illicit drugs. He has accumulated a number of criminal convictions, mainly for shoplifting. He has become estranged from his parents and does not have his own accommodation. He has been detained under the MHA 1983 twice in the past. His most recent admission under s.3 MHA 1983 has been the longest lasting and for the first time he was able to remain abstinent from drugs throughout the admission. Staff attribute this to careful and structured use of leave. Milon made good progress and was placed onto a CTO, with a requirement that he live at a care home for those with mental health problems. All went well for the first month but Milon has been showing signs of relapse and staff believe he

has started to use drugs again and have noted that his dosset box suggests that he has not been complying with medication. He appears thought-disordered but is generally co-operative. In an attempt to avoid recall to hospital and with the agreement of Milon's responsible clinician, staff ask Milon to agree to an arrangement where he does not leave the care home unescorted for a few days and where he is supervised when taking medication. If there is no improvement the responsible clinician intends to recall Milon.

Key factors pointing to a potential deprivation of liberty:

- *The provisions made in Milon's care arrangements to secure his return to the care home in the event that he leaves it (NB, that the CTO contains a residence condition does not, itself, mean that he lacks the freedom to leave: see paragraph 6.7.5.)*
- *Any assessment of whether Milon is deprived of his liberty would also have to consider whether he can consent to the arrangements and whether that consent is freely given.*
- *Care home for those with mental health problems: not a deprivation of liberty:*

6.19 The following scenario is unlikely to amount to a deprivation of liberty:

Jim is 60. He has a longstanding diagnosis of schizophrenia. In his 20s he committed two serious assaults against women. He was sentenced to ten years imprisonment. Both offences were pre-planned and had similarities. During the course of serving his sentence he was transferred to hospital and responded to treatment and was returned to prison where he completed his sentence. Since then he has continued to receive anti-psychotic medication by means of a depot. He is in regular contact with his CPN and Consultant who have known him for many years. He shares a flat with his parents who are elderly and rely on him to a significant degree. Last year he appeared to be showing signs of relapse. He was arrested on suspicion of a high-profile offence which had some similarities to the offences he committed in his youth but no charges are brought. At the request of his psychiatrist and CPN, Jim agreed to a voluntary admission to hospital but was detained under the MHA 1983 when he sought to discharge himself. He was then placed on a CTO. The conditions are:

- To reside in a care home for people with mental health problems;
- To attend a day centre 3 times a week;
- Attendance at the depot clinic for medication.

Jim is able to spend time with his family during the day (although it is quite a long journey to reach them) but has to tell staff where he is going before leaving. There is a curfew of 11pm. Jim would like to move back in with his parents and has asked his psychiatrist to vary the conditions of the CTO. The psychiatrist has refused to do so. Jim is unhappy but fearful of the consequences if he moves without the approval of the clinical team.

Key factors pointing away from a deprivation of liberty:

- *Jim is, in fact, free to leave the home because the CTO does not itself prevent him from doing so:
see paragraph 6.7.5.*

F: Care homes for adults with learning disabilities: liberty restricting measures

6.20 These homes may involve a range of restrictive measures, especially those catering for residents who present challenging behaviour. This can include hitting out, destructive behaviour, eating inedible objects ('PICA'), and self-injurious behaviour such as head-banging, hand-biting or scratching. A structure may be an important part of a behaviour support plan for residents and may be an important tool in helping a resident to feel safe but entails taking a degree of control over the resident. Liberty-restricting measures may include:

- A perimeter fence with a locked gate;
- Keypads on doors which residents cannot unlock;
- A structured routine;
- Monitoring and observation;
- Use of medication, including PRN;
- Use of physical interventions of any type in response to challenging behaviours (see note at 6.9);
- Use of sanctions such as "time out";
- Residents being told to spend time in a "quiet room" as part of de-escalation;
- A care plan which provides that a resident must be escorted outside the care home (including where this results from physical needs e.g. a resident who needs someone to push their wheelchair);
- Restrictions on developing sexual relations;
- Mechanical restraints, e.g. lapstraps;
- Decisions about contact with friends and family taken by others.

Care home for adults with learning disabilities: a deprivation of liberty

6.21 The measures in the following scenario are likely to amount to a deprivation of liberty:

John Jones is 18. He was the subject of a care order 6 years ago on the grounds of severe neglect. John has a learning disability, a diagnosis of ADHD, and presents with challenging behaviour. He had been in foster care but that broke down when the foster parents' son returned home from boarding school. John was placed by the local authority in a specialist learning disability residential care home. This home is regulated by the Care Quality Commission to take young people below 18, and they can stay on there after 18. John's medication for ADHD seems to wear off in the evenings and he is harder to manage then, but there are fewer staff on at night. The staff have frequently restrained him due to his behaviour towards staff and residents. Contact with parents is once a week in the communal lounge but there has been no contact with siblings who are in care out of county. John's parents' request to take him back home for afternoon tea has been refused. The social worker has been told that when there are incidents, John is told to go to the quiet room, not his bedroom, and if he tries to leave, he is told to go back into that room. Staff remain outside the door and every 15 minutes check on him.



Key factors pointing to a deprivation of liberty:

- *the extent of the restriction on John's movements within the home and his contact with his parents*
- *the use of restraint within the home*
- *the controls on his ability to leave the home temporarily or permanently.*

Care home for adults with learning disabilities: potential deprivation of liberty

6.22 We suggest that the measures in the following scenario may give rise to a deprivation of liberty:

Max Herner has a learning disability. He is 19. He had been placed in a specialist learning disability care home when he was 16 as his mother could no longer cope with his challenging behaviours. His mother, Greta, is divorced and cares for her younger son Trutz and has remarried. The brothers do not get along. Max has weekend contact from Saturday morning to Sunday afternoon at his mother's home. Max would like to live with his mother full time, although Greta will not admit to Max that she is quite afraid of him when he gets very agitated. Max has low impulse control and needs constant supervision to ensure that he does not assault other male residents and he is diverted when he shows signs of getting agitated. He is on medication to try to calm down his agitation. Max works 5 days a week in a local gardening project. Occasionally when he has had an argument with care staff, he has threatened that when he stays with his mother, he may not return to the placement on Sunday afternoons. When Max is with his mother, she allows him to go out and meet with his male cousins at the local pub.

Key factors pointing to a potential deprivation of liberty:

- *the extent of the supervision and control maintained over Max within the home and the use of medication.*
- *The key question for the assessment of whether this is a deprivation of liberty will be the extent to which Max is free to leave the home: this will require assessment of what exactly the care home staff will do if he carries through his threat not to return to the home.*

Care home for adults with learning disabilities: not a deprivation of liberty

6.23 The following scenario is unlikely to amount to a deprivation of liberty:

Rina is 35 and has a mild learning disability consequent to Down's syndrome. Both her parents are dead and she has no other family. For the last fifteen years she has lived in a small group home with 4 other women of similar age, one of whom she has known since childhood when they attended the same school. Staff are present twenty four hours a day. Rina's capacity to make decisions about where she lives and about her care needs has not been formally assessed since she moved into the care home on the death of her mother, at which time she was considered to lack capacity to make these decisions. Rina has her own room. She goes to college 3 days a week. She is able to travel independently. She has a key worker with whom she plans her week. When she is not at college she may visit friends from

college. She sometimes socialises with her housemates in the evening but sometimes prefers to stay in her room where she enjoys watching television and knitting. Recently there has been some concern about her relationship with Dan, a man she has met at college. He has a learning disability as well and lives with his father who has a known alcohol and drug problem. At Rina's last annual review her care manager assessed Rina's capacity to make decisions about contact with her friend and his father and also her capacity to consent to sexual relations. Rina had capacity to make decisions in all these areas. She told her care manager she never wanted to move away from her friends and she wanted to go on seeing Dan but preferred not to visit him at home as she did not like his father. Rina's care manager did not consider any intervention was needed.

Key factors pointing away from a deprivation of liberty:

- *Rina may now have capacity to decide whether to reside at the care home.*
- *There is nothing in the scenario to suggest that Rina is not free to leave the care home permanently or temporarily.*
- *She is not under continuous supervision and control and is able to exercise her autonomy.*

G: Questions for frontline staff

6.24 These questions may help establish whether an individual is deprived of their liberty in this context:

- Are any of the liberty-restricting measures described above applied to the resident concerned? If so which and for what reason?
- Are there any restrictions on the person's contact with others? If so do they restrict contact beyond the home's usual visiting arrangements?
- Is the person's access to the community restricted in anyway? For example must they be escorted? What would staff do if they left the home alone or sought to do so?
- Is the person required to be at the care home at specified times?
- Must the person be escorted either within or outside the care home?
- Is the person required to say where they are going when leaving the care home?
- Is the person required to take part in a programme of treatment? What happens if they do not?
- Is the person required to take medication? What are the arrangements for this? What happens if they do not take it?
- Is the person required to remain abstinent from alcohol or drugs?
- Are there drugs tests?
- Is any legal framework currently being used e.g. conditional discharge, CTO or guardianship? If so, what are the precise terms?
- Is the person required to observe an exclusion zone? If so how large is it and what implications does it have for (e.g.) visits to family members?



- Is the person required to avoid specific settings?
- Are decisions about contact with friends and family taken by others?
- Is choice extremely limited even in terms of everyday activities?
- Is restraint used to deliver personal care?
- Are the person's wishes often overridden, in their best interests?
- Could any of the liberty-restricting measures be dispensed with?

Appendix: Respite placements

- 6.25 Care homes can provide places of respite which can be invaluable in allowing a carer to take a break from their role. Respite plays a vital role in promoting the sustainability of arrangements where a vulnerable adult is supported at home by a carer. All the liberty-restricting measures which may apply to a permanent resident of a care home may equally apply to a resident who moves to a care home for the purpose of respite for a short period. In addition, the resident may be unfamiliar with the setting, and where the purpose of the respite is to allow a carer to go on holiday, the lack of contact with a family member will be a further liberty-restricting factor.
- 6.26 In Chapter 3 we discuss the question of how long an arrangement must be in place before it is likely to be considered a “non-negligible period of time” and may require authorisation. Paragraphs 3.29-3.32 deal with this important point.
- 6.27 In particular you should note paragraph 3.32, which is repeated here:
- “Because the period will vary from setting to setting, we have deliberately avoided giving a period of time that can be considered ‘safe.’ Our clear view is that it is unlikely under any circumstances to extend beyond a few (2-3) days and is likely to be substantially less in settings in which particularly intense measures of control are imposed. We would **strongly** suggest that it is not safe to use the rule of thumb that some public bodies have adopted that a deprivation of liberty is unlikely to arise where a person is confined for less than 7 days. We understand that this may have been taken from a reading of certain paragraphs of the DOLS Code as to the circumstances under which it is appropriate to grant an urgent authorisation.¹⁴ However, this is to conflate the question of **whether** there is a deprivation of liberty with the quite separate question of **how** such deprivation of liberty may be authorised.”*
- 6.28 Attention is also drawn to the comments of Baker J in [Re AJ](#)¹⁵ when he commented that “professionals need to be on their guard to look out for cases where vulnerable people are admitted to residential care ostensibly for respite when the underlying plan is for a permanent placement without proper consideration as to their Article 5 rights.”
- 6.29 This suggests that exactly the same questions would need to be asked by frontline staff considering whether a respite placement might constitute a deprivation of liberty. In addition staff should consider:

¹⁴ Most obviously paragraphs 6.3 and 6.4.

¹⁵ [\[2015\] EWCOP 5](#).



- The impact of being in an unfamiliar setting on the resident and how his or her care plan provides for a response to unsettled behaviour.
- The impact of reduced contact with a primary carer.
- The underlying intention of the placement: is there any prospect that it will be extended or made permanent?

6.30 To highlight the specific factors relating to respite, we revisit below some of the scenarios described above and change some of the facts to indicate how the considerations may apply in the context of respite. Note that the scenarios below do not consider the question of whether any of the individuals may in fact also be deprived of their liberty while receiving care in their own home. Questions of when such a deprivation of liberty may arise are considered in detail in Chapter 8. However, we would suggest that in reality the care arrangements at home for “Peter” and “Max” in particular would require scrutiny, addressing the factors in Chapter 8.

Peter, the care home resident with dementia described in paragraph 6.10, normally lives with his wife Jackie who provides the majority of his care with some help from her daughter. They are both going on holiday for a week, for a break. During this time Peter will be admitted to a care home for respite. Everyone who knows him considers he is unlikely to remember that this is a temporary arrangement and that he will be quite disorientated. His son who lives 300 miles away has agreed to stay locally while Jackie and her daughter are away. He will visit Peter daily. Peter is still likely to be deprived of his liberty.

Key factors pointing to a deprivation of liberty:

- *Peter will not be free to leave.*
- *Peter’s needs are such that he will be under continuous supervision and control.*

Max, who is described in paragraph 6.22, in fact lives with Greta full-time, with some help from the local authority. Greta wants to go away for a long weekend. She arranges for Max to spend from Thursday evening to Sunday evening in a care home. He has not stayed there before. Greta takes him to visit before her break so that he can meet staff and residents. Max is excited about staying at the placement because he knows that the residents go out for a meal together every Friday evening. However, the care home staff and Greta think it is likely that at some point over the weekend Max will become anxious and agitated. He will need to be supervised closely and may need physical intervention. It would not be safe for him to be at home on his own. Max will be deprived of his liberty over the weekend.



Key factors pointing towards a deprivation of liberty:

- *Max will not be free to leave the home temporarily or permanently*
- *Although the period of time at the care home will be short, Max will be under continuous supervision and control and may require intrusive intervention.*

Rina, who is described at paragraph 6.23, has exactly the same needs but is in fact living with her sister and brother-in-law in their home where she has her own room. They want to go on holiday together for a fortnight. Rina, and her sister and her care manager have arranged that Rina will stay in a care home while they are away. Rina has been there before and is familiar with the staff and residents there. Rina's routine of going to college will be no different as the care home is very close to her home. If she wishes to go home during this period she has keys to the family home and can return there, although she has never chosen to do this. Rina will not be deprived of her liberty.

Key factors pointing away from deprivation of liberty:

- *Rina may have capacity to consent to this arrangement*
- *If Rina lacks such capacity, she will be free to leave the care home temporarily while her family are away.*
- *She is not under continuous supervision and control.*

A: Introduction

- 7.1 This chapter focuses upon the intensity of care regimes provided to those lacking the capacity to consent to care arrangements in supported living services, shared lives schemes (formerly known as adult placements) and extra care housing. The deprivation of liberty safeguards are not available, therefore any deprivation of liberty will require authorisation by the Court of Protection.

B: What is a supported living service?

- 7.2 The generic term, ‘supported living’, describes a form of domiciliary care whereby a local authority arranges a package of care and accommodation to be provided to a disabled, elderly or ill person. The individual lives in their own (often rented) home and typically receives social care and/or support to enable them to be as autonomous and independent as possible. The provision of accommodation is thereby separated from the delivery of care at an organisational level. There is usually some form of tenancy or licence arrangement with a landlord attracting housing benefit, with means-tested tailored support being provided by a distinct care provider with activities of daily living, education, training, employment and social interaction. The care setting is therefore not likely to constitute a “care home” for registration purposes.
- 7.3 Supported living services need only be registered with the Care Quality Commission (“CQC”) if they carry on a regulated activity, that is nursing or personal care. If, for example, the individual is supported with cleaning, cooking and shopping, or is supervised to take prescribed medicine, the service does not require registration. If personal care is being provided but not in the place where they are living, for example at day services, registration of the service is not required. However, where nursing or personal care is provided to those, for example, with more complex needs, such care will be a regulated activity requiring CQC registration. The Care Act 2014 adopts the definition of nursing and personal care presently provided for in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010:

“nursing care” means any services provided by a nurse and involving—

- (a) the provision of care; or*
- (b) the planning, supervision or delegation of the provision of care, other than any services which, having regard to their nature and the circumstances in which they are provided, do not need to be provided by a nurse;*

“personal care” means—

- (a) physical assistance given to a person in connection with—*
 - (i) eating or drinking (including the administration of parenteral nutrition),*
 - (ii) toileting (including in relation to the process of menstruation),*
 - (iii) washing or bathing,*
 - (iv) dressing,*
 - (v) oral care, or*
 - (vi) the care of skin, hair and nails (with the exception of nail care provided by a chiropodist or podiatrist); or*

(b) the prompting, together with supervision, of a person, in relation to the performance of any of the activities listed in paragraph (a), where that person is unable to make a decision for themselves in relation to performing such an activity without such prompting and supervision.”

7.4 Such regulated activities do not apply to the provision of accommodation to someone by a carer under a shared lives scheme (see below), school, or a further education institution.

Supported living: liberty-restricting measures

7.5 The following are measures which may be found in the specific features of this care setting:

- Decision on where to live being taken by others;
- Decision on contact with others not being taken by the individual;
- Doors of the property locked, and/or chained, and/or bolted for security reasons or to prevent residents leaving;
- Access to the community being limited by staff availability;
- A member or members of staff accompanying a resident to access the community to support and meet their care needs;
- Mechanical restraint, such as wheelchairs with a lapstrap or harness (e.g. Crelling), reinforced glass in mobility vehicles, protective helmets;
- Varying levels of staffing and frequency of observation by staff;
- Restricted access to finances, with money being controlled by staff or welfare benefits appointee;
- Restricted access to personal items to prevent harm;
- Restricted access to parts of the property, such as the kitchen or certain cupboards therein, to minimise health and safety risks;
- Chemical restraint, such as medication with a sedative or tranquilising effect;
- Physical restraint/intervention, such as with personal care tasks, breakaway or block techniques, distraction methods, staff withdrawing, physical touches or holds;
- Restricted access to modes of social communication, such as internet, landline or mobile telephone, correspondence;
- Positive behavioural reward systems, to reward “good” behaviour;
- Restricted access to family, depending on level of risk and availability of staff and resources;
- Lack of flexibility, in terms of having activities timetabled, set meal times, expected sleep times.

Supported living: a deprivation of liberty

- 7.6 The measures in the following scenario are likely to amount to a deprivation of liberty:

Gordon is 30 years old and has autism, cerebral palsy, hearing and visual impairments and a learning disability. He resides in a one-bedroom flat with 1:1 staffing at all times. He requires a second member of staff to access the community who is available 35 hours per week. The front door is locked for his safety. He cannot weight bear and pulls himself around inside, and requires a wheelchair outside. Due to a history of attempting to grab members of the public, a harness is used to strap his torso to the wheelchair, allowing free movement of his arms.

Key factors pointing to a deprivation of liberty:

- *Gordon is under continuous supervision and control on a 1:1 basis at all times*

Supported living: potential deprivation of liberty

- 7.7 We suggest that the measures in the following scenario may give rise to a deprivation of liberty:

Max is 24 years old, has a mild learning disability and lives with two other residents who receive 24-hour shared staff support. Owing to his agitation and anxiety, Max is prescribed medication with a calming effect. He is employed from 9am to 4pm, five days per week in the local garden centre which he is able to get to and from independently. He has a tenancy for his bedroom and can call upon staff members for assistance in the morning and evening if he requires it. If he wishes to see his family at weekends, a member of staff will take him and be there throughout the contact session owing to previous incidents of aggression from his brother.

Key factors pointing to a potential deprivation of liberty:

- *the extent of the supervision and control inherent in the support provided to Max at the placement. A careful assessment will be required of whether he is free to leave in circumstances where he can come and go to the garden centre;*
- *focus will also be required upon the steps that would be taken if he did not return.*

Supported living: not a deprivation of liberty

- 7.8 The following scenario is unlikely to amount to a deprivation of liberty:

John, aged 42, was badly assaulted during a night out and sustained an acquired brain injury. The frontal lobe damage makes processing information difficult and he has some left sided weakness and mobility issues. He lives in a flat and, twice a day, receives two-hour visits from support workers. He can dress and wash himself. But they prompt him with medication, take him shopping, and support him to pay his bills. He chooses how to spend the remainder of the day. Often he attends day services without the need for support. Sometimes he meets with friends in the local pub.

Key factors pointing away from deprivation of liberty:

- *the limited nature of the control and supervision to which John is subject*
- *the limited nature of the restrictions placed upon John's ability to come and go from his flat as he pleases.*

C: What are Shared Lives schemes?

- 7.9 These schemes, formerly known as adult placements, differ from supported living arrangements as they involve the individual being placed in a family setting. They are likened to adult fostering arrangements and are available to those aged 16 and over. Usually a local authority arranges for the person to receive day support, short breaks or respite, or long term care in the family home of a Shared Lives carer so as to enable them to share the family life, social life and community activities. The schemes are designed for those wanting to live independently but not on their own.
- 7.10 The majority of those receiving such care have learning disabilities, although the scheme extends to those with physical disabilities, mental health issues or drug or alcohol problems. Shared Lives carers are self-employed, with rates of payment set by the local authority or the scheme itself according to the location and the person's level of need. Carers receive payments to cover some of their time, rent and a contribution towards the household running costs.
- 7.11 In 2012-13 in England there were 121 schemes with 6720 carers supporting over 9660 people, around half of which on a long term basis. In Wales that year there were 1420 people in Shared Lives arrangements.
- 7.12 Although accommodation is provided often together with personal care, it is not required to be registered as a "care home". But Shared Lives schemes are regulated under the Health and Social Care Act 2008. The schemes approve and train the carer, receive referrals (typically from the local authority), match the needs of the person with the carer, and monitor the arrangements. A maximum of three people (two in Wales) can be supported by the carer at any one time and carers do not employ staff.

Shared Lives schemes: liberty-restricting measures

- 7.13 The following are measures which may be found in the specific features of this care setting:
- Varying levels of supervision and guidance with activities of daily living;
 - Encouraging participation in family and community activities;
 - Preventing the person from leaving unaccompanied for their immediate safety;
 - Ensuring behavioural boundaries;
 - Conveying the person to health and other appointments;
 - Addressing challenging behaviour;
 - Assist with medication, including sedative effect.

Shared Lives schemes: a deprivation of liberty

7.14 The measures in the following scenario are likely to amount to a deprivation of liberty:

Nora is 18 years old with moderate to severe learning disability. She lives in a stable and secure foster placement in which she is dependent on others as she cannot not live independently. She cannot go out on her own and shows no wish to do so. She can communicate her wants and wishes in a limited manner. She lives in an ordinary domestic environment which she regards as home. She is not restrained or not locked in the house. If she tries to leave she would be prevented for her immediate safety. Continuous supervision and control is exercised over her to meet her care needs. Her limitations on movement are generally dictated by her inability and lack of awareness of danger. There are no restrictions on social contacts except by court declaration. She goes to college where she is not under the control of her carer or the local authority. Her mother accepts that Nora should remain where she is and has no objections to the care provided. Nor does she regard Nora as being confined or retained. Nora's sister supports the shared lives placement.

Key factors pointing to a deprivation of liberty:

- *the continuous and complete nature of the control and supervision exercised over her (for beneficent reasons)*
- *the steps that would be taken to prevent her leaving.¹*

Shared Lives schemes: potential deprivation of liberty

7.15 We suggest that the measures in the following scenario may give rise to a deprivation of liberty:

Matthew is 33 years old and has autism, a moderate learning disability, and little communication skills. He has lived with Mr and Mrs Morgan for four years with their daughter. He requires frequent daily support and someone with or near him all day. For example, he cannot judge water temperature so his carers run him a bath or shower. He cannot dress according to weather conditions so his carers choose his clothing and dress him. He cannot attend to personal care so his carers clean him and brush his teeth and hair. He is able to walk independently but gets anxious with loud noises so one of the family will accompany him outside, when he wears head phones to muffle the noise. The family do the weekly shop and he will only eat a limited range of food. He is able to make a simple sandwich with verbal prompts.

Key factors pointing to a deprivation of liberty:

- *Matthew requires a significant and continuous degree of support throughout the day, and the limitations upon his freedom to leave.*
- *A careful assessment would be required as to the extent to which he is under continuous/complete supervision and control, and what would happen were he to try to leave without a family member accompanying him.*

¹ Based upon the case of MIG in the Supreme Court.

Shared Lives schemes: no deprivation of liberty

7.16 The following scenario is unlikely to amount to a deprivation of liberty:

Jane is 38 years old and resides with Mr and Mrs Baker in their 4 bedroomed home. One day per week she mucks out the local farm with a job coach. She has no health concerns and she sleeps well. It is not safe for Jane to go out alone as she has no sense of road danger so every Sunday she goes to church and every Tuesday goes shopping with Mrs Baker. The family go out together on regular excursions and holiday twice a year.

Key factors pointing to a deprivation of liberty:

- *there is no evidence that Jane is under any form of continuous/complete supervision and control.*

D: What is extra care housing?

7.17 Extra care housing represents a hybrid between living at home and living in residential care. Usually purpose built, self-contained properties on a single site, schemes provide access to 24-hour domiciliary care and support and community resources. Their models differ from assistive technology in someone's own home to retirement and care villages to, for example, specialist dedicated schemes for those with dementia. Unlike residential care, those in extra care housing usually rent, purchase, or share ownership of typically a one or two-bedroomed apartment or bungalow in the housing scheme or care village and do not receive one-to-one care. Unlike living in one's own home, those in extra care housing will have 24-hour access to personal care with progressive degrees of privacy, dependent upon their level of need.

7.18 Some individuals will have a domiciliary carer. A warden is also usually on site to check on the welfare of residents. For the larger schemes, there are also on-site facilities and social care services usually available for those requiring daily support. These can include on-site care teams, rehabilitation services, day centre activities, restaurants, laundrettes, hairdressing and beauty suites, and possibly shops, cinemas, gyms, even the garden shed.

7.19 Moving into extra care housing may be a lifestyle choice. Or it may be necessary due to an individual's level of social and/or health care need. The decision to move in may or may not be made at a time when the individual had mental capacity, or their mental functioning may deteriorate subsequently, with it no longer being safe for them to go out unaccompanied. It is therefore a common occurrence for those in extra care housing to not be free to access the community but the intensity of care measures varies enormously.

Extra care housing: liberty-restricting measures

7.20 The following are measures which may be found in the specific features of this care setting:

- Location devices;
- Door sensors to raise to alert staff to the person's exit from their property;
- Movement sensors to raise alert staff to the person's movements within their property;
- Verbal or physical distraction techniques used, for example, to dissuade the person from going out unaccompanied;

- Fobs to go in and out of the scheme which the person may not know how to use;
- Doors within the property with handles at the top to prevent the individual leaving;
- Prior consent of the resident may enable staff to access their property;
- Physical intervention/restraint, such as with personal care tasks;
- Access to the community restricted due to staff levels, with residents able to go out in groups only with staff with little or no choice regarding where and when to do so;
- CCTV in entrance areas to schemes; or
- Aspects of the property restricted due to safety concerns, such as disabling a cooker.

Extra care housing: deprivation of liberty

7.21 The measures in the following scenario are likely to amount to a deprivation of liberty:

Cyril is 70 years old with Alzheimer's dementia and severe mobility difficulties. He was assessed by a social worker as lacking capacity to decide where to live in order to receive care. In consultation with Cyril and family members, it was considered to be in his best interests to move out of his home into a housing with care setting. He now resides in a one-bed apartment as part of a specialist dementia scheme of extra care housing which was purchased by his financial deputy. From 9am to 8pm he has a carer with him to assist him into and out of bed as well as to attend to his everyday needs. During the night he has pressure sensors around the bed to alert staff to a fall. Occasionally he is aggressive to staff which requires them to withdraw. Staff have unrestricted access to the apartment by means of a safe key. Cyril is able to leave the property but only with the carer.

Key factors pointing to a deprivation of liberty:

- the extent of the supervision and control exercised over Cyril whilst he is awake (and at night).
- Cyril is not free to leave save with a carer.

Extra care housing: potential deprivation of liberty

7.22 We suggest that the measures in the following scenario may give rise to a deprivation of liberty:

Charles is 80 years old with early onset dementia. He has been residing in a rented one-bedroomed bungalow in a care village for three years and is believed to have now lost the mental capacity to make decisions as to residence and care. Four hours per day he is helped by a member of staff with personal care, cooking and cleaning tasks. He has door sensors to alert staff to when he leaves the property and is required to wear an alarm device at all times for his safety. He is not allowed to leave the complex without a staff member.

Key factors pointing to potential deprivation of liberty:

- *Charles is not free to leave unaccompanied.*
- *careful examination will be required as to extent to which the remote monitoring, together with the direct support of staff four hours a day, cumulatively amounts to sufficiently continuous/complete supervision and control to satisfy the acid test.*

Extra care housing: not a deprivation of liberty

7.23 We suggest that the following scenario is unlikely to amount to a deprivation of liberty:

Mabel is 75 years old and decided with capacity to sell her home and to purchase an apartment in a local housing with care scheme as she was becoming forgetful and worried about her own safety. There are 35 apartments on the site which is accessed with a key fob or code. A warden is available 24-hours a day. She is advised not to go out without a friend, family member or staff member. If she wished to go out alone, she must ensure that a member of staff knows so that if she does not return they can follow the missing persons protocol. Mabel is otherwise left to her own devices without interference from the housing scheme.

Key factors pointing to potential deprivation of liberty:

- *Mabel is not under continuous or complete supervision or control*

E: Questions for front-line practitioners

7.24 These questions may help establish whether an individual is deprived of their liberty in this context:

- To what extent is the person's ability to access the community by themselves limited by others and in what circumstances?
- Within their place of residence, to what extent is the person (a) actively supervised, (b) liable to be supervised, (c) not even liable to be supervised by others when risks may arise?
- Is physical intervention used? If so, how often? What type? For how long? And what effect does it have on the person?
- Do others control their finances?
- How would the care regime respond to the corresponding risks if the person attempted to leave either to access the community or to simply not return?
- Are there regular private times, where the person has no direct carer supervision?
- Is their contact with the outside world restricted? If so, how often? How? For how long? And what effect does this have on the person?
- To what extent is the person able to decline assistance when it is available?

A: Introduction

- 8.1 This chapter considers how to identify deprivation of liberty in an individual's home. For the purposes of this chapter, we use 'home' to mean an individual's own home. This could be a home that they own or rent themselves, or a home owned or rented by a family member or members with whom they live. 'Home-like' arrangements made by the State to place individuals requiring accommodation because of their particular needs, which are usually referred to as "supported living", are addressed in Chapter 6.¹ The position of children is considered in Chapter 9.
- 8.2 This chapter comes with two "health warnings," one relating to the question of state responsibility, and the second stemming from the decision in *Rochdale MBC v KW*.² Both of these matters are discussed below.

B: Health Warning 1: State responsibility

- 8.3 The first health warning is highlighted in Chapter 2 at paragraphs 2.50-2.55. It is not easy to identify a precise point at which the State ceases to be directly responsible for care or health packages delivered in the home environment and, instead, is required to take the (rather vaguer) steps which are required by Article 5 ECHR to provide effective protection to the individual concerned.
- 8.4 Until there is clarification from the courts, we suggest that there is likely to be sufficient State involvement to make the situation a 'State' deprivation of liberty falling within the scope of Article 5(1) ECHR – and therefore requiring steps to be taken by the relevant State body involved to seek authorisation from the Court of Protection – if:
- 8.4.1 Arrangements are made, whether by a local authority or NHS body, to commission and provide care in the individual's own home;
 - 8.4.2 Direct payments (including personal health budgets) are made (whether for social or health care) to a family member or professional carers to arrange and provide care to the individual in the individual's own home;
 - 8.4.3 The decision that the individual should remain in their own home and be cared for there has been taken on their behalf by the Court of Protection. In such a situation, one would expect that questions of deprivation of liberty would be considered by the judge making the decision, but the order may have been made before the Cheshire West judgment or arrangements may have changed since the order.
- 8.5 Where the decision that the individual should remain in their own home and be cared for there has been taken on their behalf by a best interests decision-making process involving the relevant local authority or NHS body, we suggest that the State will then be 'on notice' of any deprivation of liberty that may arise in consequence of that decision. The relevant local authority or NHS body may therefore have an obligation under the positive limb of Article 5 ECHR (discussed at paragraphs 2.50 - 2.55) to take steps to ensure that there is authority for that deprivation of liberty.

¹ We recognise that many of those in supported living are likely to consider the place that they are living to be their home. However, we draw the distinction here in particular so as to focus on situations where an individual is not placed by the State so as to meet their care needs, but arrangements are made for them in the place that they were living prior to those needs arising (or being identified).

² [2014] EWCOP 45.

- 8.6 We also note that a situation may arise where a health and welfare deputy or a financial deputy is making private arrangements for the care of an individual in their own home (e.g. through administering a damages award received following a personal injury claim) and considers that those arrangements amount to an objective deprivation of the individual's liberty to which they cannot consent. We suggest that the deputy should seek their own legal advice as to the steps that they should take. There are arguments to suggest that, as a minimum, a deputy in such a case should notify the relevant local authority for the area in which the individual lives. The deputy may invite the local authority to consider whether any steps need to be taken under the positive limb of Article 5(1) ECHR and in the meantime to consider whether the restrictions on the individual's liberty which may amount to a deprivation of liberty can be reasonably reduced.

C: Health Warning 2: Can a person be deprived of liberty at home at all?

- 8.7 In a case decided in November 2014, *Rochdale MBC v KW*,³ Mostyn J cast doubt as to whether it is possible for a person to be deprived of their liberty at home at all, at least where their own physical disabilities were such that they were house-bound. The case concerned a woman cared for in her own home⁴ with a substantial package of care arranged jointly by the relevant local authority and CCG. Contrary to the agreed position of both the local authority and KW (acting by her litigation friend) – Mostyn J held that the woman was not deprived of her liberty. In doing so, he made a number of observations about the approach adopted by the Supreme Court in *Cheshire West*, and the proper construction of the acid test.⁵ On the facts of the case, Mostyn J then accepted (it appears) that every element required to bring KW's situation within the scope of Article 5 was satisfied⁶ except for the requirement that she was constrained from exercising freedom to leave.⁷
- 8.8 KW's appeal was allowed by consent in February 2015. In endorsing the consent order allowing the appeal, the Court of Appeal did not give a judgment explaining its reasons.⁸ However, it seems to us clear that:
- 8.8.1 The conclusions that Mostyn J reached both upon the facts of KW's case and upon the broader position of those cared for in their own homes are clearly incompatible with the decision of the majority in *Cheshire West*. We consider that Mostyn J's approach conflates freedom to leave with ability to leave. This gives rise to a different concept of physical liberty for those who are unable to take advantage of it – contrary to the clear holding of Lady Hale (with whom the other members of the majority agreed) that “*the concept of physical liberty protected by article 5 is the same for everyone, regardless of whether or not they are mentally or physically disabled,*”⁹ and also Lord Kerr's

3 [2014] EWCOP 45.

4 Rented from a Housing Association.

5 Some of which are discussed at paragraphs 3.4-3.22, in particular those relating to the question of when a person may be considered to be free to leave.

6 I.e. that she was under continuous/complete supervision and control (she required the presence of carers 24/7 (paragraph 6), that she lacked the capacity to consent to any deprivation of liberty (paragraph 4), and that any deprivation of liberty would be imputable to the State (paragraph 7).

7 At paragraph 25, he held that KW was “*not in any realistic way being constrained from exercising the freedom to leave, in the required sense, for the essential reason that she does not have the physical or mental ability to exercise that freedom.*”

8 A matter addressed by Mostyn J at [2015] EWCOP 13.

9 Paragraphs 33 and 36. We also note that the logic of Mostyn J's conclusion would extend to any other setting in which the person could have been placed by their family and which the individual regards as a home. This would mean, therefore, that many in care homes would not – on Mostyn J's analysis – be considered to be deprived of their liberty if they were unable to leave the home because of their physical or mental disabilities: this would drive a coach and horses through Schedule A1 to the MCA 2005 and further indicates, we suggest, that the approach adopted by Mostyn J was incorrect.



observation that “[liberty] does not depend on one’s disposition to exploit one’s freedom;”¹⁰ such that

- 8.8.2 Mostyn J’s judgment did not provide a sound basis upon which to conclude that individuals with severe disabilities cared for at home with a package of care arranged by public authorities cannot be deprived of their liberty.
- 8.9 Bearing in mind Lady Hale’s warning in *Cheshire West* that we should in the case of the vulnerable err on the side of caution as regards deciding what constitutes a deprivation of liberty,¹¹ we consider that it is possible for an individual to be deprived of their liberty in their own home in the context of the delivery of care and treatment and for such deprivation of liberty to be imputable to the state.
- 8.10 We should note that, as this guidance was being finalised, we were notified of a decision in which a judge of the High Court (Mr Justice Bodey) held that a woman cared for in her own home, predominantly by her own family, was not deprived of their liberty. The transcript of the judgment was not available at the time of finalising the guidance but we understand that Bodey J placed significant weight both upon the limited nature of the involvement of the local authority and that the woman continued to reside in her own home, in which she had lived for many years before losing capacity. Those who are concerned with deprivations of liberty in the home environment should make sure that they keep abreast of developments, including the full report of this judgment, by making use of the resources identified in Chapter 11.

D: The home environment: liberty restricting measures

- 8.11 Almost by definition, arrangements made at home will be more varied and more flexible than arrangements made in any institutional or quasi-institutional setting. It is also more likely that, because the arrangements are likely to be more tailored to the individual, they will less obviously be directed to the control of that individual in the interests of others within a placement (whether other service users or the staff).
- 8.12 However, it is important to remember that MIG was found to be deprived of her liberty in an adult foster placement – i.e. a home-like environment – in circumstances where the supervision and control to which she was subject was “*intensive support in most aspects of daily living*,”¹² even though she attended a further education college daily during term time and was taken on trips and holidays by her foster mother.
- 8.13 We therefore suggest that the following features may constitute liberty-restricting measures in the home environment:
- The prescription and administration of medication to control the individual’s behaviour, including on a PRN basis;
 - The provision of physical support with the majority of aspects of daily living, especially where that support is provided according to a timetable set not by the individual but by others;

10 Paragraph 76.

11 Paragraph 57.

12 *Cheshire West* at paragraph 13.

- The use of real-time monitoring within the home environment (for instance by use of CCTV or other assistive technology);¹³
- The regular use of restraint by family members or professional carers which should always be recorded in the individual's care plan;
- The door being locked, and where the individual does not have the key (or the number to a key pad) and is unable to come and go as they please, strongly suggests that they are not free to leave;
- The individual regularly being locked in their room (or in an area of the house) or otherwise prevented from moving freely about the house;¹⁴
- Use of medication to sedate or manage behaviour, including PRN.

E: Care arrangements in the home that are imputable to the State

8.14 The scenarios below all describe arrangements made to provide care to a person lacking capacity to consent to them in their own home. In all the cases the State has been involved in some way in making the arrangements and so in the question of whether these are “imputable” to the state does not arise. This issue is likely to be considered by the courts however, and therefore it will be important to keep up to date on this issue, using the resources which we set out in Chapter 11.

Care arrangements in the home: a deprivation of liberty

8.15 The measures in the following scenario are likely to amount to a deprivation of liberty:

Veronica is a widow of 75. She has a history of mental illness going back to her thirties. Her current diagnosis is of schizoaffective disorder. She has had a number of admissions to hospital under the MHA 1983. She has not been in hospital for some years but sees her psychiatrist fairly regularly and attends regular s.117 MHA 1983 after-care reviews. More recently Veronica has been showing signs of short term memory loss. Veronica lives alone in the home that she shared with her husband. She is very independent but recently her daughter Susan has become concerned that Veronica is leaving pans on the stove unattended, is becoming erratic in compliance with her medication and has visibly lost weight. Veronica's psychiatrist is also concerned and Veronica agrees to an informal admission to hospital to allow her psychiatrist to assess her. During her stay Veronica has an Activities of Daily Living assessment and is noted to be unsafe in the kitchen. An MRI scan suggests some damage. Veronica's psychiatrist assesses her capacity and reaches the conclusion that Veronica lacks capacity to make decisions about her care needs, mainly because she is unable to recognise that her ability to look after herself is impaired. The clinical team consider that Veronica needs 24 hour care. The question is where it should be provided.

13 Information for family members or carers considering use of surveillance has recently been provided by the [Care Quality Commission \(CQC\)](http://www.cqc.org.uk/content/using-hidden-cameras-monitor-care): see <http://www.cqc.org.uk/content/using-hidden-cameras-monitor-care>.

14 Munby LJ in *Re A and Re C* [2010] EWHC 978 (Fam) held that those two individuals (one a child, and one an adult) who were locked in their rooms overnight were not deprived of their liberty. Munby LJ expressly based much of his reasoning upon the judgment of Parker J in the first instance judgment in MIG and MEG; we therefore respectfully suggest that this aspect of his judgment is incorrect in light of the decision of the Supreme Court in *Cheshire West*.



A s.117 MHA 1983 meeting takes place. Veronica attends the meeting and pleads not to go to a care home. The CCG and local authority agree to fund 24 hour care in Veronica's home for a trial period. A care provider is sourced and Veronica goes home.

Veronica's care plan is that she will have one carer at home all the time. A spare room is made available for the carer, as it is not considered that waking nights are required. The carer agency will have access to a key safe and will be able to enter Veronica's home even if she does not want them to come in. Veronica will be supervised in the kitchen. She will be supported by the carer in arranging to go out when she wants to, which will include family visits, shopping and visits to galleries and museums which she likes, but the carer will dissuade her from leaving unaccompanied (and has a protocol to follow in the event that Veronica manages to leave whilst the carer is otherwise occupied). The psychiatrist specifies that Veronica must attend a day centre where she is well-known at least once a week to facilitate ongoing monitoring of her mental state.

Key factors pointing to a deprivation:

- *the continuous presence of the carer in the home*
- *the supervision of activities whilst in the home*
- *that Veronica is not able to come and go unaccompanied.*

Care arrangements in the home: potential deprivation of liberty

8.16 We suggest that the measures in the following scenario may give rise to a deprivation of liberty:

Gordon is 80 years old with early onset dementia. He lives in his own home, and is believed to have now lost the mental capacity to make decisions as to residence and care. His care package provides for carers to attend four hours a day with personal care, cooking and cleaning tasks. He has door sensors to alert his family when he leaves the property (both and day and at night) and is required to wear an alarm device at all times for his safety. Carers check after each visit that he is wearing the pendant and put it on if he has taken it off. Once he left the home at midnight and his daughter who lives nearby was alerted by the sensor. She immediately went to look for her father and guided him back home.

Key factors pointing to potential deprivation of liberty:

- *the restrictions upon his freedom to leave his own home*
- *careful examination will be required as to extent to which the remote monitoring, together with the direct support of local authority arranged carers four hours a day, cumulatively amounts to sufficiently continuous/complete supervision and control to satisfy the acid test. The fact that, for example, carers gently enforce the requirement to wear the pendant is we suggest a relevant factor.*

Care arrangements in the home: not a deprivation of liberty

8.17 The measures in the following scenario are unlikely to amount to a deprivation of liberty:

Susan and Jim are married. Both have significant histories of alcohol abuse and they met when they were both receiving treatment at a hostel. Although they have been together for a long time the relationship between them can be volatile. They have been homeless in the past but now have a joint tenancy of a housing association flat. Two years ago Susan walked in front of a car and was knocked over. She suffered a brain injury. She has made a reasonable recovery but has impaired cognitive abilities and clinical professionals consider that further improvement is unlikely. Susan's neuro-psychiatrist assesses her capacity. She is able to make decisions about whom she should see but not about her residence and care arrangements.

Jim and Susan were very keen for her to return home. Susan will need some support; for example it would not be safe for her to prepare a meal unsupervised. She is able to go out alone for short periods of time in the local area but she gets anxious about being alone and encourages Jim to accompany her as much as possible. Jim is willing to take on the majority of Susan's care. Staff feel that he will need some respite, and his own lifestyle can sometimes be chaotic. Susan's care plan provides for carers to visit for two hours daily, to supervise and support her in cooking and to ensure she maintains reasonable nutrition. The rest of the time, there is no involvement by local authority funded carers.

Factors pointing away from a deprivation of liberty:

- *the limited nature of the supervision and control exercised by the local authority arranged care as compared to the informal care delivered by Jim.*

F: Considerations for front-line practitioners

8.18 These questions may help establish whether an individual is deprived of their liberty in this context:

- Is the person prescribed or administered medication to control their behaviour, including on a PRN basis;
- What level of support is provided with aspects of daily living? And is that support provided to a timetable set by the individual or by others?
- Is technology used to monitor the individual's location within the home or to monitor when they leave?
- Does the individual's care plan provide for the regular use of restraint? If so, under what circumstances and for how long?
- Is the door to the individual's home locked? If so, do they have the key (or the code to a key pad)?
- Are they free to come and go from their own home unaccompanied as they please?
- Are they regularly locked in their room (or an area of their home) or otherwise prevented from moving freely about their home?
- Are restrictions placed upon them by professionals as to who they can and cannot see?

A: Introduction

- 9.1 In this chapter, the term “child” is used to refer to someone under the age of 16. A “young person” refers to a 16 or 17 year old. “Adult” refers to a person aged 18 or over. We do not venture into the circumstances in which those under 16 might be deprived of liberty: the focus on this chapter is exclusively on young persons. This is **not** because Article 5 ECHR is irrelevant to children; far from it. Indeed, as at the time this guidance is produced (March 2015), we understand there will be case law forthcoming that specifically addresses the impact of the Supreme Court’s decision for those **under 16**.¹ Rather, it is because the jurisdiction of the Court of Protection to authorise deprivation of liberty is available only from the age of 16. For the same reason, this chapter only addresses the relevance of Article 5 ECHR to young persons who **lack** capacity to decide where to reside in order to receive care and treatment.
- 9.2 Care and support is provided to young persons in a very broad range of living arrangements. These include (but are not limited to) the family home, foster homes, adoptive homes, children’s homes (secure, non-secure, and certain special schools), care homes, residential special schools, boarding schools, further education colleges with residential accommodation, and hospitals. Many of these care settings are considered in separate chapters to which reference should be made. Thus, where there is an issue regarding deprivation of liberty occurring in the family home, private fostering² home, or adoptive home, reference should be made to Chapter 8. This is because parental responsibility rests solely with the parent(s) rather than the State and so is analogous to the family home. For respite in care homes, please see the appendix to Chapter 6; for hospitals, Chapters 4-5; and supported living (available from the age of 16) is considered in Chapter 7.
- 9.3 When considering those other chapters please bear in mind the following important provisos. First, the acid test for “deprivation of liberty” appears to be more nuanced for those under 18 (as explained below). So what may constitute a deprivation of liberty of an adult may not necessarily be so for a young person. The relevant extracts of the Supreme Court’s judgment that are unique to those under 18 are set out below to complement Chapter 2. Second, where a young person’s inability to consent to their care arrangements results from immaturity, rather than impaired mental functioning, the MCA 2005 is not applicable. So recourse may be needed to alternatives, such as parental responsibility, the family courts or the inherent jurisdiction of the High Court.³ Finally, a whole raft of legislation, statutory guidance and minimum standards apply to those under 18 and may bear upon the young person’s deprivation of liberty.
- 9.4 This chapter is necessarily modest given the dearth of analogous case law and focuses on those care settings relating to 16 and 17 year olds which are most likely to raise potential deprivation of liberty issues. They are foster homes (in the absence of a residence order), children’s homes, and residential educational establishments.⁴ Neither DOLS nor the MHA

1 See Chapter 11 for details of how to stay abreast of developments.

2 Private fostering is governed by Part 9 of, and Schedule 8 to, the Children Act 1989, and the associated Children (Private Arrangements for Fostering) Regulations 2005. See also the ‘Replacement Children Act 1989 guidance on Private Fostering: Every Child Matters’ (2005). Whilst a private foster carer becomes responsible for providing the day-to-day care, the overarching responsibility for safeguarding and promoting the child (under 16, or 18 if disabled) remains with those with parental responsibility. Although they do not formally approve or register private foster carers, local authorities are duty bound to satisfy themselves that the welfare of privately fostered children within their area is satisfactorily safeguarded and promoted.

3 For guidance on the relevant provisions of the Children Act 1989, see generally Department of Education, ‘Court orders and pre-proceedings: For local authorities’ (2014).

4 Other forms of deprivation of liberty, for example under s.23 Children and Young Persons Act 1969 and secure accommodation orders under s.25 Children Act 1989, fall outside the scope of this chapter.



1983 are available to authorise deprivations of liberty here, so judicial authorisation will be required. The Court of Protection can authorise the deprivation of liberty of young persons lacking the relevant mental capacity: [Barnsley MBC v GS & Ors](#).⁵ The inherent jurisdiction of the High Court is also available, regardless of the person's age.⁶ The chapter is therefore divided into the following areas:

- Parental responsibility and the nuanced acid test
- Universal constraints
- Liberty-restricting measures
- Foster homes
- Children's homes (non-secure)
- Educational establishments (residential special schools, further education colleges)
- Considerations for front-line practitioners

B: Parental responsibility and the nuanced acid test

9.5 In [RK v BCC, YB and AK](#)⁷ it was decided that “[d]etention engages the Article 5 rights of the child and a parent may not lawfully detain or authorise the detention of a child.” Although cited to the Supreme Court in the *Cheshire West* case, this decision was not referred to in any of the judgments. However, in our opinion, the principle remains good law. It follows that if a young person is deprived of their liberty, the consent of those with parental responsibility cannot be relied upon to authorise it: the decision falls outside the scope of parental responsibility. Logically this would apply as equally to local authorities sharing parental responsibility under a care order as it does to parents.

9.6 One of the individuals before the Supreme Court was 17 years of age and some of the judges considered the application of Article 5 to children and young persons. Our impression is that the test for deprivation of liberty is more nuanced when it comes to this age group because children and young persons are compared with those of the same age and maturity. This tends to reflect aspects of the European jurisprudence as identified in *Nielsen v Denmark*:⁸

*“61. It should be observed at the outset that family life in the Contracting States encompasses a broad range of parental rights and responsibilities in regard to care and custody of minor children. The care and upbringing of children normally and necessarily require that the parents or an only parent decide where the child must reside and also impose, or authorise others to impose, various **restrictions** on the child's liberty. Thus the children in a school or other educational or recreational institution must abide by certain rules which limit their freedom of movement and their liberty in other respects. Likewise a child may have to be hospitalised for medical treatment. Family life in this sense, and especially the rights of parents to exercise parental authority over their children, having due regard to their corresponding parental responsibilities, is recognised*

5 [\[2014\] EW COP 46](#), paragraphs 23-24. See also regulation 20(3) of the Children's Homes (England) Regulations 2015 which confirms that the Regulations “do not prevent a child from being deprived of liberty where that deprivation is authorised in accordance with a court order”.

6 With regard to those under 18, see also *Re C (Detention: Medical Treatment)* [1997] 2 FLR 180.

7 [\[2011\] EWCA Civ 1305](#) at paragraph 14.

8 See also [M and RT and F v Austria](#) (Application no. 14013/88) and [Canepa v Italy](#) (Application no. 43572/98).



and protected by the Convention, in particular by Article 8. Indeed the exercise of parental rights constitutes a fundamental element of family life.” (emphasis added)

9.7 With regard to the situation of MIG and MEG, Lady Hale held at paragraph 54:

“If the acid test is whether a person is under the complete supervision and control of those caring for her and is not free to leave the place where she lives, then the truth is that both MIG and MEG are being deprived of their liberty. Furthermore, that deprivation is the responsibility of the state. Similar constraints would not necessarily amount to a deprivation of liberty for the purpose of article 5 if imposed by parents in the exercise of their ordinary parental responsibilities and outside the legal framework governing state intervention in the lives of children or people who lack the capacity to make their own decisions.”

9.8 The other critical paragraphs applicable to those aged under 18 are:

“72 In the case of children living at home, what might otherwise be a deprivation of liberty would normally not give rise to an infringement of article 5 because it will have been imposed not by the state, but by virtue of what the Strasbourg court has called “the rights of the holder of parental authority”, which are extensive albeit that they “cannot be unlimited” (see Nielsen v Denmark (1988) 11 EHRR 175, para 72, a decision which, at least on its facts, is controversial, as evidenced by the strength of the dissenting opinions). However, it is fair to say that, while this point would apply to adoptive parents, I doubt that it would include foster parents (unless, perhaps, they had the benefit of a residence order). But in the great majority of cases of people other than young children living in ordinary domestic circumstances, the degree of supervision and control and the freedom to leave would take the situation out of article 5.4. And, where article 5.4 did apply, no doubt the benignly intimate circumstances of a domestic home would frequently help to render any deprivation of liberty easier to justify.⁹

77 The question whether one is restricted (as a matter of actuality) is determined by comparing the extent of your actual freedom with someone of your age and station whose freedom is not limited. Thus a teenager of the same age and familial background as MIG and MEG is the relevant comparator for them. If one compares their state with a person of similar age and full capacity it is clear that their liberty is in fact circumscribed. They may not be conscious, much less resentful, of the constraint but, objectively, limitations on their freedom are in place.

78 All children are (or should be) subject to some level of restraint. This adjusts with their maturation and change in circumstances. If MIG and MEG had the same freedom from constraint as would any child or young person of similar age, their liberty would not be restricted, whatever their level of disability. As a matter of objective fact, however, ***constraints beyond those which apply to young people of full ability are and have to be applied to them. There is therefore a restriction of liberty in their cases. Because the restriction of liberty is and must remain a constant feature of their lives, the restriction amounts to a deprivation of liberty.***

9 Lord Neuberger.



*79 Very young children, of course, because of their youth and dependence on others, have an objectively ascertainable curtailment of their liberty but this is a condition common to all children of tender age. There is no question, therefore, of suggesting that infant children are deprived of their liberty in the normal family setting. A comparator for a young child is not a fully matured adult, or even a partly mature adolescent. While they were very young, therefore, MIG and MEG s liberty was not restricted. **It is because they can and must now be compared to children of their own age and relative maturity who are free from disability and who have access (whether they have recourse to that or not) to a range of freedoms which MIG and MEG cannot have resort to that MIG and MEG are deprived of liberty.**¹⁰” (emphasis added)*

- 9.9 It appears to follow that for young persons, the acid test should be considered in the context of the liberty-restricting measures that are universally applied to those of the same age and maturity who are free from disability. As a general rule, the younger the person is, the greater the level of constraint to which they would typically be subject. A 5 year old, for example, regardless of their disability, would be under continuous or complete supervision and control wherever they are and not free to leave. The fact that they are under such control, whether in the care of their family or the State, does not mean they are deprived of liberty. However, if the level of constraint typically afforded to a non-disabled 5 year old is provided to a disabled 16 year old, then those constraints must be taken into account in determining whether the acid test is satisfied.
- 9.10 In deciding whether someone aged 16 or 17 is deprived of their liberty, in addition to the content discussed in Chapters 2 and 3, it is therefore necessary to consider the extent to which the care arrangements differ to those typically made for someone of the same age and relative maturity who is free from disability. Universal disability-free measures constraining the liberty of all those of that age and maturity who are not physically or mentally disabled should not be taken into account. We also note that the duration of the constraints were a key feature, at least for one of the judges.

C: Universal constraints

- 9.11 It is not altogether easy to gauge what amounts to a universal degree of age-appropriate constraint in a multicultural society. What level of constraint is universally applied to all non-disabled 16 year olds, for example? Moreover, it is important to bear in mind the importance of Article 8 in this context because the exercise of parental rights constitutes a fundamental element of family life. So what follows are merely general comments to provide some context to illustrate the universal constraints required of all young persons by those with parental responsibility.¹¹ Crucially, what is clear is that, as young people approach adulthood, the intensity or degree of such constraint is expected to lessen as they mature and gain independence.
- 9.12 The living arrangements for young persons should provide a positive, supportive and caring environment. Their welfare must be safeguarded and promoted. But, equally, they must have the physical and emotional freedom to develop and make, and learn from, their own mistakes. Strategies for coping with challenges and stress factors need to be nurtured. How to approach

¹⁰ Lord Kerr.

¹¹ For those cared for in children’s homes, see Department of Education, ‘[Guide to the Children’s Homes Regulations including the quality standards](#)’ (2015).

relationships with learning and respect for others needs to be taught. Privacy and dignity must be respected. Responsible parenting, whether in the care of the family or of the State, is therefore a social norm for those under 18.

- 9.13 Responsible parenting provides a homely environment with a certain degree of freedom exercisable alongside sensible precautions. It protects against avoidable risks but avoids excessive caution. It meets the person's needs, especially their disabled needs, and reasonable preferences for clothing, footwear, personal necessities, and perhaps an age appropriate personal allowance. It facilitates religious observance if the individual belongs to a religious persuasion. Subject to restrictions necessary to safeguard and promote welfare, responsible parenting promotes contact with family and friends, and provides access to the world outside.
- 9.14 Responsible parenting promotes and protects physical, emotional and mental health. It provides the person with some private space. After compulsory school age, it assists with arrangements for further education, training and employment opportunities. It encourages the pursuit of age appropriate leisure interests. It grants permission to engage in normal and acceptable age appropriate activities at home and in the community. It aims to develop important life skills, personal responsibility, and the ability to choose and to be independent. This cannot be imposed from upon high: it is nurtured through explanation, discussion, and negotiation within positive, constructive relationships between those parenting and the parented.
- 9.15 As in every family, we cannot always get what we want. The young person's expressed views or wishes may not accord with those with parental responsibility or, of course, the law. For example, those under 18 cannot buy alcohol, cigarettes, fireworks, vote, watch adult movies, or get tattoos. Responsible parenting therefore takes a reasonable, reasoned view as to the best way forward in the interests of all concerned. It provides safety, with rules that are sensibly implemented, taking into account the person's age, without unnecessarily preventing them from taking part in everyday activities. Indeed, those aged 16 or 17 can drink alcohol in a restaurant if having a meal and accompanied by an adult. They can permanently leave home without their parents' consent, secure full-time employment, claim certain welfare benefits, have sexual intercourse, get married (with parental permission), buy National Lottery tickets, drive mopeds (from 16) or cars (from 17), and travel abroad.

D: Liberty-restricting measures

- 9.16 Mere placement in foster care, a children's home or residential special school of someone lacking the capacity to consent will not in itself constitute a deprivation of liberty. However, the combined effect of more specific measures may do. As explained above, constraints may be universal to a 5 year-old but liberty-restricting when applied to a 16 year-old. Thus, continual supervision would be universally expected of the former but not of the latter.
- 9.17 The following list of measures might be identified in foster care arrangements, children's homes or residential special schools. Some are more relevant to one care setting than another. The list also comes with an important health warning: if the measure would be universal for someone of that age and maturity who is disability-free, it should **not** be taken into account in determining whether the nuanced acid test is met.

- Decision on where to reside being taken by others;
- Decision on contact with others not being taken by the individual;
- Restrictions on developing sexual relations;
- Doors of the property locked, and/or chained, and/or bolted for security reasons or to prevent the children or young persons leaving;
- A member or members of staff accompanying the person to access the community to support and meet their care needs;
- Access to the community being limited by staff availability;
- Mechanical restraint, such as wheelchairs with a lapstrap or specialist harness;
- Varying levels of staffing and frequency of observation by staff;
- Provision of “safe spaces” or “chill out” rooms or spaces during the day or night from which the person cannot leave of their own free will (eg padded tent to sleep in);
- Restricted access to personal allowances;
- Searching of the person and/or their belongings;¹²
- Restricted access to personal belongings to prevent harm;
- Medication with a sedative or tranquilising effect;
- Physical restraint/intervention, such as with personal care tasks, breakaway or block techniques, distraction methods, staff withdrawing, physical touches or holds (e.g. “Team-Teach” methods);¹³
- Restricted access to modes of social communication, such as internet, landline or mobile telephone or correspondence;
- Positive behavioural reward systems to reward “good” behaviour which might thereby involve restrictions on favoured activities or aspects of the curriculum to improve behaviour;
- Disciplinary penalties for poor behaviour;¹⁴
- Restricting excessive pursuance of activities;
- Lack of flexibility, in terms of having activities timetabled, set meal times, expected sleep times;
- Managing food intake and access to it;
- Police called to return the person if they go missing;
- Restricted access to parts of the property, such as the kitchen or certain cupboards therein, to minimise health and safety risks.

¹² For example, see ss. 550ZA to 550ZD of the Education and Inspections Act 1996

¹³ Increasing guidance on the use of restrictive practices is becoming available: see, for example, Department of Health [‘Positive and Proactive Care: reducing the need for restrictive interventions’](#) (2014); Skills for Care and Skills for Health, [‘A positive and proactive workforce. A guide to workforce development for commissioners and employers seeking to minimize the use of restrictive practices in social care and health’](#) (2014). For restraint in children’s homes, see Department of Education, [‘Guide to the Children’s Homes Regulations including the quality standards’](#) (2015), paras 9.48-9.63.

¹⁴ See Department of Education, [‘Behaviour and discipline in schools: Advice for headteachers and school staff’](#) (February 2014).

E: Foster homes for looked after persons¹⁵

9.18 Foster care arrangements range from emergency provision to long-term placements with varying aims. Short breaks¹⁶ also form part of a continuum of services to support young persons in need and their families. Their Foster Care Agreement requires carers to care for any young person placed with them as if that person was a member of the foster carer's own family. Accordingly, they should have delegated to them the maximum appropriate flexibility to make day-to-day caring decisions within the framework of an agreed placement plan and parental responsibility.

Foster home: a deprivation of liberty

9.19 The measures in the following scenario are likely to amount to a deprivation of liberty:

David is 16 years old and has Smith Magenis syndrome. His condition is characterised by self-injurious and destructive behaviour, aggression, hyperactivity, and severe sleep disturbances including frequent and prolonged night waking. He also destroys furniture, eats copious amounts of, sometimes uncooked, food. In accordance with the assessments and care plan prepared by the local authority, his foster parents lock him in his bedroom from 7pm until 7am every night to keep David safe. Doors and windows around the house are also kept locked at all times with keys hidden. During the day he receives intensive support from his foster parents with all aspects of daily living, and at least one of them is with him at all times.

Factors pointing to a deprivation of liberty:

- *David is regularly locked in his room for 12 hours of each 24, and the doors to the house are locked.*
- *David is supervised and accompanied by a foster parent on a 1:1 basis throughout the day.*

Foster home: potential deprivation of liberty

9.20 We suggest that the measures in the following scenario may give rise to a deprivation of liberty:

Michaela is a 16 year-old girl with severe learning disability and hearing, visual and speech impediments and is largely dependent on others. She does not communicate very readily, hardly at all in sentences, and lives most of her time in her own world, typically listening to music. She can read familiar words and, with support, is able to give a basic account of her living arrangements and to describe her feelings in often monosyllabic speech. She is emotionally attached to her foster mother in a good loving home with the person she regards as 'mummy'. She is supported with basic life skills and personal care with clear boundaries and routines. She attends a school every day during term time and her foster mother provides her with educational input. Continual support is available to meet her care needs and she is taken on exciting holidays and trips. She shows no wish to go out on her own. She is not physically restrained or locked in the home in any way. But if she wished to leave the home by herself she

15 See, in particular, Parts 3, 7 and 8 of the Children Act 1989, Care Standards Act 2000, Fostering Services (England) Regulations 2011, the National Minimum Standards for Fostering Services (2011) and ['The Children Act 1989 Guidance and Regulations Volume 4: Fostering Services'](#) (revised 2011).

16 Pursuant to ss. 17(6) or 20(4) of the Children Act 1989.

would be prevented from doing so for her own immediate safety as she has no sense of safety, in particular road safety. Some of the parenting provided is in line with that usually provided to a much younger child.

Key factors pointing to potential deprivation of liberty:

- *These facts are similar to those of MIG, who was found by the Supreme Court to be deprived of her liberty.*
- *However, as Michaela is two years younger, the key question for professionals is the extent to which the measures applied to her are comparable to those which would be applied to a non-disabled young person of comparable age and maturity.*

Foster home: not a deprivation of liberty

9.21 The following scenario is unlikely to amount to a deprivation of liberty:

Nathan is 16 years old with mild learning disability. His foster parents prepare his meals, wash his clothes, and are available around the house if he needs them. They do not otherwise support him with activities of daily living any more than they do the activities of Carole, the 16½ year-old daughter of his foster parents. He attends a mainstream school with pre-arranged transport. At weekends the family go shopping and on trips. Once his foster parents have helped Nathan to familiarise himself with the route, he is able to go out with his friends and has a mobile phone to call them if he needs help.

Key factors pointing away from deprivation of liberty:

- *Nathan's age and the extent to which the measures applied to him are comparable to those which would be applied to a 16 year old without disabilities, a direct comparison being Carole.*

F: Children's homes

9.22 A children's home (defined in s.1 Care Standards Act 2000) is generally an establishment providing care and accommodation wholly or mainly for children. Since 1 April 2015 it is subject to the Children's Homes (England) Regulations 2015 and the quality standards therein. Care models differ from the larger children's homes designed with routines to meet the needs of teenagers, to homes providing therapeutic input for young persons with complex needs, to one-bedded homes.

Children's home: a deprivation of liberty

9.23 We suggest that the measures in the following scenario are likely to amount to a deprivation of liberty:

Ahmed, a 16 year old boy with autism and learning disability resides in a children's home and attends specialist school. On a daily basis he screams, kicks, bites, and hits out at staff and his peers. He receives two-to-one support throughout the day. Once or twice per week he goes into a soft play area, or 'safe space', in order to calm down, during which the door is closed, not locked, and a teaching assistant watches him through the door window. At many other times he is physically restrained using Team-Teach methods to prevent him assaulting others. He

receives visits from his grandparents and mother; his father decides not to visit but could do so if he wished.

Key factors pointing to deprivation of liberty:

- *the intensive and continuous nature of the control and supervision exercised over him*
- *the use of the 'safe space' on a regular basis*
- *the use of physical restraint - Ahmed would not be free to leave the children's home.*

Children's home: potential deprivation of liberty

9.24 We suggest that the measures in the following scenario may give rise to a deprivation of liberty:

Joanna, aged 16, has autism, severe learning disability and epilepsy, and aggressive and self-harming behaviours. She resides in a children's home from Monday to Friday, which her parents can visit at any time, and spends the weekends at her parents' home. During term time she attends school. Both at school and in the children's home she is supervised most of the daytime to prevent her harming herself or others. She compliantly takes her prescribed medicines. She is not physically restrained other than on a few occasions to prevent her attacking others. Her behaviour has led to minor sanctions being imposed on a few occasions, such as not allowing her to eat a takeaway meal or stopping her listening to music when in a car. The front door to the children's home is not locked but, were she to run out of it, she would be brought back.

Key factors pointing to potential deprivation of liberty:

- *similar circumstances were held in [RK v BCC, YB and AK](#)¹⁷ not to amount to a deprivation of liberty*
- *however, in light of the decision in Cheshire West, we suggest that this conclusion would have to be revisited, in particular, given her age, the continuous nature of the supervision to which she is subjected, and the fact that she is not free to leave.*

Children's home: not a deprivation of liberty

9.25 The following scenario is unlikely to amount to a deprivation of liberty:

Connie is 16 years old and has a mild learning disability. After breakfast she is transported to school for 9am and brought back at 3.20pm. From then until 5pm she is supported to do her homework, attend any health or social care appointments, and is able to go out the home to see her friends. Along with the other young persons, Connie helps to prepare the dinner. After eating together, staff spend time with them pursuing their hobbies and interests, watching television and socialising.

Key factors pointing away from deprivation of liberty:

- *the extent to which the measures applied to Connie are comparable to those which would be applied to a young person of comparable age and maturity.*

17 [\[2011\] EWCA Civ 1305](#)

G: Educational establishments

- 9.26 Educational establishments come in many guises: from nurseries and child minders, to schools maintained by the local authority, independent schools, academies and free schools, through to special schools and further education colleges. Those most relevant to this guidance are establishments providing care and accommodation alongside special education: that is, residential special schools.¹⁸
- 9.27 Proportionate restraint is permitted.¹⁹ In particular, school staff may use reasonable force to prevent a pupil committing an offence, causing personal injury or damage to property, or behaving in a manner prejudicial to the maintenance of good order or discipline.²⁰

Residential special school: a deprivation of liberty

- 9.28 The measures in the following scenario are likely to amount to a deprivation of liberty:

David, aged 17, has been resident in a school for some years. He has autism and severe learning disability with extremely challenging behaviour. His behaviour is managed in large part by the use of a padded blue room in which he was secluded when he exhibited challenging behaviour. He has developed a number of behaviours that are particularly prevalent when in the 'blue room' including defecating, smearing and eating his own urine and faeces, and stripping naked. He is prevented from leaving the blue room for reasons of aggression and nakedness. The blue room is also used as a room to which David had been encouraged to withdraw as a safe place.

Key factors pointing to a deprivation of liberty:

- *the particular techniques used to manage his behaviour*
- *the use of seclusion in a blue room from which he was prevented from leaving.*²¹

Residential special school: potential deprivation of liberty

- 9.29 The measures in the following scenario may give rise to a deprivation of liberty:

Gary is 17 years old and has severe learning disability. He is non-weight bearing. Throughout the year he lives in a special school which is in 10 acres of land and surrounded by a high perimeter fence. There are three houses, each with their own care team, in which 2 to 5 children and young persons reside. Entry is via keypad which he cannot use. Gary needs two members of staff to assist him with all personal care interventions and to hoist him from bed to his electric wheelchair. From 9am to 3pm at school, and from 3pm to 9pm in the house, he is supported by one staff member. Waking staff check on him every hour during the night. After a number of incidents when Gary drove his wheelchair into his peers and staff causing injury, staff decided to replace the arm to a slow speed version so as to minimise the risk.

18 See the *National Minimum Standards for Residential Special Schools* (2013). Where a school provides, or intends to provide, accommodation to children for more than 295 days a year, it must be registered as a children's home and becomes subject to the Children's Homes (England) Regulations 2015 and the quality standards therein.

19 See s. 550A Education Act 1996. In relation to young persons lacking the material capacity, ss.5-6 MCA 2005 will also be relevant

20 See s. 93 of the Education and Inspections Act 2006.

21 See *R (C) v A Local Authority and others [2011] EWHC 1539* (Admin) where it was held that similar circumstances were unlawful in the absence of judicial authorisation.

Key factors pointing to a potential deprivation of liberty:

- *Gary is not free to leave*
- *whether or not he is deprived of his liberty will depend crucially on the extent to which to the support provided by staff can properly be described as support or whether it is to be considered supervision and control. In light of MIG's case (discussed further at paragraph 2.26), we suggest that caution would need to be exercised before such a conclusion is reached.*

Residential special school: not a deprivation of liberty

9.30 The following scenario is unlikely to amount to a deprivation of liberty:

Vanessa is 16 years old and has autism. For 38 weeks per year she lives in a school set in 25 acres which has 11 house groups, each accommodating between 4 and 8 students. It has high fences to prevent students reaching the road and to deter intruders and access to buildings and accommodation is via keypads or double-handled doors. Each house has a care team and each student has a key worker. Throughout the day there is usually one staff member for four students, although some activities like swimming require a higher ratio. All students have a structured, predictable daily routine of activities. During the week they wake at 7am, get washed and dressed, have breakfast, with school starting at 9.15am and finishing at 3.40pm. She has some down-time until 5pm when she eats with the others in her house. Evening activities with staff include art, cookery and sometimes outings. Vanessa is helped to go to bed in her personalised room at 9pm, with waking staff available during the night. Her door is always slightly ajar so staff can check on her. Timings are more flexible at weekends. Staff are trained in positive physical intervention techniques and follow her education and health care plan which does not envisage its use. Paediatricians and psychiatrists visit the school monthly and weekly respectively. Her videos, DVDs and CDs are checked to ensure they are age appropriate. She is encouraged to phone her parents every week and they are encouraged to visit at weekends.

Key factors pointing away from a deprivation of liberty:

- *the extent to which the measures applied to Vanessa are comparable to those which would be applied to a child of comparable age and maturity in an educational establishment.*

H: Considerations for front-line practitioners

9.31 These questions may help establish whether an individual is deprived of their liberty in this context:

- Compared to another person of the same age and relative maturity who is not disabled, how much greater is the intensity of the supervision, support, and restrictions?
- Can the person go out of the establishment without the carer's permission? Can they spend nights away? How do the arrangements differ to the norm for someone of their age who is not disabled?

- To what extent is the person able to control his or her own finances? How does this differ to the norm for someone of the same age who is not disabled?
- Can the person choose what to wear outside school hours and buy his or her own clothes?
- To what extent do the rules and sanctions differ from non-disabled age appropriate settings?
- Are there regular private times, where the person has no direct carer supervision?
- What is the carer to person ratio and how different is this to what would usually be expected of someone of that age who is not disabled?
- Is physical intervention used? If so, what type? How long for? And what effect does it have on the person?
- Is medication with a sedative effect used? If so, what type? How often? And what effect does it have on the person?
- How structured is the person's routine compared with someone of the same age and relative maturity who is not disabled?
- To what extent is contact with the outside world restricted?

Introduction

The cases summarised here represent the key English cases relating to deprivation of liberty since 2009,¹ together with (at the end) a list of cases that we consider should not be followed in light of the decision of the Supreme Court in *Cheshire West*. We attach what we call “health warnings” to those cases.

The chapter includes not just the cases relating to what constitutes a deprivation of liberty but also the most important cases relating to how deprivations of liberty in this context can be authorised.

Not all the issues in each case are summarised; rather, the focus is on questions relating to deprivation of liberty.

The cases are set out in chronological order. There are hyperlinks to publicly available transcripts. In the majority of cases, more detailed discussions can be found on the (free) 39 Essex Chambers case summaries database, available at www.copcasesonline.com.

References to paragraphs are to paragraphs in the main body of the guidance unless the context makes clear.

1. *A Primary Care Trust v P and Ors* [2009] EW Misc 10 (EWCOP) (Hedley J)

Facts: P was 24 years old at the time of the hearing. P had lived with his adoptive mother AH for a period of 18¹/₂ years. He suffered from a severe form of uncontrolled epilepsy and a mild learning disability. There was also a dispute as to whether P suffered from ME. The PCT and the local authority were concerned that both P and his adoptive mother AH were not complying with the medication regime set out by the doctors. P had been admitted as an emergency to hospital with life-threatening epileptic seizures in circumstances where AH had without medical advice withdrawn anti-epileptic medication a few days before. The matter had been before the court on a number of occasions and at the time of the hearing P was accommodated on a hospital ward.

Issues to be decided: 1) issues relating to his capacity to make decisions in respect of his medical treatment, residence, care and contact and ability to conduct litigation and, in the event that he lacked capacity; 2) his best interests in particular in relation to where he should live and the extent and frequency of contact with AH. In considering best interests, there were two conflicting proposals before the court. The PCT supported by the local authority concerned wished to provide P with independent living accommodation with limited contact with his mother. AH wished to resume the care of P on a full time basis. P wished to return to live with AH.

Decision: Hedley J found that P lacked capacity in all regards. He concluded that it was in P’s best interests to live in independent living accommodation and for his contact with his mother to be restricted and that these arrangements amounted to a deprivation of P’s liberty within the meaning of Article 5(1) of the ECHR. In reaching the conclusion that the arrangements in this case amounted to a deprivation of liberty Hedley J took the following 5 factors into account:

- 1) The degree of control to be exercised by the staff.
- 2) The constraint on P leaving if it was his intention to go back to AH.
- 3) The power of the staff to refuse a request from AH for the discharge of P to her care.

¹ A date that we have picked since the ‘DOLS regime’ came into force in April 2009.

- 4) Necessary restraints on contact between P and AH.
- 5) It involved a fairly high degree of supervision and control within the placement.

Hedley J made orders under s.16 (2)(a) MCA 2005 accordingly.

2. *Re P (Scope of Schedule A1) (30 June 2010) (Unreported) (Mostyn J)*

This case concerns the scope of the powers that are granted by a standard authorisation under Schedule A1 to the MCA 2005. In it, Mostyn J was considering the extent of the powers granted to a local authority and a care home under existing (and any renewed) standard authorisations. He noted that it was common cause that these powers extended to a power to restrain P if he tried to leave the care home. The question for him was whether within those powers there was a power to coerce P to return if he refused to return to the care home from a period of leave. Mostyn J noted that it was understandably in P's interests that he should have access to society in the community and 'escape' the confines of the care home, and that the relevant PCT had agreed to fund 'befrienders' to encourage access to the community.

Mostyn J therefore asked himself whether the powers under the existing standard authorisation extend to coercing P back to the nursing home if P refused to return. He noted that it would be little short of absurd if the local authority and care home had powers to restrain P from leaving but not to compel him to return, and that the greater power must include the lesser. Mostyn J therefore declared that the power was implicit in the current and any future standard authorisation.

Note: this case does not, we suggest, provide authority for the proposition that a standard authorisation can be used to authorise a deprivation of liberty in relation to the transfer in or the transfer out of a placement (for instance the initial move into a hospital, or the permanent transfer from one hospital to another). See further in this regard the discussion at paragraph 4.15.

3. *BB v AM [2010] EWHC 1916 (COP) (Baker J)*

Facts: P was a 31 year old Bangladeshi woman, known as BB. She was said to have complex needs, being profoundly deaf with a diagnosis of schizoaffective disorder and probable learning difficulties. She lacked capacity to decide where she should live. In April 2010 BB was removed from home by support workers employed by the Community Mental Health Team, following reports that her parents had assaulted her. After a series of moves she was finally transferred to a hospital managed by a Mental Health NHS Trust in May 2010. BB's deprivation of liberty was authorised by that Trust under an urgent authorisation under the MCA 2005 in June 2010. The authorisation lapsed. The medical evidence was that BB was not detainable under the MHA 1983 because she was happy to stay in hospital and take medication. She had made no attempts to leave and she reported being happy. She changed the subject when asked about her home and family but she did so without showing any negative emotion or particular interest. It was contended by the Official Solicitor on behalf of BB that the arrangements amounted to a deprivation of her liberty and that there was no longer any lawful authorisation for BB's deprivation of liberty.

Issues to be decided: Issues relating to residence and contact were resolved by consent. However, the issue of whether or not BB was (1) ineligible to be deprived of her liberty within the meaning of the eligibility requirements in Schedule 1A MCA 2005 and (2) deprived of her liberty, were unresolved. A declaration was sought by the Official Solicitor acting for BB that the circumstances amounted to a deprivation of liberty.



Decision: Baker J found that BB was not ineligible to be deprived of her liberty within the meaning of the eligibility requirements in Schedule 1A. Accordingly the court was empowered to make an order in relation to her deprivation of liberty under s.16(2)(a) MCA 2005. In the circumstances of the case he found that BB was deprived of her liberty. In reaching this conclusion he took the following 'cumulative' factors into account: (1) BB was away from her family; (2) she was in an institution under sedation; (3) she was in circumstances where her contact with the outside world was strictly controlled; (4) her capacity to have free access to her family was limited by court order; and (5) her movements were under strict control and supervision of hospital staff. Baker J made the declaration sought and made an order authorising her deprivation of liberty under s.16 (2)(a) MCA 2005.

4. *A County Council v MB, JB and a Residential Home* [2010] EWHC 2508 (COP) (Charles J)

Facts: Mrs B had been admitted to a care home following concerns about her being physically assaulted by her husband. An urgent authorisation was granted and then a standard authorisation lasting for one month. Prior to the expiry of the standard authorisation, a further standard authorisation was sought, but the best interests assessor concluded that the best interests requirement was no longer met. This was because Mrs B had displayed emotional and physical signs of distress at having been removed from her home. The local authority supervisory body sought advice as to what they should do, and following some confusion due to difficulty in contacting the Court of Protection urgently, they requested the care home to issue a second urgent authorisation.

Issues to be decided: The question of her best interests in respect of where she should live was no longer an issue at the time of the hearing. The issue before the court was whether the issuing of the second urgent authorisation was lawful.

Decision: Charles J found that the second urgent authorisation could not lawfully be issued. Once an urgent authorisation has been given, detention can only lawfully be extended by a standard authorisation or by court order. The court granted a declaration that Mrs. B had been unlawfully deprived of her liberty from the expiry of the standard authorisation until the court declared the deprivation of liberty lawful at a subsequent hearing. Charles J did not, however, make any award of damages under the Human Rights Act 1998, noting that – in his view correctly – no such award had been sought. See further in this regard the discussion at paragraphs 2.44-2.48.

Charles J went on to give useful guidance about the duties of managing and supervisory authorities; a full discussion can be found at: http://www.39essex.com/court_of_protection/search.php?id=2825.

5. *R (C) v A Local Authority and others* [2011] EWHC 1539 (Admin) (Ryder J)

Facts: C was an 18 year old boy who had been resident in a school for some years. He had autism and severe learning disability with extremely challenging behaviour. His behaviour was managed in large part by the use of a padded blue room in which he was secluded when he exhibited challenging behaviour. He had developed a number of behaviours that were particularly prevalent when in the 'blue room' including defecating, smearing and eating his own urine and faeces, and stripping naked. He was prevented from leaving the blue room for reasons of aggression and nakedness. The blue room was also used as a room to which C had been encouraged to withdraw



as a safe place and was said to have a calming influence on him. C had brought judicial review proceedings against the local authority, through his mother as his litigation friend. The local authority made an application to the Court of Protection and the two cases were heard together. The Official Solicitor replaced C's mother as his litigation friend.

In the judicial review proceedings the Official Solicitor sought declarations that C's rights under Articles 3, 5 and 8 ECHR had been violated, and damages for C as a result. The Official Solicitor sought orders compelling the local authority to provide an appropriate care plan, and make appropriate transitional arrangements.

It was accepted that C had been deprived of his liberty when he was secluded in the blue room. The DOLS procedure could not be used as the school was not a care home or hospital.

Issues to be decided: Whether C's rights under Articles 3, 5 and 8 ECHR had been violated; whether the Code of Practice to the MHA 1983 should apply to C when the provisions of the MHA 1983 were not being used and he was not in hospital.

Decision: Ryder J made the following findings: (1) since at least C's 16th birthday the approach of the MCA 2005 was more relevant to his situation than the Children Act 1989, but this approach was not applied to C; (2) as the DOLS Code of Practice and Schedule A1 of the MCA did not apply to C, an application should have been made to the COP before any deprivation of liberty occurred. In this case the application should have been made on C's 16th birthday; (3) since at least C's 16th birthday there had been no lawful authority to deprive C of his liberty; (4) the court could not make even interim declarations as to whether the conditions in which C was being deprived of his liberty were in his best interests until it had heard oral evidence from a number of those caring for C and from instructed experts; (5) the application of good practice in the COP in any determination of best interests must have regard to the same material as that contained in the DOLS Code of Practice; (6) the MHA 1983 Code of Practice reflects best practice in relation to seclusion. It applies to the care, treatment, and in particular seclusion and restraint of those with mental disorder, whether they are being treated in hospital or in the community, and whether the MHA is being used. As such, the provisions applied to C whose condition fell within the definition of mental disorder in the MHA. Moreover the Code should be applied as a matter of good practice to the seclusion of children and young people in children's homes whose disability does not fall within the definition of a mental disorder.

The court considered the limited number of situations in which secluding C could be lawful and in his best interests. Ryder J considered that seclusion could be used to control aggressive behaviour, but only so long as it was necessary and proportionate and it had to be the least restrictive option. It had to be exercised in accordance with an intervention and prevention plan designed to safeguard C's psychological and physical health. However, Ryder J held that it would be not lawful to seclude C used solely for nakedness, such seclusion being little more than "an amateur attempt at behaviour modification which is not proportionate to any risk or the least restrictive option." Nor would it be lawful to seclude C as a punishment as part of a behaviour management plan, or solely for reasons of him self-harming.



6. London Borough of Hillingdon v Neary [2011] EWHC 1377 (COP) (Peter Jackson J)

Facts: Steven Neary had autism and a severe learning disability and could become very anxious at unexpected changes. Sometimes this would be manifested through lashing out at others. Steven had grown up with his parents Mark and Julie Neary and had lived with his father Mark after his parents separated, remaining in regular contact with Julie. Between January and May 2008 Steven had lived in a support Unit but then returned home. In December 2009 Mr Neary was unwell and agreed to Steven being placed in respite in a Unit. Staff found his behaviour difficult to manage and it was accepted that Steven wanted to go home. Mr Neary sought Steven's return home. Hillingdon had decided that Steven should not return home but did not tell Mr Neary its position until April 2010. Following an incident in April 2010 when Steven wandered off, an urgent authorisation was granted under DOLS, followed by a series of standard authorisations. Mr Neary was appointed as Steven's representative ("relevant person's representative" or RPR. He made it clear that he wanted to challenge the authorisation insofar as it was being used to enforce Steven's stay at the Unit. He had great difficulty in obtaining legal advice. In October 2010 the local authority applied to the Court of Protection seeking declarations which would allow it to make decisions as to Steven's residence and care. In November 2010 an IMCA's report raised serious questions about Hillingdon's refusal to allow Steven to return home and suggested a trial return home. In December 2010 Mr Neary appealed against the current authorisation to the Court of Protection. The Official Solicitor was appointed to represent Steven. On 23 December 2010 Mr Justice Mostyn terminated the standard authorisation and Steven returned home. An independent psychiatrist and social worker were instructed and both concluded it was in Steven's best interests to remain at home with a package of care. This was agreed between the parties. In the meantime the Official Solicitor sought findings that Steven's human rights had been violated in a number of ways.

Relevant issues to be decided: the nature of, and the extent of, the breaches of Steven's rights under Articles 5(1) and (4) and 8 ECHR.

Decision: Peter Jackson held that Article 8 was the "nub" of the matter in the case before the court, and fell to be considered first. He held that Steven's Article 8 ECHR rights had been breached throughout the relevant period. He emphasised that the fact that a court disagrees with a local authority's beliefs as to an individual's best interests does not necessarily imply a breach of Article 8. However, in this case the following factors led the judge to conclude the local authority had not respected Steven's Article 8 rights: the lack of any attempt to weigh up the advantages and disadvantages of care at home or in the Unit; the local authority's unwillingness to listen to Mr Neary or accept the validity of his concerns which persisted to the final hearing; its pursuit of a double agenda and its delay in applying to the Court of Protection.

As regards Article 5, Peter Jackson J held that there had been no lawful authority to deprive Steven of his liberty between January and April 2010 (as no DOLS authorisation had been place). Although a DOLS authorisation was in place between April and December 2010, the deprivation of his liberty was unlawful because the best interests assessments were flawed. Peter Jackson J emphasised that, where best interests assessments are inadequate and the supervisory body knows or ought to know this, the supervisory body is not bound to follow the recommendations. Peter Jackson J also found that Steven's rights under Article 5(4) ECHR were also breached by the failure to appoint an IMCA under s.39D MCA 2005; the failure to hold an effective review; and the delay in applying to the court. It was not enough, he found, to suggest that Mr Neary should have taken the case to



court. The fact that he did not do so did not excuse the local authority of the obligation to act – it redoubled it.

In a subsequent settlement approved by the High Court, Steven Neary was awarded £35,000 in damages (together with costs).

7. *A Local Authority v PB and P* [2011] EWHC 2675 (COP) (Charles J)

Facts: P was a 49 year old man, who had a life-long learning disability. He had been cared for by his mother for the majority of his life, but had been removed from his mother's care in 2008 to be cared for by the local authority. P suffered from glaucoma and at the time of the hearing was effectively blind, with little chance of regaining his eyesight. P had also had significant difficulties with his teeth and all his upper teeth had been removed, as had a number of his lower teeth. On the first occasion that the matter had been before the court, Charles J had found that P lacked capacity to make decisions about where he should live and arrangements with regards to contact. P's mother wished P to return to her care. The evidence showed that P's current placement was 'exceptional' and that he required one to one support throughout the day and support that was quickly available during the night because of his multiple needs.

Issues to be decided: (1) where it was in P's best interests to live. The local authority was not prepared to offer a supported placement at home that would provide one to one support during the day. The choice was therefore between the present placement and regime and a return home on the basis that his mother would shoulder the day-to-day care of P with some respite care provided by the local authority; (2) whether the proposed care regime amounted to a deprivation of P's liberty.

Decision: It was in P's short, medium and long-term best interests to continue at his present placement, and not to return to live at his mother's home. In the circumstances, Charles J chose not to come to a concluded view as to whether P was deprived of his liberty. He was satisfied that the proposed care plan and regime for P promoted his best interests and that such aspects of it, if any, that meant that he was being deprived of his liberty by its implementation should be authorised by the court. He made orders under s.16(2)(a) MCA 2005 accordingly.

In the course of his judgment Charles J commented that:

- (1) In the exercise by the court of the welfare jurisdiction and the approach under the MCA 2005 more generally the most important issue is whether consent or authorisation should be given to a care regime on behalf of a person who does not have the capacity to give consent himself. That question is not determined by whether or not the person is being deprived of his liberty but by an assessment of whether the care regime is in his best interests. This will include a determination of whether a less restrictive regime would promote P's best interests and when reviews should take place.
- (2) In borderline cases where there is a question whether a person is being deprived of his liberty, and cases in which there will be a deprivation of liberty if identified contingency planning is implemented (involving say restraint), care providers should ensure that there is no breach of Article 5 ECHR and review the regime to ensure it remains in P's best interests. This may involve applying the DOLS regime, or, at the very least considering the qualifying requirements identified in Schedule A1 to the MCA 2005;

- (3) If the DOLs regime under Schedule A1 applies, it should be used in preference to authorisation and review by the court.

Note: this judgment pre-dates that of the Supreme Court in *Cheshire West* but we suggest that the approach outlined above remains equally applicable.

8. *RK v (1) BCC(2) YB (3) AK* [2011] EWCA Civ 1305 (Court of Appeal (Thorpe LJ and Gross LJ and Baron J))

Facts: This was an appeal by RK against a decision by Mostyn J, who had decided that: (1) the provision of accommodation to a child (of any age) under s. 20 Children Act 1989 was not capable – in principle – of ever giving rise to a deprivation of liberty within the terms of Article 5 ECHR; and (2) the factual circumstances of the case did not amount to a deprivation of RK’s liberty. The parents had consented to the arrangements by which their child was placed in accommodation under s.20 Children Act 1989.

Issues to be decided: (1) Whether the provision of accommodation to a child (of any age) under s.20 Children Act 1989 is ever capable – in principle - of giving rise to a deprivation of liberty within the terms of Article 5 ECHR; (2) whether the restrictions authorised by the parent(s) individually or cumulatively amount to detention.

Decision: An adult in the exercise of parental responsibility may impose, or authorise others to impose, restrictions upon the liberty of a child but such restrictions may not in their totality amount to a deprivation of liberty. Detention engages the Article 5 rights of the child and a parent may not lawfully detain or authorise the detention of a child. The provision of accommodation to a child under arrangements made between a local authority and the child’s parent(s) may therefore give rise to a deprivation of liberty within the terms of Article 5(1) ECHR.

RK’s appeal was therefore dismissed.

Note: the Court of Appeal agreed with Mostyn J’s conclusion that RK was, on the facts, not deprived of her liberty. Key to the Court of Appeal’s decision appears to have been the purpose of the restrictions imposed. We therefore suggest that this aspect of their decision needs to be approached with caution in light of the decision of the Supreme Court in *Cheshire West*.

9. *J Council v GU (1), J Partnership NHS Foundation Trust (2), CQC (3) and X Limited (4)* [2012] EWHC 3531 COP (Mostyn J)

Facts: This case concerned a man known as “George.” Mostyn J described him as “very seriously challenged,” with a history which told a very sad story. George had childhood autism, OCD, personality disorder and paedophilia. He lived at Y Care Home, under the terms of a standard authorisation. As a result of George’s paedophilia he would write letters about his fantasies and leave them in public places, and would try to leave messages for children. Therefore, George’s placement regime involved rigorous restrictions on his contact with others including strip searching, monitoring correspondence and telephone calls to protect the public. It was common ground that George’s placement constituted a deprivation of his liberty but also curtailed his rights to respect for private and family life under Article 8 ECHR.



Issues to be decided: The question was whether the restrictions impacting on George's private life – and therefore his rights under Article 8 ECHR - were lawful. This was a separate question to consideration of his rights under Article 5 ECHR and therefore had to be considered, even though a standard authorisation was in force.

Decision: Although the parties reached agreement in this case, and the judge approved of the order they all sought, Mostyn J gave a written judgment. He noted that the simple fact that George was lawfully deprived of his liberty did not itself authorise restrictions on his right to a private life. But his right to a private life could not be allowed to destroy the purpose of his detention. The example that the judge gave was that of prisoners whose Article 8 rights extend to allowing them to use payphones or write letters but not enjoy conjugal visits. For the restrictions to be "in accordance with the law" the measures had to (1) have a basis in national law (which could include statutory guidance such as the Code of Practice to the MHA 1983); (2) be accessible to the person concerned (i.e. to George); and (3) compatible with the rule of law. Mostyn J noted that, for a person in George's situation, and by contrast with those detained in high security under the MHA 1983, there were no nationally required procedures or safeguards. He endorsed as necessary to secure George's rights under Article 8 ECHR detailed written policies setting out when George's correspondence could be monitored, when his telephone calls could be monitored and when he could be searched. These included oversight by the CQC. Mostyn J stated that in many cases involving deprivation of liberty where there was also an interference with P's Article 8 rights, a one-off order of the Court would be sufficient. But where there is going to be a long-term restrictive regime accompanied by invasive monitoring of the kind to which George was subject, then Mostyn J indicated that policies overseen by the applicable NHS Trust and the CQC are likely to be necessary if serious doubts as to Article 8 compliance are to be avoided.

10. *DM v Doncaster MBC and Secretary of State for Health* [2011] EWHC 3652 (Admin) (Langstaff J)

Facts: Both husband (FM) and wife (DM) were in their 80s and had been married for 63 years. He had dementia and was being detained in a care home pursuant to a DOLS authorisation; she wanted him back home. The care home fees were being paid out of his limited income and their joint savings. His wife brought a claim to recover the fees.

Issues to be decided: Whether by virtue of the DOLS authorisation, the local authority was under a duty to accommodate FM under the MCA 2005 (no power to charge) rather than under s.21 of the National Assistance Act 1948 (duty to charge in s.22, subject to means testing).

Decision: The MCA 2005 did not impose a duty or power on local authorities to accommodate detained care home residents. As the DOLS supervisory body, they were obliged to ensure that the DOLS assessments were carried out, to check whether the six qualifying requirements were made out and, if they were, to grant the requested standard authorisation. They were not obliged to accommodate the person, to arrange for their accommodation, or to pay for it.

Note: this decision is also important for making clear that an authorisation under Schedule A1 does not **require** detention; rather its effect is to authorise a public body to deprive a person of their liberty if the relevant conditions are met.



11. Secretary of State for Justice v (1) RB (2) Lancashire Care NHS Foundation Trust [2011] EWCA Civ 1608 (Court of Appeal (Kay, Arden and Moses LJ))

Facts: RB was 75. He had a persistent delusional disorder. He was detained under ss. 37/41 MHA 1983. RB wanted to be discharged from hospital. There was general agreement that he could be managed in the community, but that he would need to be subject to conditions for the protection of the public. These conditions included residence in a care home, and a condition that he was escorted at all times in the community. There was no dispute that this proposed care regime amounted to a deprivation of his liberty. Despite the diagnosis of mental illness RB had capacity to decide about residence and treatment, and the question of capacity did not arise in this case. The Upper Tribunal granted RB a conditional discharge, setting conditions which had the effect of depriving RB of his liberty in the care home. RB was content with this arrangement but the Secretary of State appealed to the Court of Appeal.

Issues to be decided: The question for the Court of Appeal was whether s.73 MHA 1983 allowed a Mental Health Tribunal to discharge a patient and set conditions which amounted to a deprivation of his or her liberty. The Upper Tribunal had concluded that such a power existed and that the word “discharge” in s73 does not automatically imply “release from detention to a state of liberty.” The Secretary of State disagreed. His argument was that the effect of the Upper Tribunal’s decision was to create a new category of patients detained under the MHA 1983, but where there was no obligation to provide treatment and where the patient had reduced rights to apply to the Tribunal.

Decision: The Court of Appeal noted that any deprivation of liberty must be “in accordance with a procedure prescribed by law” to comply with Article 5(1) ECHR. The original order made under ss.37/41 MHA 1983 authorised detention in hospital only, not detention in another setting. Furthermore a patient who was deprived of his liberty following a conditional discharge could apply to a Tribunal but would not know what test he had to satisfy. The detention would not be in accordance with a procedure prescribed by law. The Court of Appeal held that detention in a care home other than for the purpose of treatment and without appropriate medical treatment being available would be counter to the whole scheme of the MHA 1983. It held that a Tribunal could not rely on the best interests of the patient to order conditional discharge on terms that inevitably amount to deprivation of liberty.

(Note that DOLS could not be used in this case as RB had capacity to consent to being accommodated in the care home, and the restrictions proposed were to protect the public, not RB).

12. Y County Council v ZZ (by his litigation friend the Official Solicitor) [2012] EWCOP B34 (Moor J)

Facts: Mr ZZ was a man of young middle age who had a mild learning disability with some autistic traits. From his twenties onwards he had a history of sexualised behaviour towards children and appeared to be sexually aroused by creating emergency situations (for example fire-setting and criminal damage). In 1999 he was placed under a hospital order (s.37 MHA 1983) following charges of arson. After 18 months he moved into residential care and was placed under guardianship. During his period Mr ZZ met and married another service user at the home where he lived. Between 2006 and 2010 concerns about Mr ZZ’s behaviour escalated. He carried out a serious assault against a member of staff and was moved to another placement in 2006. His wife remained at the



original home and subsequently the relationship between her and Mr ZZ broke down and she moved into independent living. At the new placement Mr ZZ continued to be involved in low level assaults. However, his sexualized behaviour towards children caused even greater concern. He began dropping notes for children with his phone number asking them to contact him, offering money for sexual activity. He would ask to be allowed to go to places where there were likely to be children, such as corner shops. He was noted to be masturbating over children's television programmes. He applied to adopt a child with his wife. At one point ZZ was confronted by the relative of a child who had received a note from ZZ. In September 2010 the situation deteriorated and Mr ZZ was given notice. He was moved to the J. Although it is clear that Mr ZZ was subject to a high level of supervision in his previous placements the J is a locked environment and Mr ZZ was not free to leave and was closely supervised and monitored inside and outside. In summer 2010 Mr ZZ underwent the first sexual offenders treatment plan. He engaged with this but there were concerns he was "going through the motions." The forensic psychologist considered ZZ still had a strong desire for deviant activity with children. After his move to the J home, Mr ZZ was placed under guardianship and a standard authorisation and the local authority made an application to the Court of Protection asking the court to determine whether the deprivation of Mr ZZ's liberty was lawful.

Issues to be decided: whether ZZ was deprived of his liberty and, if he was, whether this was in ZZ's best interests.

Decision: Moor J reminded himself that a standard authorisation under DOLS can run alongside a guardianship order. Whilst the guardianship order was in force, which specified that ZZ should reside at the J home, he did not, as a Court of Protection judge, have jurisdiction to make decisions about ZZ's place of residence. Moor J found that ZZ was deprived of his liberty at the J home. He found that complete and effective control was being exercised over ZZ. The restrictions included being checked hourly, not leaving the J unescorted, using his mobile phone for only one hour a day; and that ZZ was not allowed unsupervised access to the garden as there were children living next door.

Moor J held that he had no doubt that the restrictions upon ZZ were in his best interests. He said "*They are designed to keep him out of mischief, to keep him safe and healthy, to keep others safe, to prevent the sort of situation where the relative of a child wanted to do him serious harm, which I have no doubt was very frightening for him and they are there to prevent him getting into trouble with the police.*"

13. *Commissioner of Police for the Metropolis v ZH* [2013] EWCA Civ 69 (Court of Appeal (Dyson MR, Richards LJ, Black LJ))

This was an appeal by the Metropolitan Police against the decision of Sir Robert Nelson awarding substantial damages to reflect their breaches of common law and the Disability Discrimination Act 1995. Sir Robert Nelson had found [2012] EWHC 604 (Admin) that the police had not only committed the torts of trespass and false imprisonment, but had also breached ZH's rights under Articles 3, 5 and 8 ECHR and also the DDA 1995

Facts: ZH was a severely autistic, epileptic sixteen year old young man who suffered from learning disabilities and could not communicate by speech. In September 2008 he was taken by the specialist school he attended to a swimming pool for a familiarisation visit. During the visit he became fixated by the water and could not be persuaded to move from the side of the pool. After



30 minutes a decision was taken by the manager of the pool to ring the police. The arrival of the police gave rise to an escalating series of events which culminated in ZH jumping into the pool, being forcibly removed from it, being handcuffed, put in leg restraints and placed in a cage in the back of a police van, while still wet, for a period of around 40 minutes. His carers were not permitted to get into the cage to comfort him. ZH suffered consequential psychological trauma and an exacerbation of his epileptic seizures.

Issues to be determined: Whether the circumstances amounted to a deprivation of liberty, as found by Sir Robert Nelson, or merely a restriction on movement.

Decision: The Court of Appeal upheld Sir Robert's decision that ZH had been deprived of his liberty. Lord Dyson noted that the restraint of ZH was "*closely analogous to the classic or paradigm case of detention in a prison or police cell. In particular, it is difficult to see any difference in kind between being detained in the caged area at the back of a police van and being detained in a police cell. In fact, ZH was deprived of movement throughout the entire period of the restraint. The restraint was intense in nature and lasted for approximately 40 minutes and its effects on ZH were serious.*"

Note: In light of the decision in *ZH* it is clear that a person can be subjected to a deprivation of liberty which may only last a relatively short period of time (the restraint whilst he was at the pool-side lasted about 15 minutes and the restraint in the police van lasted about 25 minutes). The decision also makes clear the extent to which the intensity of the restrictions is of significance in determining how long a period of time is 'non-negligible.' See further the discussion at paragraphs 3.29-3.32.

14. *A PCT v LDV, CC and B Healthcare Group* [2013] EWHC 272 (Fam) (Baker J)

Facts: LDV was a former Winterbourne View patient. She was 33 years old and suffered from a mild learning disability and emotionally unstable personality disorder. On 25 May 2012, a tribunal had ordered her discharge from detention under s.3 of the MHA 1983 ('MHA') to take effect on 28 September 2012. It decided that she needed a residential establishment in the community rather than the medium-secure unit. Identifying a suitable community placement was underway and, as a preliminary step, LDV was moved to a hospital closer to home ('WH') in early September 2012.

At around the same time, doctors from the medium-secure unit provided two medical recommendations that she be re-detained under s.3 MHA 1983. However, with no material change in circumstances since the tribunal's decision in May, the Approved Mental Health Professional ('AMHP') concluded that such re-detention would be unlawful and declined to make the s.3 application. As a result, the deferred discharge took effect on 28 September 2012. But LDV remained in WH; now on an informal basis.

During her assessment, the AMHP identified that the restrictions in LDV's care plan seemed to constitute a deprivation of liberty and advised the Primary Care Trust ('PCT') and the hospital trust that an authorisation should be sought through a court order.

LDV was subject to a significant number of restrictions, including as to her ability to leave unaccompanied and to move within the unit. She was also subject to continuous observation (the precise time-frame varying depending upon the level of risk), restraint, searches of her property and person, administration of sedative medication and control over contact with her mother.



On 12 October 2012 an urgent authorisation under Schedule A1 MCA 2005 was granted, and a request for a standard authorisation was made. The best interests assessor concluded that there was indeed a deprivation of liberty but LDV was ineligible to be deprived of her liberty because she was within the scope of the MHA. On 23 October 2012, the PCT therefore made an urgent application to the Court of Protection.

Issue to be determined: (1) Whether LDV's circumstances amounted to a deprivation of liberty; (2) what salient details are relevant to the decision whether to be accommodated in hospital for the purpose of being given relevant care or treatment (i.e. the details that the individual must be able to understand, retain and use/weigh).

Decision: (1) The restrictions included in the care plan objectively amounted to a deprivation of LDV's liberty; (2) On the facts of LDV's case, the salient details were that she was in hospital to receive care and treatment for a mental disorder, and the material liberty-restricting features of that care and treatment plan.

Note: this decision is important not only in the psychiatric context, because in determining the question of whether LDV had the material capacity, Baker J proceeded as if he were considering the capacity requirement in paragraph 15 of Schedule A1 (although he was not, strictly, bound to do so). See further in this regard the discussion at paragraphs 2.17-2.20.

15. *Re M (Best Interests: Deprivation of Liberty)* [2013] EWHC 3456 (COP) (Peter Jackson J)

Facts: This s. 21A MCA 2005 application was brought by M, a 67 year old woman, through her IMCA as her litigation friend, who had been resident in a care home since June 2012. M suffered from diabetes which was poorly controlled and lacked capacity to make decisions about her diabetes management due to her "*inflexible but mistaken belief that she [could] manage her own diabetes*" which resulted in her being unable to weigh up the serious risks to her health that would be posed by returning home, with an inevitable reduction in the level of supervision.

The two options for M's care were continued residence in the care home, or a return home with a "*standard care package*" which involved twice daily visits from district nurses to supervise M's insulin regime, and regular visits each day from carers. Since being at the care home, M's physical condition had improved, but her mental health had worsened. She was being treated for mild depression with antidepressants. She repeatedly and consistently said that she wanted to return home and had said that she would take her own life if that were not allowed to happen. She was still only partially compliant with her insulin regime and refused to eat any food provided by the home.

A psychiatrist commissioned to provide a report to the court under s.49 MCA 2005 took the view that it was in M's best interests to return home despite the risks to her health, and that all options to achieve this had not been fully explored.

The issue to be decided: M's best interests. A return home carried with it a real risk of death as a result of M's diabetes and her non-compliance. Remaining at the care home carried a real risk that M would self-harm because of her strongly held wish to return home.



Decision: it was in M's best interests for the standard authorisation to be terminated. The judge stated that considerable weight had to be attached to M's wishes, bearing in mind that her incapacity extended only to one area of her life – her diabetes management – and that she was otherwise very aware of her circumstances. He summed up the position as follows:

“38. In the end, if M remains confined in a home she is entitled to ask ‘What for?’ The only answer that could be provided at the moment is ‘To keep you alive as long as possible.’ In my view that is not a sufficient answer. The right to life and the state’s obligation to protect it is not absolute and the court must surely have regard to the person’s own assessment of her quality of life. In M’s case there is little to be said for a solution that attempts, without any guarantee of success, to preserve for her a daily life without meaning or happiness and which she, with some justification, regards as insupportable.”

The judge emphasised that the Court of Protection is the place to make the difficult decisions about whether risks are justified.

“41.... my decision implies no criticism whatever of any of the witnesses from the local authority or by the CCG. I understand the position taken and the reasons for it; indeed it would be difficult for them to have taken a different view on the facts of the case. There are risks either way and it is perfectly appropriate that responsibility for the outcome should fall on the shoulders of the court and not on the shoulders of the parties.”

16. *AM v (1) South London and Maudsley NHS Foundation Trust (2) Secretary of State for Health* [2013] UKUT 0365 AAC (Charles J)

Facts: AM was detained under s.2 MHA 1983. She was 78 years old. She applied to the First Tier Tribunal to be discharged. She argued at the hearing that she would remain in hospital informally. The Tribunal did not discharge her from detention, considering that if it did AM's daughter would take her home and would not prevent AM's ongoing treatment, even though AM was content on the ward. AM appealed to the Upper Tribunal and argued that she should be discharged from detention under s.2 by a Tribunal and her treatment in hospital could be continued using the Deprivation of Liberty Safeguards.

Issues to be decided: What approach should be taken by decision-makers (either AMHPs or the First Tier Tribunal) when considering the admission for assessment and/or treatment of a mentally-disordered patient who lacked capacity to consent to admission to hospital.

Decision: Charles J said that, in introducing DOLS, Parliament must have intended to provide an alternative to the MHA 1983 to authorise the detention of an incapacitated person, and that this must have been intended to include occasions where such a person would be detained using DOLS in hospital for mental disorder. Decision-makers under the MHA 1983 (which would include AMHPs and also Tribunals) therefore needed to consider the availability of treatment when a patient's deprivation of liberty was authorised under the DOLS regime.

In such cases, Charles J held, decision-makers should go through the following questions and take into account the following considerations:



- Is admission to hospital required?
- Will P be a mental health patient and if so does he object to all or part of the relevant treatment? If so, he is ineligible for DOLS and the MHA 1983 must be used;
- Does the relevant person have capacity to consent to admission to hospital?
- Can the hospital rely on the provisions of the MCA 2005 to assess and treat the person lawfully? This requires consideration of the likelihood of the person remaining compliant with their treatment (and therefore remain eligible to be deprived of their liberty using DOLS); and also whether there is a risk that cannot sensibly be ignored that the treatment regime will amount to a deprivation of liberty;
- How should the existence of a choice between reliance on the MHA 1983 and the MCA 2005 be taken into account? This involves the FTT (or earlier decision-maker, for example, an AMHP) taking a fact-sensitive approach to try to identify the least restrictive way of best achieving the proposed assessment or treatment. DOLS will not always be less restrictive than detention under the MHA, but may carry less stigma in the eyes of some;
- An AMHP or a Tribunal cannot compel a managing authority to apply for an authorisation or a supervisory body to grant one, so the AMHP or Tribunal needs to know whether those who could implement the MCA/DOLS will do so.

Note: in his judgment, Charles J expressly made clear that his reference in *GJ v The Foundation Trust* [2009] EWHC 2972 (Fam) to the MHA 1983 having ‘primacy’ was not intended to be a general statement.

17. *An NHS Trust v Dr A* [2013] EWHC 2442 (COP) (Baker J)

Facts: Dr A was a fifty year old Iranian whose application for asylum in the UK had been refused. He was detained under s.3 MHA 1983, and was receiving treatment for delusional disorder. But he was also on hunger strike, as part of an attempt to compel the UK Border Agency to return his passport. He was being fed through a naso-gastric tube. Dr A’s mental state improved and the section was rescinded and he remained in hospital informally. A few weeks after this, he removed the nasogastric tube. His physical health deteriorated and reached a life-threatening state. The Trust considered that Dr A lacked capacity to refuse nutrition and hydration and issued an application to the Court. Interim declarations were made allowing him to be fed via the tube. Dr A continued to resist this and was detained under s 3 MHA.

Issues to be decided: (1) Whether Dr A lacked capacity to make decisions about nutrition and hydration; (2) If he lacked capacity to make such decisions, where did his best interests lie; (3) What powers did the court have to direct provision of nutrition and hydration as this would mean depriving Dr A of his liberty?

Decision: Baker J found that Dr A lacked capacity to make decisions about hydration and nutrition and associated treatment, and that it was in his best interests for the Court to make an order permitting forcible feeding. Baker J concluded this treatment could not be carried out under s.63 MHA 1983, which permits treatment under the supervision of the patient’s approved clinician for the mental disorder from which the patient is suffering, without the patient’s consent. This was because the judge was not satisfied that the force-feeding was treatment for the mental disorder from which Dr A was suffering. Instead it was for a physical disorder which resulted from his decision to refuse food.



Because he was detained under s.3 MHA 1983, Dr A was ineligible to be deprived of his liberty either through DOLS or through an order of the Court by operation of Schedule 1A to the MCA 2005. So, if in order to receive the force-feeding it was necessary to deprive Dr A of his liberty, this could not be lawfully authorised and a new “Bournewood Gap” appeared to be opening. Referring to the “ambiguity, obscurity and possible absurdity” of the legislation surrounding DOLS, the judge found himself able to use the inherent jurisdiction to make orders authorising Dr A to be deprived of his liberty in order to receive force-feeding, whilst remaining on s.3 MHA 1983.

Note: the effect of this judgment is to make clear that where a patient is detained under the MHA 1983, requires treatment for a physical disorder which cannot be administered under the provisions of s.63 MHA 1983, and that treatment itself will involve a deprivation of their liberty, an application to the High Court will be required because the fact of the detention under the MHA 1983 means the patient will be ineligible for an authorisation under Schedule A1 or an order of the Court of Protection under s.16(2)(a) MCA 2005.

18. *Re P* [2014] EWHC 1650 (Fam) (Baker J)

Facts: An NHS Trust made an extremely urgent application in the middle of the night for a declaration that it was lawful for its doctors to treat a seventeen-year-old girl following a drug overdose notwithstanding her refusal to consent to that treatment.

Issue to be decided: Whether P had the capacity to make decisions concerning her medical treatment, whether treatment should be administered against her consent, and whether the circumstances of that treatment would amount to a deprivation of her liberty.

Decision: The Court was not satisfied that P lacked capacity to make decisions concerning her medical treatment, but was satisfied that – P being a minor – it could authorise treatment to be administered against her consent. Baker J accepted that it might be necessary in the course of administering life-sustaining treatment – which would have to be administered continuously over a 21 hour period – to sedate or restrain P. He declared that such steps would be lawful notwithstanding the fact that they amounted to a deprivation of liberty.

19. *Liverpool City Council v SG & Ors* [2014] EWCOP 10 (Holman J)

Facts: SG was aged 19, and, whilst arrangements were made to move her into supported living, she continued to be resident in the same children’s home as she was in prior to the age of 18, subject to a regime that indisputably amounted to a deprivation of her liberty. She was the subject of very considerable staffing on a 3:1 basis. The staffing includes monitoring her while she was in the bathroom (ensuring her dignity was maintained at all times), locking the front door as a preventative measure, following, observing and monitoring her on visits into the community, and if she “attempted to leave the staff supporting her, they would follow several paces behind her and attempt to maintain conversation.” Items which could be used for self-harm were removed, and she remained supported 3:1 during the day and 2:1 during the night. She lacked capacity to decide as to her residence and care arrangements.

Issue to be decided: Whether the Court of Protection in light of Guidance issued jointly by the President of the Court of Protection and OFSTED on 12 February 2014 entitled “*Deprivation of Liberty – Guidance for Providers of Children’s Homes and Residential Special Schools*,” had power to make an order which authorised a deprivation of her liberty at the children’s home.



Decision: The Court of Protection has the power to make an order which authorises that a person who is not a child (i.e. who has attained the age of 18) may be deprived of his liberty in premises which are a children's home as defined in section 1(2) of the Care Standards Act 2000 and are subject to the Children's Homes Regulations 2001 (as amended). Further, it is the duty of the person or body, in this case the local authority, who is or are depriving the patient of his liberty, to apply to the court for an authorisation; and, indeed, the duty of the court to make such authorisation as in its discretion and on the facts and in the circumstances of the case it considers appropriate.

Note: See also *Barnsley MBC v GS & Ors* [2014] EWCOP 46, in which Holman J held that the Guidance was wrong in suggesting that a non-secure children's home or a residential school was unable to deprive a child of their liberty; he further held that, in principle, the Court of Protection could authorise the deprivation of liberty of a 16 or 17 year old lacking the material capacity in such a place.

20. *The Mental Health Trust/The Acute Trust & the Council v DD (by her litigation friend the Official Solicitor), BC (Number 1 and Number 2)* [2014] EWCOP 11 and [2014] EWCOP 13 (Cobb J)

Facts: Both these cases concern DD, a 36 year old woman with a mild to borderline learning disability and autism spectrum disorder. At the time of the hearings she was at an advanced stage of pregnancy. She had what the judge described as "an extraordinary and complex obstetric history" and was expecting her sixth baby. DD and BC's wishes were for a home birth without social or health care assistance; DD's five children were all cared for by permanent substitute carers and four of the children had been adopted. DD and BC had completely failed to engage with the Authorities.

Issues to be decided: The Applicants sought declarations and orders in relation to DD's capacity; the care and health of DD during the final stage of her pregnancy, and in the safe delivery of the unborn baby; *authorisation for the deprivation of DD's liberty; the use of restraint (even for a short time) and permission to intrude, by force if necessary, into the privacy and sanctity of her home.*

Decision: (I) she lacked capacity to litigate the application in so far as it relates to the delivery of her baby; and that (ii) she lacked the capacity to make a decision about the mode of delivery of her unborn baby. (2) It was in DD's best interests to authorise the caesarean and associated actions (which included forced entry into her home, restraint and sedation).

The judge authorised the necessary steps to deprive DD of her liberty but set out in his judgment a number of restrictions:

"Any physical restraint or deprivation of liberty is a significant interference with DD's rights under Articles 5 and Article 8 of the ECHR and, in my judgment, as such should only be carried out:

- i by professionals who have received training in the relevant techniques and who have reviewed the individual plan for DD;*
- ii as a last resort and where less restrictive alternatives, such as verbal de-escalation and distraction techniques, have failed and only when it is necessary to do so;*
- iii in the least restrictive manner, proportionate to achieving the aim, for the shortest period possible;*
- iv in accordance with any agreed Care Plans, Risk Assessments and Court Orders."*



21. *NHS Trust & Ors v FG* [2014] EWCOP 30 (Keehan J)

Facts: At the time of the application FG was 24 years old and she was in the late stages of her first pregnancy. She had been diagnosed with a schizoaffective disorder and was detained at Hospital under s 3 MHA 1983. FG suffered from persecutory delusions that included a belief that the mental health services were ‘murderers’ and would murder her and her unborn child. The plans for the delivery of the child included plans for FG’s transfer from Trust 1 to the maternity unit in Trust 2, plans for her to receive obstetric, midwifery and anaesthetic care and for her to be returned to Trust 1.

Issues to be decided: Whether the proposed plan for FG’s transfer and obstetric care was in her best interests. In the event that the court decided that the proposed plan for her transfer and care was in her best interests, the Trusts sought authorisation for the proposed transfer and orders that it was lawful for their staff to use reasonable and proportionate measures to carry out the plans including those which involved physical or medical restraint and a deprivation of liberty.

Decision: (1) Keehan J was satisfied that the orders sought by the Trusts in respect of her medical treatment were in her best interests and (2) he made orders accordingly, including orders in relation to physical or medical restraint and deprivation of FG’s liberty. In the course of his judgment Keehan J gave detailed guidance, attached as an annex to the judgment, on the steps to be taken when a local authority and/or medical professionals are concerned about and dealing with a pregnant woman who has mental health problems and, potentially lacks capacity to litigate and to make decisions about her welfare or medical treatment.

Note: This judgment is important because Keehan J confirmed that the acid test applies in the acute setting. Keehan J observed at paragraph 96 that:

“It will commonly be the case that when at the acute hospital P:

- i will have obstetric and midwifery staff constantly present throughout her labour and delivery;*
- ii will be under the continuous control of obstetric and midwifery staff who, because she lacks capacity to make decisions about her medical case, will take decisions on her behalf in her best interests;*
- iii will often not be permitted to leave the delivery suite.*

Those factors may, when applying the acid test, lead to a conclusion that P is or will suffer a deprivation of her liberty when at the acute hospital. If the Trusts are to deprive P of her liberty, they have a duty not to do so unlawfully.”

22. *Re AJ (Deprivation of Liberty Safeguards)* [2015] EWCOP 5 (Baker J)

Facts: An elderly lady, AJ, had lived for a considerable period of time in an annexe of the home of her niece and her husband (‘Mr and Mrs C’). She developed vascular dementia and became increasingly dependent on others, in particular Mrs C. In agreement with the relevant local authority, she was taken to a care home by Mr and Mrs C purportedly for respite but, in fact, on the basis that she was to be permanently cared for there if she settled. Mr C was appointed as her unpaid RPR, and a s.39D IMCA was appointed. AJ was objecting to her presence at the care home she was initially placed at, and then the care home she was moved to shortly thereafter, for several



months before her RPR ultimately brought proceedings on her behalf in the Court of Protection under s.21A MCA 2005.

Issues to be decided: Whether the local authority had breached AJ's rights under Articles 5(1), 5(4) and 8 ECHR in failing to take appropriate steps to ensure that the deprivation of her liberty had been suitably authorised in advance and she had been supported to bring a challenge to that authorisation.

Decision: In concluding that AJ's ECHR rights had been breached, Baker J gave wider guidance, which can be summarised thus. (1) In the vast majority of cases, it should be possible to plan in advance so that a standard authorisation can be obtained before the deprivation of liberty begins. It is only in exceptional cases, where the need for the deprivation of liberty is so urgent that it is in the best interests of the person for it to begin while the application is being considered, that a standard authorisation need not be sought before the deprivation begins. (2) Professionals need to be on their guard to look out for cases where vulnerable people are admitted to residential care ostensibly for respite when the underlying plan is for a permanent placement without proper consideration as to their Article 5 rights. (3) It is likely to be difficult for a close relative or friend who believes that it is in P's best interests to move into residential care, and has been actively involved in arranging such a move, into a placement that involves a deprivation of liberty, to fulfil the functions of RPR, which involve making a challenge to any authorisation of that deprivation. (4) The appointment of a RPR and IMCA does not absolve the local authority from responsibility for ensuring that P's Article 5 rights are respected. The local authority must monitor whether the RPR is representing and supporting P in accordance with his statutory duty. (5) The local authority must make sufficient resources available to assist an IMCA and keep in touch with the IMCA to ensure that all reasonable steps are being taken to pursue P's Article 5 rights. (6) In circumstances where a RPR and an IMCA have failed to take sufficient steps to challenge the authorisation, the local authority should consider bringing the matter before the court itself. This is likely, however, to be a last resort since in most cases P's Article 5 rights should be protected by the combined efforts of a properly selected and appointed RPR and an IMCA carrying out their duties with appropriate expedition.

Note also that Baker J emphasised the importance of properly recording of the use of physical restraint of incapacitated adults in their care plans and documenting such use in the assessment of whether an authorisation under Schedule A1 should be granted.

CASES WITH HEALTH WARNINGS

1. *DH NHS Foundation Trust v PS* [2010] EWHC 1217 (Fam) (Sir Nicholas Wall P)

Facts: PS was 55. Evidence was accepted that she lacked the capacity to make decisions about her healthcare and treatment. She also lacked the capacity to conduct or defend proceedings. PS had cancer of the uterus. The treating doctors were of the opinion that she required a hysterectomy and removal of the fallopian tube and ovaries. PS also suffered from needle phobia. The clinical team treating her came to the conclusion that special arrangements would need to be put in place both to ensure that she had the operation and that she remained in hospital for her post-operative recovery. Such arrangements included sedation if necessary in order to convey her to hospital, the administration of anaesthetic during the operation, and post operatively analgesic with a sedative effect, close supervision and the use of force (as a last resort) to stop her absconding.

Issues to be decided: (1) whether it was in her best interests to undergo the proposed operation; and (2) whether it was in her best interests to sedate PS and if necessary for force to be used in order to convey her to hospital, to administer the anaesthetic (because of her needle phobia) and to detain PS in hospital during the period of post-operative recovery.

Decision: (1) It was in PS's best interest to undergo a hysterectomy and removal of the fallopian tubes and ovaries. (2) it was necessary and in PS's best interests to use sedation and force, if required, to convey PS to hospital, during the operation and to detain her in hospital post operatively.

Health Warning: Sir Nicholas Wall P appeared on the face of the judgment to have come to the view that it was not necessary to invoke the provisions of Schedule A1 to the MCA 2005 because it was necessary for P to have the operation and therefore there was no deprivation of liberty. It is our view following on from the decision in *Cheshire West* that the planned sedation and restraint during the transfer to hospital, and during the administration of the anaesthetic for the operation itself, and the arrangements post operatively, would now be likely to be held to meet the acid test and to be a deprivation of PS's liberty requiring authorisation.

2. *Re A and Re C* [2010] EWHC 978 (Fam) (Munby J)

Facts: A and C were both female. A was born in 2001 (and therefore a child), and C was born in 1987 (and was an adult). Both suffered from a rare genetic disorder called Smith Magenis Syndrome, characterised by "self-injurious behaviour, physical and verbal aggression, temper tantrums, destructive behaviour, hyperactivity, restlessness, excitability, distractibility and severe sleep disturbances, which include frequent and prolonged night waking and early morning waking." Both lived at home "in the exemplary and devoted care of their parents" in the area of the same local authority. The only way that their parents could keep them safe at night was by locking their bedroom doors.

Issues to be decided: Whether the circumstances amounted to a deprivation of liberty, engaging Article 5 of the ECHR and, if so, what (if any) role the local authority had in such cases.

Decision: (1) The State was not directly involved in either of the cases. The local authority was providing support services only. It was not directly involved in what happened in the home of



either person. It was not the decision-maker. Mere knowledge was not enough, although this might trigger a duty to investigate and seek judicial assistance. Accordingly, the local authority could not be in breach of Article 5 ECHR in these cases even if a deprivation of liberty had occurred. (2) Neither A nor C were deprived of their liberty. Following the reasoning of Parker J at first instance in *MIG and MEG*, Munby J decided that a loving, caring, proportionate and appropriate regime by devoted parents in a loving family relationship whose objective was solely “*the welfare, happiness and best interests of A and C respectively – fell significantly short of anything that would engage Art 5.*” He decided that the restrictions imposed were not to restrict their liberty but to maximise their opportunities and help them to lead their lives to the full. This amounted to an appropriate and proportionate restriction upon liberty, not a deprivation of liberty.

Accordingly as there was no deprivation of liberty, there was no need to decide whether it could be justified as an Article 5 compliant exercise of parental responsibility in respect of A.

Health Warning: We consider that it is unlikely that the approach adopted to the question of whether A and C were deprived of their liberty would be the same now, post *Cheshire West*. However, the outcome could well be the same since it seems unlikely on the facts that any such deprivation of liberty would be imputable to the State (or, if it was, that the State could have been required to do anything more than it did by way of bringing the matter to court).

3. *R (Sessay) v South London and the Maudsley NHS Foundation Trust* [2011] EWHC 2617 (QB) (Divisional Court (Pitchford LJ and Supperstone JJ))

Facts: Ms Sessay was removed from her home by the police following concerns about her welfare and ability to care for her child. She was taken to the s.136 MHA 1983 suite at SLAM’s hospital where she was held for thirteen hours before a decision was made to admit her under s.2 MHA 1983. At least some of the Trust staff at the s.136 suite were under the impression that she had been brought to the suite under s. 136 but this was incorrect. The Trust policy was that the maximum time any patient should be held in the s136 suite should not exceed 8 hours and the aim was for the patient to remain there not more than four hours. Had the Trust been aware that Ms Sessay was not detained under s135 or s136 her admission might have been progressed more quickly.

Issues to be decided: (1) whether Ms Sessay was deprived of her liberty pending the decision to admit her under s.2 MHA 1983; (2) whether there was any authority for detention during this period; (3) whether the Trust could rely on the common law doctrine of necessity.

Decision: Ms Sessay had been detained under the common law, without lawful authority during the thirteen hour period. The court held that not all cases of false imprisonment would also involve a deprivation of liberty for the purpose of Article 5 because of the requirement that the detention had been for “a not negligible length of time”: but in the circumstances of this case the cumulative effect of the Trust’s actions had been to deprive Ms Sessay of her liberty under Article 5 ECHR as well. The MHA 1983 provided a complete statutory framework for the detention of incapacitated people in hospital for care and treatment and its powers could have been used in this case. The Trust could not rely on the common law doctrine of necessity to detain her.

The court observed that in the normal course of events Article 5 would not have been engaged (nor would she have been imprisoned for purposes of the common law) had Ms Sessay’s admission been dealt with within the four to eight hours specified by the Trust’s policy.



Health warning: Whilst we are of the view (see paragraph 3.27) that regard will be had to the context in which measures are imposed when determining whether the length over which they are imposed will be considered 'non-negligible,' the observation made by the Divisional Court in relation to the Trust's policy was made on the basis of authority from the European Court of Human rights relating to purpose that the ECtHR has now said should not be followed. It may very well be that a court considering the question now would still reach the same conclusion, but may do on the basis of slightly different reasoning.

4. *C v Blackburn with Darwen Borough Council and others* [2011] EWHC 3321 (COP) (Peter Jackson J)

Facts: C was 45 at the time of the judgment. He had a learning disability and lacked capacity to make decisions about where to live. He had a history of aggression, self-harm, and impulsive behaviour such as running into traffic. After a period of time detained under the MHA he went abroad and on return he was admitted to a care home. He was then received into guardianship and, following an incident when he kicked down a door, a standard authorisation under DOLS was granted. C appealed against the authorisation to the Court of Protection. The First Tier Tribunal refused his application to be discharged from guardianship. During the hearing in the Court of Protection, C told the judge that he wanted to go somewhere else and that being in the care home caused him a lot of stress.

Issues to be decided: (1) whether C was ineligible for DOLS; (2) whether C was deprived of his liberty; (3) whether the regime at the care home was necessary; (4) the relationship between the guardianship order and DOLS.

Decision: C was not ineligible for the use of DOLS; however, the judge found that he was not deprived of his liberty and the standard authorisation was set aside. In coming to this conclusion the judge relied on the decision of the Court of Appeal in *Cheshire West*. A particular feature in this case was that although C was unhappy at the care home and wanted to live somewhere else, there was no alternative available. The restrictions on his liberty were necessary for his safety and that of others.

Peter Jackson J held that the Court of Protection does not have the power to determine C's place of residence while the guardianship order was in effect. However, he held, genuinely disputed issues about the residence of an incapacitated adult should be determined by the Court of Protection. In this case there was a question about whether the use of guardianship was the right vehicle to determine where C should live. The judge invited the local authority, who was the guardian, to consider renouncing its role so the court could make decisions about C's welfare.

Health warning: We consider that a court considering these facts now would most probably conclude that C was deprived of his liberty following the decision of the Supreme Court in *Cheshire West*. Importantly, that C had nowhere else to go is not relevant (see paragraph 3.21.3). However the judge's comments about the use of guardianship hold good and should be followed (they are also consistent with the approach taken by the Upper Tribunal in *NL v Hampshire County Council* ([2014] UKUT 475 (AAC)), a decision expressly considering the effect of the Supreme Court decision on guardianship, in which Upper Tribunal Judge Jacobs held that the operation of guardianship does not, itself give rise to ad deprivation of liberty).

5. *CC v KK* [2012] EWHC 2136 (COP) (Baker J)

Facts: KK was an 82-year old woman with Parkinson's Disease, vascular dementia, and paralysis down her left side. Following the death of her husband, she moved and settled in a rented bungalow. However, incapacity and best interests determinations had resulted in her being placed in a nursing home between July and October 2010 and from July 2011. Her deprivation of liberty was authorised under Schedule A1 of the MCA from 12 August 2011 which she challenged under s.21 MCA on 2 September 2011. Trial home visits commenced in November 2011 and subsequent requests for DOLS authorisations under Schedule A1 were refused on the basis that there was no deprivation of liberty. The s.21A challenge was dismissed and interim declarations granted as to her incapacity and best interests. By the time of the final hearing in May 2012, she was having daily home visits.

Issues to be decided: (1) whether KK had capacity to make decisions about her residence and care, and (2) whether she had been, and or was being, deprived of her liberty.

Decision: (1) KK had capacity to make decisions about her residence; and (2) she had not been, and was not being, deprived of her liberty because despite the staff exercising a large measure of control over KK's care and movements and KK objecting strongly to her residence, the arrangements for her care could not be described as one of "continuous control."

Health Warning: This decision was arrived at while the Supreme Court's decision in *Cheshire West* was awaited. Baker J was therefore bound by the decision of the Court of Appeal, but we consider it clear from the facts that KK was under complete/continuous supervision control and was not free to leave, such that she would be found (applying the approach in *Cheshire West*) objectively to be deprived of her liberty.

6. *Rochdale MBC v KW* [2014] EWCOP 45 (Mostyn J)

Facts: A 52 year old woman, KW, was cared for in own home. As a result of a subarachnoid haemorrhage sustained during a medical operation many years previously, she had cognitive and mental health problems, epilepsy and physical disability. She was cared for in her own home with a package of 24/7 care funded jointly by Rochdale MBC and the local CCG.

Issue to be decided: Whether KW was deprived of her liberty.

Decision: Mostyn J held that she was not deprived of her liberty because she was "*not in any realistic way being constrained from exercising the freedom to leave, in the required sense, for the essential reason that she does not have the physical or mental ability to exercise that freedom.*" Mostyn J made it very clear that he considered that the Supreme Court had adopted the wrong approach in *Cheshire West* and that the issue of deprivation of liberty should be revisited by that Court.

Health warning: KW's appeal against the decision was allowed by consent by the Court of Appeal in February 2015 (without any judgment). As discussed in Chapter 3, the conclusions reached by Mostyn J in this judgment are not compatible with the reasoning of the majority in *Cheshire West* and should not be followed.



7. The decisions of the lower courts in the Cheshire West cases (apart from the decision of Baker J in Mr P's case)

The judgment of Baker J in Mr P's case ([\[2011\] EWHC 1330 \(COP\)](#)) was held by the Supreme Court to have been correct on the law and on the facts.² However, the decision of the Court of Appeal ([\[2011\] EWCA Civ 1257](#)) was overturned by the Supreme Court and should not be followed. The facts of Mr P's case are given at paragraphs 2.24-2.25.

The decisions of Parker J in P and Q ([\[2010\] EWHC 785 \(COP\)](#)) and of the Court of Appeal in the same case (known as MIG and MEG) ([\[2011\] EWCA Civ 190](#)) should not be followed as they were overturned by the Supreme Court. The facts of P and Q are given at paragraphs 2.26-2.28.

² Although the minority made clear that they might have reached a different conclusion if they had been considering his situation for themselves.

A: Cheshire West and its implications

- *Cheshire West* judgment, available on [Bailii](#)ⁱ

Official guidance

- Department of Health [Guidance](#)ⁱ on the obligations of local authorities following the decision in *Cheshire West* (28 March 2014)
- Department of Health [Guidance](#)ⁱⁱⁱ on reducing the use of restrictive practices, inter alia in health care settings, issued by Department of Health (April 2014)
- Care Quality Commission [briefing](#)^{iv} for providers in health and social care settings (updated April 2014)
- The [letter](#)^v from Niall Fry of the Department of Health to MCA DOLS leads addressing the initiatives that are in place to address the impact of the Supreme Court decision (September 2014)
- ADASS [Advice Note](#)^{vi}: “Guidance for Local Authorities in the light of the Supreme Court decisions on deprivation of liberty” (November 2014)
- The [letter](#)^{vii} from Niall Fry of the Department of Health to MCA DOLS leads addressing, amongst other things, palliative care and unconsciousness (January 2015)
- The [letter](#)^{viii} from the Chief Social Worker, Lyn Romeo, on the MCA 2005 and the vital role of social workers (January 2015)

Commentary

- [P, P and Q: The key to the gilded cage](#)^{ix} - a video featuring Jenni Richards QC, Fenella Morris QC, Nicola Greaney and Ben Tankel, all of Thirty Nine Essex Street (March 2014)
- [P v Cheshire West and Chester Council – Supreme Court decision – March 2014](#)^x - a webinar produced by Ben Troke of Browne Jacobson (March 2014)
- “*Psychiatry and the Law: An enduring interest for Lord Rodger*”: The Lord Rodger Memorial Lecture 2014, a [speech](#)^{xi} given by Lady Hale in October 2014, which includes a very interesting discussion of the judgment.

Particular practice areas

- [Deprivation of liberty in the hospital setting](#)^{xii}: a paper written by Alex Ruck Keene and Catherine Dobson of 39 Essex Chambers, which considers the law relating to deprivation of liberty in the hospital setting, including what it takes to have capacity to consent to such a deprivation of liberty, and whether the MCA 2005 or the MHA 1983 will apply (March 2015)
- [Mental Capacity Act - Update following P v Cheshire West and P & Q v Surrey County Council cases](#)^{xiii}: a paper focusing on the impact of the decision for psychiatrists and AMHPs by Julie Chalmers, Specialist Advisor in Mental Health Law to the Royal College of Psychiatrists (April 2014)
- [Guidance](#)^{xiv} from the Intensive Care Society as to the implications of the decision in the intensive care setting (October 2014)

¹ All hyperlinks are given in full in the endnotes to this chapter for those who have printed it out.

B: Changes to the procedures for the authorisation of deprivation of liberty

DOLS

- ADASS's [new forms](#)^{xv} for applications for DOLS authorisations (January 2015). These also include a new form (28) for notifying a Coroner of a death of a person subject to an authorisation.

Re X

- The [first](#)^{xvi} and [second](#)^{xvii} judgments of the President of the Court of Protection setting out the outlines of the 'streamlined' court authorised DOL process, in particular for supported living and DOL in a person's own home. NB, these are under appeal to the Court of Appeal, the hearing being in February 2015, and judgment being awaited at the time of writing.

Re X process

- [Practice Direction: 10AA: Deprivation of Liberty applications](#)^{xviii} (note, the material paragraphs for these purposes are paragraphs 27 and onwards). Even though this is still called Practice Direction 10AA, it now contains both the procedures for an appeal against a DOLS authorisation as well as the procedures for the Court's handling of applications under the Re X cases.
- COP DOL10 [form](#)^{xix} and unofficial [Word version](#)^{xx}
- Model [order](#)^{xxi} (in Word)
- A [guide](#)^{xxii} to Re X applications written by members of the 39 Essex Chambers Court of Protection team

C: Other resources relating to deprivation of liberty

- DOLS [Code of Practice](#)^{xxiii} (though Chapter 2 must now be read subject to the cases decided since the Guide was written – see paragraphs 2.59-2.61 of the main body of this guidance)
- For procedures to resolve issues between local authorities as to which local authority is responsible for a DOLS authorisation, see ADASS [Protocol for inter authority management of DOLS applications](#)^{xxiv} (November 2009). Note this that does not reflect the changes that came into force in April 2013 in England with the abolition of PCTs.
- The Chief Coroner's [Guidance](#)^{xxv} on Deprivation of Liberty safeguards

D: Other free legal resources^{xxvi}

Website	Contents
www.bailii.org	British and Irish Legal Information Institute: transcripts of judgments including increasing numbers of decisions of the Court of Protection and older judgments accessible in the Family Division area.
www.copcasesonline.com	Site maintained by 39 Essex Chambers with searchable database of cases relating to mental capacity law, as well as back issues of newsletter (available for free on a monthly basis. To be added to the mailing list email: marketing@39essex.com)
www.courtsofprotectionhandbook.com	A free site accompanying the Court of Protection Handbook (Legal Action 2014) with links to relevant statutory material and updates on practice and procedure cross-referenced to the book.
www.gardensocial.co.uk	Garden Court Chambers has a website and newsletter dedicated to social welfare, including community care, mental health and incapacity issues.
www.gov.uk/apply-to-the-court-of-protection http://hmctsformfinder.justice.gov.uk/HMCTS/GetForms.do?court_forms_category=court_of_protection	Contains all the Court of Protection forms and current details as to fees
www.judiciary.gov.uk/publication-type/practice-directions/ https://www.justice.gov.uk/courts/rcj-rolls-building/court-of-protection	Contains Practice Directions and Court of Protection Rules
http://hmctsformfinder.justice.gov.uk/courtfinder/forms/cop042-eng.pdf	A booklet giving guidance on applying to the Court of Protection
www.justice.gov.uk/about/opg	A useful guide to LPAs and deputyship which can be of assistance when trying to assess what powers (if any) an attorney or deputy has in relation to deprivation of liberty
http://www.law.manchester.ac.uk/medialibrary/Main%20site/LAC/Acting-as-a-Litigation-Friend-in-the-Court-of-Protection-October-2014.pdf	Guidance commissioned by the Department of Health for IMCAs, RPRs and others considering acting as a litigation friend in the Court of Protection; includes a guide to welfare proceedings in the Court of Protection written for the benefit of non-lawyers.



Website	Contents
www.mentalhealthlawonline.co.uk	Extensive site containing legislation, case transcripts and other useful material relating to both the Mental Capacity Act 2005 and Mental Health Act 1983. It has transcripts for more Court of Protection cases than any other site (including subscription-only sites).

E: Other useful free resources related to mental capacity law

Website	Contents
www.scie.org.uk	The Social Care Institute for Excellence website includes good practice guidance in a number of areas relating to mental capacity and related law. It also includes a directory of mental capacity resources.
www.mclap.org.uk	A website maintained by Alex Ruck Keene dedicated to improving understanding of the law and practice in the field of mental capacity law, including articles, papers and other resources on the MCA 2005 and discussion forums.
http://thesmallplaces.wordpress.com	Blog site maintained by Lucy Series, socio-legal researcher and expert commentator upon the Court of Protection.
www.communitycare.co.uk	Online magazine dedicated to community care matters, which frequently includes useful stories relating to the MCA 2005.

- i <http://www.bailii.org/uk/cases/UKSC/2014/19.html>
- ii http://www.39essex.com/docs/newsletters/dh_letter_re_supreme_court_dols_judgment_final_28_march_2014.pdf
- iii https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300293/JRA_DoH_Guidance_on_RP_web_accessible.pdf
- iv http://www.cqc.org.uk/sites/default/files/20140416_supreme_court_judgment_on_deprivation_of_liberty_briefing_v2.pdf
- v <http://www.mentalcapacitylawandpolicy.org.uk/wp-content/uploads/2014/09/DH-Letter-to-MCA-DoLS-Leads-September-2014.pdf>
- vi http://adass.org.uk/uploadedFiles/adass_content/policy_networks/mental_health/key_documents/DoLS%20Guidance%20note%20November%202014.pdf
- vii <http://www.mentalcapacitylawandpolicy.org.uk/wp-content/uploads/2014/04/DH-Letter-to-MCA-DoLS-Leads-14-January-2015-FINAL.pdf>
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Practitioner Group

The authors would like to express their gratitude to the Practitioner Group, whose advice and oversight throughout the production of this guidance was invaluable:

- Sue Adams, Conwy County Council
- Dr Julie Chalmers, Royal College of Psychiatrists (Dr Chalmers also coordinated input from the following psychiatrists: Dr Rajnish Attavar, Dr Gwen Adshead, Dr Mayura Deshpande, Dr Marinos Kriakopoulos, Dr Hetal Mehta, Dr Richard Latham, Dr Mark Scheepers and Dr Adran Treloar)
- Lorraine Currie, Shropshire County Council
- Dr Chris Danbury, Intensive Care Society and Royal Berkshire Hospital
- Julian Sheather, British Medical Association



Acknowledgements

The authors would also like to thank the following individuals for their invaluable comments upon chapters in drafts of the Guidance and/or other practical input:

- Dr Dominic Bell, Consultant in Intensive Care, Leeds General Infirmary
- Dr Tim Exworthy, Member of the Law Society's Mental Health and Disability Committee and Clinical Director
& Consultant Forensic Psychiatrist, St Andrew's Healthcare
- Sue Garwood, Independent Consultant and Extra Care Specialist
- Camilla Parker, Member of the Law Society's Mental Health and Disability Committee and director,
Just Equality
- Ben Troke, Partner, Browne Jacobson Solicitors



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