The Law Society

Identifying a deprivation of liberty: a practical guide

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[Author]

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1. Introduction

A: Introduction

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.

1.2 The State is under an obligation to make sure that there is lawful authority for such deprivation of liberty, whether it arises in the context of care and treatment being delivered by social care or health professionals, or where such professionals are or should be aware that care and treatment being delivered by private individuals gives rise to a potential deprivation of liberty.

1.3 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]

1.4 By way of amendments to the Mental Capacity Act 2005 ('the MCA'),[2] 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. The DOLS only applied to those in care homes and hospitals, and those aged over 18. However, the 2014 decision of the Supreme Court in *P v Cheshire West and Chester Council* and *P & Q v Surrey County Council*[3] made clear

[1] Separately, some may well be aware of the debates around how the United Kingdom is to discharge its obligations under the UN Convention on the Rights of Persons with Disabilities, including the obligation under Article 14 to secure the right to liberty on an equal basis for disabled people. The obligations imposed by the CRPD do not form part of English law, so cannot be relied upon directly before English courts; it is for that reason that we do not discuss the CRPD further here. Those wanting more on the implications of the CRPD are directed to Annex B of the report of the Independent Review of the Mental Health Act 1983, published in December 2018.
[2] Introducing new sections to the main body of the Act, but in particular adding Schedules 1A and A1.
[3] [2014] UKSC 19.

that the concept of deprivation of liberty was a much broader one than had been understood at the point that the DOLS were brought into force.

1.5 In 2015, guidance was commissioned from the Law Society by the then-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 arrangements. Its purpose was to provide practical assistance in identifying whether they are or may be deprived of their liberty, and hence to ensure that appropriate steps could be taken to secure their rights under Article 5 ECHR. The guidance was published in 2015 as *Identifying a deprivation of liberty: a practical guide*.

B: Why this new edition of guidance has been produced

1.6 Since the publication of the guidance in 2015, there have been important developments in the law relating to deprivation of liberty, including, in particular, clarification of the position of those under 18 and also those in receipt of life-sustaining medical treatment. For several years, it had been anticipated that these developments would be reflected in an updated version of the statutory Code of Practice: in other words, in guidance approved by Parliament.

1.1 However, with the announcement of an indefinite delay to the implementation of the Liberty Protection Safeguards ('LPS') in April 2023, there is no prospect of an updated version of the Code being published to accompany the LPS during the course of this parliament. Nor is there any immediate prospect of the current Code of Practice accompanying DOLS being updated. Chapter 2 of that Code provides some guidance to identify a deprivation of liberty, but it pre-dates Cheshire West and is therefore significantly out of date.

1.2 The Law Society has therefore produced a new edition of its 2015 guidance,[4] seeking 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 liberty. We also thank those individuals who provided ad hoc input on specific chapters to ensure that they reflect practical realities.[5]

C: The draft Code accompanying the LPS

1.3 In conjunction with the abortive moves towards implementation of the LPS, the Department of Health and Social Care published a draft updated version of the Code of Practice to the Mental Capacity Act, which combined sections relating to the main body of the Act, and sections relating to the LPS.[6] Chapter 12 of that draft Code contained detailed discussion of the Department's view of the meaning of deprivation of liberty. That part of the draft Code is not being taken forward, and we do not draw upon it here for three reasons:

1.3.1 It would only be if draft Chapter 12 were finalised and laid before Parliament that it would have statutory weight (requiring professionals to have regard to it – see further paragraph 1.10). At present, it has no formal weight, nor has it been considered by a court in any reported judgment of which we are aware;

1.3.2 It is not possible for a Code of Practice to create the law, as opposed to reflect what the law says.[7] The law here – for instance, the definition of who is to be considered to be deprived of their liberty – has been set down by the Supreme Court, reflecting the case-law of the European Court of Human Rights. We harbour considerable doubts about the extent to which the draft of Chapter 12 accurately reflects the domestic and European case-law. We

[4] Which has therefore been superseded, but an archive copy will be available at:www.lawsociety.org.uk/topics/private-client/guides/deprivation-of-liberty-safeguards-a-practical-guide-september-2019.
[5] Full details of the authors and other acknowledgments can be found in the Appendix.
[6] Available at https://www.gov.uk/government/consultations/changes-to-the-mca-code-of-practice-and-implementation-of-the-lps.
[7] See the decision of Hayden J in *Re Lawson, Mottram and Hopton (appointment of personal welfare deputies)* [2019] EWCOP 22 at paragraph 16, and *An NHS Trust v Y* [2018] UKSC 46 at paragraph 97.

note that concerns were referred to by Welsh Government in its summary of responses to the consultation carried out in Wales on ancillary matters relating to the LPS;[8]

1.3.3 Following the very much narrower approach suggested in draft Chapter 12 would both expose public authorities to liability for failing to take appropriate steps to secure the rights to liberty of those with impaired decision-making capacity, and, more seriously, leave those individuals without the protections afforded them by Article 5 ECHR.

D: Status of this guidance

1.4 Whilst this guidance can be seen as an informal update to the DOLS Code, it 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.[9]

E: Audience for the guidance

1.5 Whilst we anticipate that some of those who will read this 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.

[8] Published in June 2023, and available here: https://www.gov.wales/sites/default/files/consultations/2023-06/summary-responses.pdf: see page 59 ff.

[9] 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 2.65-2.66.

F: Outline of the guidance

1.6 This guidance is divided into chapters as follows:

Part I: Overview
Chapter 1: Introduction

Chapter 2: The law

Chapter 3: Four key factors in applying the 'acid test'

Chapter 4: Children and young people aged under 18

Part II: Specific settings
Chapter 5: Deprivation of liberty in hospital

Chapter 6: The psychiatric setting

Chapter 7: The care home setting

Chapter 8: Supported living services, shared lives schemes and extra care housing

Chapter 9: Deprivation of liberty at home

Chapter 10: The hospice and palliative setting

Part III: Furher information
Chapter 11: Further resources

Appendix: Note on authors and acknowledgments

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

G: How to use this guidance

1.8 In Part II, we detail the most common settings in which a deprivation of liberty may occur. For each, we:

1.8.1 Identify factors that may point towards there being a deprivation of liberty. 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;

1.8.2 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);

1.8.3 Pose questions that professionals can ask to identify which side of the line a specific situation confronting them may fall.

1.9 It is important to emphasise that:

1.9.1 The test for considering whether authorisation is required is never whether the professional is **certain** that there is a deprivation of liberty, but rather where there is a **risk** of a deprivation of liberty.[10] If there is such a risk, that should trigger further assessment;

1.9.2 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 on similar facts;

[10] 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).

1.9.3 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 or situations they should stop and think very carefully about whether or not they may represent a deprivation of liberty (and, if necessary, seek legal advice);

1.9.4 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 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;

1.9.5 Even if the line is not crossed, and the person is 'only' subject to a restriction on their liberty, this is not something which can simply be taken lightly.[11]

H: Limits of the guidance

1.10 The courts have now decided in broad terms how the concept of deprivation of liberty applies to a very wide range of contexts with which health or social care professionals may be concerned. However, as we identify in a number of places here, there are still areas which have yet to be examined in reported cases.[12] This means that there are of necessity areas where any guidance is tentative. And in all cases, it is always necessary to look at exactly what is going on to reach a conclusion about whether the person is or may be deprived of their liberty.

[11] See (in England) the Care Quality Commission's 2023 policy on restrictive practices, which addresses matters either side of the deprivation of liberty line: https://carequalitycomm.medium.com/restrictive-practice-a-failure-of-person-centred-care-planning-b9ab188296cf#:~:text=CQC%20policy%20position%20on%20restrictive%20practice&text=They%20must%20listen%20to%20and,use%20of%20any%20restrictive%20practice.

[12] The guidance is based upon the law as it stands in January 2024; at chapter 11 we provide useful resources which can be used to keep to up to date.

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

1.11.1 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 2.43-2.44, 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;

1.11.2 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,[13] are sufficiently different that space precludes consideration of these jurisdictions. It may nonetheless be useful for frontline professionals who are or may be confronted with the same questions as their counterparts in England and Wales;

1.11.3 For the most part, this guidance is concerned with those over the age of 16 who lack the capacity to make decisions about being accommodated for care and treatment, and hence who fall within the scope of the Mental Capacity Act 2005 ('MCA 2005'). Therefore, in general, when we use terms such as best interests, we are using those terms as they are defined in the MCA 2005. However, in Chapter 4, we also explore the position of those to whom the MCA 2005 does not apply, either because they are aged 16 or 17 and do not lack the relevant decision-making capacity, or because they are under 16.

1.11.4 This guidance does not constitute legal advice, which must be sought – if necessary – on the facts of any specific individual case. We should emphasise that if a situation warrants legal advice there is rarely any benefit, and often great harm, from delay in obtaining or acting on that.

[13] The Mental Capacity Act (Northern Ireland) 2016 has a framework for deprivation of liberty, together with a statutory Code and helpful – informal – scenarios, all available at: https://www.health-ni.gov.uk/mca. For an overview of the position in Scotland, see the Mental Welfare Commission's Advice Note on Deprivation of Liberty (2021), available via: https://www.mwcscot.org.uk/good-practice/guidance-advice.

I: The bigger picture

1.12 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?

1.13 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?

1.14 As important as the procedural steps required to authorise a deprivation of liberty are (including the right to challenge that deprivation of liberty), 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.[14] Because such decisions are taken by others, these individuals are extremely vulnerable.[15] 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.

1.15 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.

[14] In most cases covered by the guidance, this is because they lack capacity to do so; in the context of children, their age may mean that they may be in a position where, as a matter of law, their decisions are not seen as determinative.
[15] See paragraph 57 of the judgment in *Cheshire West*.

Deprivation of liberty is not the only issue

1.16 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.

1.17 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 individual and their placement.

1.18 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 has emphasised how much more personal autonomy means for those who are the subject of 'authorised' deprivations of liberty.[16]

1.19 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 individual acts of care and treatment (for instance, the administration of medication, or assistance with personal care), 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:

1.19.1 On the basis of the provisions of ss.5-6 MCA 2005,[17] in terms of the delivery of 'routine' care and treatment;

[16] See *Munjaz v United Kingdom* [2012] ECHR 1704 at paragraph 80, in the context of detention under the Mental Health Act 1983.
[17] 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.

1.19.2 On the basis of a court order, where the care and treatment goes beyond the 'routine;'

1.19.3 In some circumstances in relation to those under the age of 18, on the basis of the consent of a person with parental responsibility;[18]

1.19.4 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).

1.20 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

1.21 As noted above, this guidance does not seek to answer the question of what individuals, organisations and public bodies should 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 arise[19] and what they are meant to do if it does. Only if such policies are in place can frontline professionals get on with their primary task of making appropriate arrangements and caring for individuals, confident that they know what to do if those arrangements and that care may amount to a deprivation of liberty.

[18] See Chapter 12 of the MCA Code of Practice and Chapter 19 of both the English and Welsh Codes of Practice accompanying the Mental Health Act 1983.
[19] 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 3.32.-3.35.

2. The law

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 or may be 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 As this guidance went to press in March 2024, Lieven J handed down a judgment relating to a 12 year with profound disabilities, who was (on the evidence) said to be incapable either physically of leaving the place she was being cared for, or of communicating in any form: Peterborough City Council v Mother & Ors [2024] EWHC 493 (Fam). Lieven J considered that such a child was not to be considered to be deprived of their liberty. The approach in the judgment is difficult to reconcile in a number of respects with the Supreme Court's decisions in Cheshire West and Re D, and we therefore suggest that, until and unless it is considered further by the appellate courts, it should be approached with caution both as regards children under 16 and, in particular, before applying its reasoning to those to those aged 16 and above whose situations are directly governed by the ratios in those two decisions.

2.3 This chapter is broken down as follows:

2.3.1 First, we outline the central principles of Article 5 ECHR;

2.3.2 Second, we summarise the key elements of the Supreme Court's three decisions concerning deprivation of liberty: *Cheshire West*, *Re D* and *Ferreira*;

2.3.3 Third, (briefly) the authorisation of deprivation of liberty and the consequences of **not** getting appropriate authorisation;

2.3.4 Fourth, we address the somewhat different legal issues that arise in the case of 'private' deprivations of liberty;

2.3.5 Finally, we 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'[20]).

2.4 Before we go further, however, it is worth reminding ourselves that there will be a continuum from 'routine' decisions or interventions in an individual's life to provide them with care and treatment, through to interventions that constitute restraint, to interventions that go beyond 'mere' restraint to a deprivation of liberty. In broad terms, it is likely that interventions that do not amount to a deprivation of liberty do not need formal authority.[21]

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 there is no statutory definition, either in the MCA 2005 or otherwise, of what constitutes a deprivation of liberty. The MCA 2005 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 European Court of Human Rights ('ECtHR') – which has ultimate responsibility for interpreting the Convention – would say.[22]

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*

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[20] 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.

[21] Depending on the age of the person, and whether or not they are competent (for a child under 16) or have capacity under the MCA 2005, the basis upon which care can be provided will vary. In broad terms, it is as follows. For a child under 16, it will either be the child's consent if they competently give it or (in most cases) the operation of parental responsibility; for a young person aged 16-17, it will either be their capacitous consent or (if they cannot give it) through the operation of s.5/6 MCA 2005 or the operation of parental responsibility. For an adult, it will be through the operation of ss.5/6 MCA 2005.

[22] This also applies in relation to those under 16 to whom the MCA 2005 does not apply, or those between 16 and 17 who have capacity but who might be viewed through the prism of the inherent jurisdiction: see chapter 4.

Council [2014] UKSC 19, commonly known as '*Cheshire West*.' As set out in more detail at paragraphs 2.22-2.35 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 DOLS, as well as creating the requirement for applications to be made to court for judicial authorisation deprivations of liberty that fall outside DOLS.

2.8 However, as outlined in Chapter 1, it is important to remember that determining care and treatment arrangements 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 information about further 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."*

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 2.47, 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 ECtHR 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**: that the person is confined to a particular restricted place (this is the focus of the *Cheshire West* acid test) for a non-negligible period of time; and

2.12.2 The **subjective element**: that the person does not consent (or cannot, because they do not have the capacity to do so) to that confinement; and

2.12.3 **State imputability**: 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 enshrines[23] 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,[24] 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;[25] 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 decision[26] has to be taken as to which side of the line the circumstances fall.[27]

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.[28]

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

[23] In Article 2.
[24] 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.
[25] *Cheshire West* at paragraph 20 citing *Stanev* at paragraph 115.
[26] Ultimately by the ECtHR.
[27] *Cheshire West* at paragraph 20 citing *Stanev* at paragraph 115. See also *A Local Authority v AB* [2020] EWCOP 39.
[28] *Cheshire West* at paragraph 20 citing *Stanev* at paragraph 115.

place for a non-negligible period of time.[29] 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 3.32-3.35.

2.16 Part of the objective element (confinement, 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.[30] For purposes of English law, a person can only give valid consent to being subject to circumstances amounting to a deprivation of their liberty if;

2.17.1 (If they are under 16), they have the *Gillick* competence to do so (see paragraphs 4.16-4.17); or

2.17.2 (If they are 16 or over), they have the mental capacity to do so applying (now) the test set down in ss.2-3 MCA 2005.[31]

[29] *Cheshire West* at paragraph 20 citing *Stanev* at paragraph 117.
[30] *Cheshire West* at paragraph 20 citing *Stanev* at paragraph 117.
[31] *Cheshire West* at paragraph 23 citing *Stanev* at paragraph 118 and, in turn, *HL v United Kingdom* (2004) 40 EHRR 761 at paragraph 90, and *Re D* at paragraphs 26(iii), 49 and 123.

2.18 There have been very few decisions identifying what it is required for someone to have the ability to consent to what would otherwise be a deprivation of liberty. The situation of those under 16 is considered at paragraph 4.15. In relation to those to whom the MCA 2005 applies, in *M v Ukraine*,[32] 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."*[33]

2.19 In the English (and Welsh) setting, in *A PCT v LDV & Ors*[34] – 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: "*whether or not he should be accommodated in the relevant hospital or care home for the purpose of being given relevant care or treatment*;"[35] 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.[36]

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[32] [2012] ECHR 732.
[33] 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.
[34] [2013] EWHC 272 (Fam).
[35] See paragraph 29.
[36] See paragraphs 39 and 40 of the LDV judgment 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, 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).

2.21 Two issues arise in relation to consent that have not yet been considered by the courts:

Advance consent

2.21.1 In the 2015 iteration of this guidance, we noted the following in relation to admission to an in-patient hospice facility:

> *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). This, 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 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.*

2.21.2 We noted that this view was in line with the position taken by the then Department of Health.[37] Although no court has yet expressly considered the issue, we remain of the view that this approach is legitimate within in this specific context.

[37] See the letter from DH to MCA DoLS leads available via: http://www.mentalcapacitylawandpolicy.org.uk/wp-content/uploads/2014/04/DH-Letter-to-MCA-DoLS-Leads-14-January-2015-FINAL.pdf.

2.21.3 However, our clear view is that, until and unless a court has decided that such represents the law, it is dangerous to rely upon advance consent to anything either more restrictive, less predictable, or less bounded in time than palliative/hospice care, whether that be admission to a mental health hospital in circumstances of confinement or admission on an open-ended basis to a care home. The Law Commission in its work on mental capacity and deprivation and liberty considered that there was a case for enacting statutory provision for advance consent,[38] but such statutory provision has not been made.[39] Further, it is important to recall that the effects of relying upon advance consent are two-fold. The first is that everyone is then proceeding on the basis of a fiction that a person who is currently incapable of agreeing to their confinement is, in fact, doing so. The second is that the person would then fall outside the scope of (for instance) the DOLS framework, so would not have access to the procedural safeguards, representation and support that is required by that framework.

Consent and the concrete setting

2.21.4 As a matter of logic, it may well be easier for a person to be able to understand, retain, use and weigh the fact that they are being cared for in a setting with which they are familiar. That familiarity could be because it is their own family home. It could also be because it is a supported living placement in which they have been living for a long period of time. That may make it feel easier to establish that a person has capacity to consent to being confined in a setting with which they are **both** familiar **and** comfortable. It is important, however, to remember that it is always the same test of capacity – it is simply being applied in a context where the person has very concrete experiences to think about. It is also necessary for professionals to be careful not to allow a sense that they are doing the 'right thing' to drive them to mischaracterise a situation as being one where the person is capable to of consenting to a situation where, in fact, they do not have the capacity to do so.

[38] See Law Commission's Mental Capacity and Deprivation of Liberty report (available via https://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/) at paragraphs 15.2-15.24.
[39] It did not, for instance, feature in the Mental Capacity (Amendment) Act 2019, which introduced the LPS.

E: Imputable to the State

2.22 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,[40] two of which are relevant for present purposes:[41]

2.22.1 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;

2.22.2 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 2.53-2.64.

F: *Cheshire West*

2.23 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.[42] This case is more commonly known as the "*Cheshire West*" judgment. The general principles established by the majority of the Supreme Court[43] 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.

2.24 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.

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[40] *Storck v Germany* (2006) 43 EHRR 6 at paragraph 89.
[41] 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).
[42] Parts of this section draw (with permission) upon summaries produced by the 39 Essex Chambers Mental Capacity Law Report editors, available at https://www.39essex.com/information-hub/mental-capacity-resource-centre.
[43] 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.

Mr P

2.25 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 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.

2.26 Baker J held[44] 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.[45] The Official Solicitor appealed to the Supreme Court.

[44] [2011] EWHC 1330 (COP).
[45] [2011] EWCA Civ 1257.

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

2.27 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.

2.28 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.

2.29 When the care proceedings were transferred to the Court of Protection in 2009, Parker J held[46] 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.[47] The Official Solicitor appealed to the Supreme Court.

The decision of the Supreme Court[48]

2.30 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 decision[49] in relation to Mr P, the Supreme Court justices were also divided 4 to 3 as to the governing questions of principle.

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[46] [2010] EWHC 785 (COP).
[47] [2011] EWCA Civ 190
[48] The decision is discussed in more detail in the April 2014 edition of the 39 Essex Chambers Mental Capacity Law Newsletter.
[49] 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.

2.31 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 – elsewhere[50] – complete) supervision and control and was not free to leave.[51] 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.[52]

2.32 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.

2.33 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*."[53]

2.34 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*."[54]

[50] Paragraph 53.
[51] Paragraphs 48-49.
[52] At paragraph 49, citing *HL v United Kingdom* (2004) 40 EHRR 761 at paragraph 91.
[53] Paragraph 26.
[54] Paragraph 46.

2.35 Speaking extra-judicially in a speech in October 2014, Lady Hale summarised the judgment of the Supreme Court thus:[55]

> *"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'."*

2.36 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."*

2.37 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,[56] 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.

2.38 It is important to note that the local authorities involved in the case could not appeal to the ECtHR. 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

[55] "*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.
[56] At paragraph 57.

determined in *Cheshire West* or the ECtHR 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.[57]

2.39 We address the elements of the 'acid test' in more detail in Chapter 3.

G: Re D and Ferreira

2.40 In 2019, in a case called *Re D*,[58] the Supreme Court held, again by a majority:[59] (1) that the principles set down in *Cheshire West* applied equally to those aged 16 and over; and (2) that it is not within the scope of parental responsibility for a parent to consent on their 16 or 17 year old child's behalf to confinement.

2.41 Lady Hale noted that she considered that her conclusion would also apply to a younger child whose liberty was restricted to an extent which was not normal for a child of their age,[60] but this observation did not form part of either her judgment or the overall decision of the Supreme Court. As discussed further in Chapter 4, this means that the law remains that (subject to certain significant limits) a parent can consent to the confinement of a child under 16.

2.42 In *Re D*, Lady Arden also returned to a decision that she had been part of when a Court of Appeal judge, *R (Ferreira) v Inner South London Senior Coroner*.[61] Now sitting as a Supreme Court judge, she summarised that decision as follows:

> "[…] *there will be cases where a person loses their liberty but the acid test in Cheshire West, as Lady Hale describes it, does not apply. That conclusion is shown by observing that D's case is about living arrangements. It is not about a child, or anyone else, needing life-saving emergency medical treatment. For the reasons which the Court of Appeal*

[57] 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/).
[58] [2019] UKSC 42.
[59] The lead judgment was given by Lady Hale, with whom Lady Black and Lady Arden agreed. Lords Carnwath and Lloyd-Jones gave a joint dissenting judgment.
[60] At paragraph 50.
[61] [2017] EWCA Civ 31.

(McFarlane LJ, Sir Ross Cranston and myself) gave in [Ferreira], the situation where a person is taken into (in that case) an intensive care unit for the purpose of life-saving treatment and is unable to give their consent to their consequent loss of liberty, does not result in a deprivation of liberty for article 5 purposes so long as the loss of liberty is due to the need to provide care for them on an urgent basis because of their serious medical condition, is necessary and unavoidable, and results from circumstances beyond the state's control (para 89)."

2.43 We address the elements of the 'acid test' in more detail in Chapter 3.

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

2.44 If the three key elements of the Article 5(1) 'trinity' are met – for example, if 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 the individual's Article 5 ECHR rights.

2.45 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.[62] In broad terms:

2.45.1 If they are over 18, 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),[63] detained under the Mental Health Act 1983, 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

[62] If the person can consent (i.e. they have the competence (for a child) or 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.
[63] 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.

inherent jurisdiction).[64] Reference should be made to the DOLS Code,[65] as well as the Code of Practice accompanying the Mental Health Act 1983.[66] 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 11A,[67] which provides more detail about the steps that are required;

2.45.2 If they are under 18, then they will have to be the subject of an application to court (depending upon the circumstances, either the Court of Protection or the High Court: see further paragraph 4.3).

I: The effect of authorisation

2.46 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 a court order) 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, subject to variation if the situation materially changes in a way that is more restrictive.

2.47 In relation to adults, this has implications for the situation where a person is cared for in more than one setting, only one of which is covered by DOLS. We address this further at paragraphs 7.25-7.34 in relation to respite placements.

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[64] 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.
[65] 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.
[66] Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/396918/Code_of_Practice.pdf.
[67] https://www.judiciary.uk/guidance-and-resources/court-of-protection-practice-directions/.

J: Consequences of a failure to obtain an authorisation

2.48 As noted above, if a public body deprives an individual of their liberty without authority to do so, they will be acting unlawfully contrary to s.6 Human Rights Act 1998.[68] The individual in question will be entitled to a declaration that their rights have been breached. The question that is often asked, however, is whether they will be entitled to more – and, in particular, whether they will be entitled to financial compensation.

2.49 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:[69]

2.49.1 In *London Borough of Hillingdon v Neary*,[70] a period of a year's detention resulted in an award of £35,000 to Steven Neary (no judgment being made public to accompany the consent order approved by the High Court);

2.49.2 In *A Local Authority v Mr and Mrs D*,[71] 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 benchmark;

2.49.3 In *Essex County Council v RF*,[72] 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

[68] 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.
[69] These do not necessarily serve as precedents (and they also include both decisions relating to unlawful deprivation of liberty and false imprisonment which for technical reasons may not necessarily attract the same awards of damages) but they nonetheless serve as a useful guide to the approach which may be adopted.
[70] [2011] EWCOP 1377.
[71] [2013] EWCOP B34.
[72] [2015] EWCOP 1.

detention would have made no difference to P's living or care arrangements and 'substantive' breaches that 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 the two decisions cited 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.[73]

2.49.4 In *Esegbona v King's College Hospital NHS Trust*,[74] a failure to make an assessment of Mrs Esegbona's capacity to decide whether or not to leave hospital at the point she said she wanted to go home gave rise to an (admitted) period of false imprisonment of 119 days, and an award of £15,470, explicitly based on a rate of £130 per day, which was extrapolated from the award in the *RF* case. In addition, an award of £5,000 was made as "aggravated damages" for the "high handed" and "oppressive" approach taken by the hospital in their failure to follow the MCA 2005 properly;

2.49.5 In *London Borough of Haringey v Emile*,[75] the local authority commenced proceedings seeking payment of £80,913.38 outstanding care fees, and were successful, but ended up also being ordered to pay damages of £143,000) for seven years and 10 months of unlawful deprivation of liberty,[76] and costs following their refusal of an offer to settle. It unsuccessfully appealed the decision from the District Judge to a Circuit Judge. His Honour

[73] 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.
[74] [2019] EWHC 77 (QB).
[75] Unreported, but available here: https://www.mentalhealthlaw.co.uk/media/%282020%29_MHLO_70_%28CC%29.pdf.
[76] Note, that the 'unlawful deprivation of liberty' here was pleaded on a common law basis, rather than Article 5 ECHR, but it was said to be common ground that the quantum of damages would be the same under either head in this case (see paragraph 13).

Judge Saggerson observed (at paragraph 25) that

> *"in assessing the damages, the District Judge was entitled to bear in mind that for nearly eight years the local authority had been unwittingly officious and had overridden properly formulated considerations of the Defendant's best interests and the potential this yielded for trespassing on her freedom of movement more than was essential in the light of family or other supported residential options that could have been considered short of consigning her to a care home. He was entitled to bear in mind that historically the Defendant had expressed a firm preference not to live in a residential home and that for six years the local authority had not properly reviewed the Defendant's status; neither had the position been properly reviewed after the death of her husband in 2013. Any award would also have to take into account, as did the District Judge, the fact that in her declining years the Defendant was unlawfully subject to routine direction by residential staff, had her daily life and visits subjected to a formal regime and contact with family subjected to official approval (however benign), or at least there was a greater degree of control than the family's evidence would have warranted. These are all real consequences of a confinement albeit falling short of being locked down or physically restrained."*

2.50 By contrast, in *A County Council v MB, JB and a Residential Home*,[77] 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 unsuccessfully.

2.51 The distinction between 'procedural' and 'substantive' breaches has also been highlighted – in the context of detention under the Mental Health Act 1983 – by the

[77] [2010] EWHC 2508 (COP).

decision of the Court of Appeal in *Bostridge v Oxleas Foundation NHS Trust*,[78] 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.[79] In other words, if the public body could show[80] 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.

2.52 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:

2.52.1 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;

2.52.2 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.

2.53 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 regulators[81] and/or the relevant Ombudsman. Regulatory sanctions will be much more likely to be imposed where the failures are systemic.

[78] [2015] EWCA Civ 79. *HL* had also been awarded £1 by the Court of Appeal before its decision was overturned by the House of Lords: see

[79] 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.

[80] 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.

[81] The CQC includes compliance with the MCA 2005 – including (where relevant) with provisions relating to deprivation of liberty – as one of its Key Lines of Enquiry.

K: 'Private' deprivations of liberty and the positive obligation under Article 5(1) ECHR

2.54 As noted at paragraph 2.11 above, a deprivation of liberty only falls within the scope of Article 5(1) ECHR if it is 'imputable' to the State. A deprivation of liberty is obviously imputable to the State if it is being carried out in a State-run facility (such as an NHS hospital), or under arrangements commissioned by the State (for instance in a private care home commissioned by the NHS or a local authority).

2.55 However, as Lady Hale made clear in *Re D*, the first sentence of Article 5 "imposes a positive obligation on the State to protect a person from interferences with liberty carried out by private persons, at least if it knew or ought to have known of this".[82] This raises the question of how far the obligations of the State go in relation to 'private' confinements.

2.56 As a starting point, we note that, whilst, strictly, those who are 'self-funding' in private care homes or private hospitals (i.e. who have had arrangements made for them by family members and who are not reliant on State funding to pay for or provide 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 DOLS authorisations if they meet the acid test. The precise rationale for this is not explained in the DOLS Code[83] but it is clear, we suggest, that this 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 DOLS.

2.57 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

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[82] See *Re D* at paragraph 43, citing *Storck v Germany* (2006) 43 EHRR 6 at paragraph 89; see also *Cheshire West* at paragraph 25 and the decision of the Court of Appeal in *Secretary of State for Justice v Staffordshire County Council & Ors* [2016] EWCA Civ 1317 at paragraph 62.

[83] 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.

privately, but where there is some State involvement. That State involvement could take the form of direct payments to an appropriate person on the individual's behalf for the purposes of arranging their care. A good example of such a situation was that considered by Senior Judge Hilder in *Re AEL*,[84] where the woman in question was being cared for in the family home, primarily by her parents, alongside with two private carers funded (it appears) by direct payments. In the face of strong objections by AEL's father to the situation being characterised as a deprivation of liberty, Senior Judge Hilder was clear that she was so deprived because she was confined, and was unable to consent to that confinement. Senior Judge Hilder further noted (at paragraph 50):

> *Finally, like Sir Mark Hedley in A Local Authority v. AB,[85] I have regard to the "policy" of Cheshire West. However benevolent AEL's carers, however much all relevant parties consider that the current arrangements for her care are in her best interests, AEL's disabilities make her vulnerable. If there is any room for doubt as to whether or not AEL's living arrangements are a deprivation of her liberty (which in my judgment there is not), as Baroness Hale identified, we should err on the side of caution. AEL should have the benefit of a periodic, independent check that arrangements continue to be in her best interests. Such requirement is not to stigmatise her or her loving family, but quite the opposite – to ensure recognition of her equal dignity and status as a human being* (emphasis in the original).

2.58 There may be situations where the State involvement is much less, such as visits by a nurse on a monthly basis, or simply the fact of a GP being aware that a person with dementia is being cared for by their family at home in circumstances of confinement. The precise point at which the arrangements cease to be the direct responsibility of the State and be a matter for which private individuals are responsible is something that has yet to be definitively decided by the courts. However, it is important to understand that simply because the State is not directly involved, that is not the end of the matter.[86]

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[84] [2021] EWCOP 9.
[85] [2020] EWCOP 39.
[86] The decision of Bodey J in *W City Council v L* [2015] EWCOP 20 is therefore, a problematic one because the judge in that case held that arrangements (if they did give rise to a confinement) were, in essence, private ones and outside the scope of Article 5 (see paragraph 27). However, he did not appear to have had his attention drawn to the obligation that the State was on notice that the

2.59 Where a deprivation of liberty can truly be said to arise out of arrangements that the State has had no part in making, but which the State is or should be aware, the obligation on the State bodies is to take measures "*providing effective protection*" of the individual.[87] In *Re A and Re C*[88] 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.*
>
> *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*

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arrangements were taking place, and hence had the positive obligation identified here. Especially in light of the decision of the Court of Appeal in *Secretary of State for Justice v Staffordshire County Council & Ors* [2016] EWCA Civ 1317 and the Supreme Court's decision in *Re D*, we suggest that the L case should be treated as either wrongly decided or, at the very lowest, with a very serious health warning.

[87] *Stanev* at paragraph 120.

[88] [2010] EWHC 978 (Fam), at paragraph 95.

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.

2.60 In *Secretary of State for Justice v Staffordshire County Council & Ors* (often called 'SRK'),[89] the Court of Appeal made clear that the State's obligations under Article 5 were engaged where a deputy is administering a care package paid for out of a personal injury compensation payment. In so doing, it rejected the Secretary of State's argument that the private care arrangements were not imputable to the State. It is perhaps important to note that the Court of Appeal rejected arguments put forward by the Secretary of State that the existing safeguarding and monitoring regimes deployed by local authorities and bodies such as the Care Quality Commission were sufficient:

The critical point, as Ms Nageena Khalique QC, for the Council, emphasised, is that, although local authorities and the CQC have responsibilities for the quality of care and the protection of persons in SRK's position, they will only act if someone has drawn the matter to their attention and there is nothing to trigger a periodic assessment. The same is true of doctors and other health professionals. Save where there are already proceedings in the CoP (when the functions of the Public Guardian will be engaged), the current domestic regime depends on people reporting something is wrong, and even then it will only be a

[89] [2016] EWCA Civ 1317.

> *notification of grounds for concern at that specific moment in time. That may be particularly problematic in cases where no parents or other family members are involved in the care and treatment. It does not meet the obligation of the State under Article 5(1) to take reasonable steps to prevent arbitrary deprivation of liberty*. (emphasis added)

2.61 In *SRK's* case, given where the person was living, an application was required to the Court of Protection because their circumstances could not be considered by reference to the DOLS framework. In practice, such applications should be made by the relevant local authority

2.62 It remains 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 in this context.[90]

2.63 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 (in other words, '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.[91] False imprisonment is also a common law criminal offence involving the unlawful and intentional or reckless detention of the victim.[92]

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

[91] See *Bostridge v Oxleas Foundation NHS Trust* [2015] EWCA Civ 79.

[92] For a review of the complicated law in this area, see the Law Commission's Mental Capacity and Deprivation of Liberty report (available via https://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/) at paragraphs 15.39-15.50. Recognising the potential for a gap in some situations, the Law Commission proposed that a person should be able to bring civil proceedings against the managers of a private care home or an independent hospital when

2.64 The interaction between false imprisonment and unlawful deprivation of liberty contrary to Article 5 ECHR is not straightforward,[93] 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 ECHR[94]). These are matters that lie outside the scope of this guidance.

2.65 It should, finally, be noted that, depending upon the circumstances, a private individual depriving an incapacitated individual in a purely private setting may also be potentially guilty of an offence under s.44 MCA 2005 if the conditions under which the individual is 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.

L: The DOLS Code

2.66 The DOLS Code (2008) is a statutory one, to which all professionals providing care and treatment to individuals lacking capacity must have regard.[95] The Code itself provides that it must be read subject to subsequent[96] so it is absolutely clear that Chapter 2 of the Code – 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.

2.67 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

arrangements giving rise to a deprivation of their liberty have been put in place and have not been authorised under the Mental Capacity Act, the Mental Health Act or by an order of a court. This recommendation was not taken forward in the (now aborted) LPS.

[93] 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.

[94] 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.

[95] Section 42(4) MCA 2005.

[96] Chapter 2, introduction.

restricted that they are thereby deprived of their liberty. As the courts have emphasised, Article 5 ECHR "contemplates individual liberty in its classic sense, that is to say the physical liberty of the person."[97] Imposing restrictions on contact with others interferes with the broader concept of autonomy, protected by Article 8 ECHR. It does not, in and of itself, necessarily mean that the person is deprived of their liberty. Conversely, this also means that is very important to note that the DOLS regime cannot be used to authorise restrictions on contact or – we suggest – such other restrictions as control over access to a mobile phone, the internet and social media: 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.

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

[97] *Manchester City Council v P (Refusal of Restrictions on Mobile Phone)* [2023] EWHC 133 (Fam) at paragraph 26.

3. Four key factors in applying the acid test

A: Introduction

3.1 This chapter provides a high-level view of four factors that need to be considered in any case, before the remainder of the guidance applies them to different settings:

3.1.1 The first two come from the 'acid test' formulated in Cheshire West, namely the concepts of 'continuous/complete supervision and control' and 'freedom to leave.' These have both been considered in sufficient detail subsequently by the courts to be able to give a clear 'steer' as to what they look like in practice.

3.1.2 The third factor is what constitutes a 'non-negligible' period of time after which a confinement satisfying the acid test crosses the line from restriction to deprivation of liberty. Judicial interpretation of this concept has been frustratingly inconsistent.

3.1.3 The fourth factor is whether the acid test applies at all, given the 'carve-out' identified by the courts in relation to medical treatment in some situations.

3.2 We emphasise two points at the outset:

3.2.1 Here, and throughout the guidance, our approach is predicated upon the warning of Lady Hale in *Cheshire West* 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."[98]

3.2.2 Unless otherwise stated, we are dealing here with adults. Those concerned with individuals aged under 18 will want to focus their attention primarily on Chapter 4, which explains how the concept of deprivation of liberty applies to that cohort.

[98] Paragraph 57. See also *Re AEL* [2021] EWCOP 9 and *A Local Authority v AB* [2020] EWCOP 39.

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

3.3 The phrase "continuous supervision and control" was taken by Lady Hale from the European Court of Human Rights' judgment in *HL v United Kingdom*.[99] This concept, or variations of it, has been used in the major ECtHR cases subsequently.[100] In seeking to interpret the phrase, we consider that it is of use to have regard to the ECtHR case-law.

3.4 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, then the necessary degree of continuity or completeness will be satisfied. But it can be satisfied even if the supervision and control is apparently 'lighter touch.'

3.5 Perhaps the two most significant ECtHR cases here are:

3.5.1 *Ashingdane v the United Kingdom*,[101] 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

3.5.2 *Stanev v Bulgaria*,[102] 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 leaves of absence were entirely at the discretion of the home's management, who kept

[99] [2004] ECHR 471 at paragraph 91.
[100] In *Stanev*, the term was "constant supervision" (paragraph 128).
[101] (1985) 7 EHRR 528.
[102] (2012) 55 EHRR 22.

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,"[103] and was therefore deprived of his liberty.

3.6 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.

3.7 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:

3.7.1 where the individual is; and

3.7.2 what they are doing at any one time.

3.8 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.

3.9 We also suggest that it is clear that the test for completeness/continuousness 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.

[103] *Stanev* at paragraph 128.

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

3.10 What of 'supervision and control'? It is necessary to focus 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.

3.11 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.

3.12 More recently, in *A Local Authority v AB*[104], Sir Mark Hedley made the important points[105] that:

3.12.1 The question of supervision and control must be viewed in the context of the fact that there is a plan in place which requires them to reside at a particular place. Even if – as was the situation in AB's case – they are free to leave that place temporarily as they choose, it will be highly relevant if they are subject to state control requiring their return should they be unwilling to return;

3.12.2 Even if the supervision (in AB's case of her comings and goings from the supported living placement) was not, itself, intrusive, it was highly relevant if the person's movements are known and noted;

3.12.3 It is necessary not just to see what happens in practice, but to consider what the 'true powers of control' actually are, and not to slip into conflating the beneficence of the actions with their intrusion on the person's liberty.

[104] [2020] EWCOP 39.
[105] At paragraphs 13 and 14.

D: 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 in *Cheshire West*. As Lord Kerr noted, liberty is "*predominantly an objective state. It does not depend on one's disposition to exploit one's freedom*."[106] 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.[107]

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 or someone else 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. Of course, such steps either way must be in P's best interests, if they cannot make the relevant decisions for themselves – but being in their best interests does not stop them from being a potential deprivation of liberty.

3.16 Approaching matters on that basis helps make clear that, for example, whether or not there are locks or keypads on the doors is not the answer.[108] 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

[106] *Cheshire West* at paragraph 76.
[107] The Court of Appeal made clear that the suggestion made by Mostyn J in *Rochdale MBC v KW* [2014] EWCOP 45 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 should not be followed. The Court of Appeal also made clear that the Supreme Court had settled the question of what amounts to deprivation of liberty and accordingly Mostyn J's analysis "was, and could be, of no legal effect. It was irrelevant" (paragraph 31).
[108] Indeed, this is also clear from the Strasbourg case-law: see *HL* at paragraph 92.

liberty.[109] Questions of deprivation of liberty are not only raised when the individual is continuously resisting personal care, subject to hands-on restraint or attempting to leave.

3.17 The courts have confirmed[110] that, as a general proposition, 'freedom to leave' should be understood as meaning freedom to move from the place of apparent confinement to another one on a permanent basis (or simply to leave those premises permanently, even if they do not have a clear destination[111]).

3.18 However, it is also important to take a step back and apply Lady Hale's approach from *Cheshire West*. When doing so, it is clear that a person of unimpaired health and capacity who is 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 is said that they would be able to relocate permanently whenever they wished. Indeed, it is unlikely 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.

3.19 Drawing the threads together, therefore, we suggest the following:

3.19.1 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. Depending on the other measures imposed upon them, this may be something for which the body imposing the restrictions can rely upon the provisions of sections 5-6 MCA 2005, or it may amount to a potential deprivation of their liberty that requires scrutiny/authorisation to comply with Article 5 ECHR;

3.19.2 A person will clearly not be 'free to leave' if they a) are only able permanently to relocate from the place with the permission of the person(s)

[109] 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.
[110] See *Re D* [2017] EWCA Civ 1695, at paragraph 22. The decision in *Re D* was overturned by the Supreme Court, but without casting doubt on this proposition.
[111] 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).

or bodies responsible for their care and treatment; and b) if they do seek to leave that location, steps may be taken to locate and bring about their return;

3.19.3 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.

3.20 Four further broad points should be made here:

3.20.1 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 the appendix to Chapter 7.

3.20.2 If those who are making the decisions on the ground (especially if they are public bodies) would not be content for the individual to live anywhere that they might be able to choose[112] other than one specific location, then this may indicate that they are not "free to leave" for the purposes of the acid

[112] I.e. the place that they chose is actually available.

test.[113] It will, in any event, give rise to significant issues in relation to their rights under Article 8 ECHR[114] 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;

3.20.3 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;

3.20.4 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 welfare[115] may request that they be allowed to leave. So, even if a person is unable even to suggest leaving, it would be appropriate to consider what the decision makers would do if a family member, for example, said that they wished to move them from the placement. Professionals should note *HL v United 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.[116] 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.

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[113] 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.
[114] 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.
[115] 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).
[116] Paragraph 91.

E: Both elements of the acid test must be satisfied

3.21 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."[117]

3.22 But what about 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,[118] 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. This not least because absurd results could easily result: a person locked in a prison cell who is simply left there by prison staff would clearly be deprived of their 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 or within that place.

3.23 Therefore, professionals should note that wherever a person is subject to a residence requirement imposed under the Mental Health Act 1983 ('MHA 1983'),[119] it should not be assumed that such requirement will, itself, give rise to a deprivation of that person's liberty. That is because: (1) in general, the power to impose such requirements does

[117] Paragraph 49.
[118] 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.
[119] E.g. by a guardian.

not, itself, amount to power to confine the person there;[120] 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.[121]

F: Irrelevant factors

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

3.24.1 The person's compliance or lack of objection;

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

3.24.3 The reason or purpose behind a particular placement.[122]

3.25 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). Arguably, the reality following *Cheshire West* is that pressure of numbers means that it is still only those who are 'objecting' in some way who receive detailed and timely attention.

3.26 However, and 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 is sitting quietly in the corner of the care home and apparently acquiescing to the arrangements made for them never meant – and still does not mean – that they could not be considered to be deprived of their liberty. The

[120] See, in the context of CTOs, *Welsh Ministers v PJ* [2018] UKSC 66, in the context of conditional discharges: Secretary of State for Justice v MM [2018] UKSC 60, and in the context of guardianship, *A Local Authority v AB* [2020] EWCOP 39. Section 17(3) MHA 1983 does, however, appear to provide a power to confine the person: see *MM* at paragraph 36, as it provides for a responsible clinician to direct that a patient given leave of absence remain in custody.
[121] See the decision of the Upper Tribunal in *NL v Hampshire County Council (Mental health: All)* [2014] UKUT 475 (AAC) at paragraphs 14-19 and *A Local Authority v AB* [2020] EWCOP 39.
[122] See paragraph 50.

irrelevance of compliance has long been acknowledged by the ECtHR.[123] A focus not just on the individual's behaviour 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 3.32-3.35 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, because (as set out in Chapter 2), both decisions relied in different ways upon a concept of 'relatively normality'). 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.[124] 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.[125]

3.29 The third factor is equally self-explanatory, because otherwise why what is being done starts to cloud the issue of what is being done. Why a person is being confined is very

[123] Mr L was compliant, and never tried to leave Bournewood Hospital (at least on the facts accepted by the court, if not in reality). That having been said, there are complex arguments whether there is a distinction to be drawn for those lacking capacity to consent to confinement between compliance and manifestation of positive desire to remain somewhere. These arguments may be considered in due course either by the European Court of Human Rights or the Supreme Court, but the distinction is not one that is applicable at present.
[124] See Lady Hale in the speech quoted at paragraph 2.34 above.
[125] See *Cheshire West* at paragraph 46.

relevant to the question of whether such a confinement is justified. But it does not alter the fact that they are confined.

G: Non-negligible period of time

3.30 As noted at paragraph 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.[126] 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.[127]

3.31 By way of two examples from English decisions (which consider ECtHR cases):

3.31.1 The total and "*intense*" restraint by police officers of an autistic 16-year old for a period of 40 minutes was held to amount to a deprivation of his liberty;[128]

3.31.2 By contrast, it was held that in the 'ordinary case' it would be unlikely that a person required to remain in the section 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 eight hours.[129]

3.32 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

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[126] *Cheshire West* at paragraph 20 citing *Stanev* at paragraph 117.
[127] See, for instance, *Rantsev v Cyprus and Russia* (App. No. 25965/04) [2010] ECHR 22: "I*n 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).
[128] *ZH v Commissioner of the Police for the Metropolis* [2013] EWCA Civ 69 at paragraph 83.
[129] *Sessay v South London & Maudsley NHS Foundation Trust & The Commissioner of Police for the Metropolis* [2011] EWHC 2617 (QB).

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.'

3.33 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' from being a potential deprivation of liberty. Our clear view is that it is unlikely under any of the circumstances considered in this guidance to extend beyond a few (two-to-three) 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 seven 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.[130] 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. Furthermore, even if the code was trying to say that there is no deprivation of liberty where the period of confinement lasts less than seven days, this could not make it so in law. The law – here – is set by the courts, which have confirmed that a deprivation of liberty can arise in very much less time than that.

[130] Most obviously paragraphs 6.3 and 6.4.

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

3.34 It is clear that the Supreme Court in *Cheshire West* 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. The Supreme Court has now made clear that the 'acid test' does not apply in the context of the delivery of medical treatment in some circumstances. In *Re D*,[131] Lady Arden also returned to a decision that she had been part of when a Court of Appeal judge, *R (Ferreira) v Inner South London Senior Coroner*.[132] Now sitting as a Supreme Court judge, she summarised that decision at paragraph 89 as follows:

> "[…] there will be cases where a person loses their liberty but the acid test in Cheshire West, as Lady Hale describes it, does not apply. That conclusion is shown by observing that D's case is about living arrangements. It is not about a child, or anyone else, needing life-saving emergency medical treatment. For the reasons which the Court of Appeal (McFarlane LJ, Sir Ross Cranston and myself) gave in [Ferreira], the situation where a person is taken into (in that case) an intensive care unit for the purpose of life-saving treatment and is unable to give their consent to their consequent loss of liberty, does not result in a deprivation of liberty for article 5 purposes so long as the loss of liberty is due to the need to provide care for them on an urgent basis because of their serious medical condition, is necessary and unavoidable, and results from circumstances beyond the state's control."

3.35 We address the implications of those observations in Chapters 5 and 10.

[131] [2019] UKSC 42.
[132] [2017] EWCA Civ 31.

I: Concluding observations

3.36 In light of the decisions in *Cheshire West* and *Re D*, it can sometimes feel as if almost everyone with complex needs is deprived of their liberty. It is undoubtedly true that the concept of deprivation of liberty is one that is of very wide application. However, there does remain in law a distinction between a restriction on freedom of movement and a deprivation of liberty.[133] 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.

[133] 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.

4. Children and young people under 18

A: Introduction

4.1 Whether the proposed care arrangements are likely to give rise to a deprivation of liberty is as an important question for people under the age of 18 as it is for adults. The right to liberty under Article 5 ECHR applies to everyone, whatever their age. The test for determining whether a deprivation of liberty has arisen is also the same, irrespective of age. However, the process for determining whether the test is satisfied differs in important respects when applied to those aged under 18. Accordingly, this chapter considers the circumstances in which the care arrangements for those aged under 16 ("children") and those aged 16 and 17 ("young people") give rise to a deprivation of liberty. It should be noted that the law is continuing to develop in this area.[134]

4.2 As this guidance went to press in March 2024, Lieven J handed down a judgment relating to a 12 year with profound disabilities, who was (on the evidence) said to be incapable either physically of leaving the place she was being cared for, or of communicating in any form: Peterborough City Council v Mother & Ors [2024] EWHC 493 (Fam). Lieven J considered that such a child was not to be considered to be deprived of their liberty. The approach in the judgment is difficult to reconcile in a number of respects with the Supreme Court's decisions in Cheshire West and Re D, and we therefore suggest that, until and unless it is considered further by the appellate courts, it should be approached with caution both as regards children under 16 and, in particular, before applying its reasoning to those to those aged 16 and above whose situations are directly governed by the ratios in those two decisions.

4.3 Care and support can be provided to children and young people in a very broad range of living arrangements and a deprivation of liberty can arise in any of them. They 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. For additional information about hospital settings see chapter 5; chapter 6 also covers children and young people's admissions to Child and Adolescent Mental Health in-patient wards.

[134] See Chapter 11 for details on how to stay abreast of developments.

4.4 If the care arrangements for the child or young person are likely to mean that they will be deprived of their liberty, legal authority for the deprivation of liberty must be sought without delay (unless the restrictions can be reduced so that they do not give rise to a deprivation of liberty). As noted in Chapter 1, this guidance does not provide detailed answers as to how such legal authority should be obtained.[135] As can be seen from the following summary, the appropriate legal mechanism for authorising an under 18-year old's deprivation of liberty will depend on the proposed setting and the child or young person's circumstances:

4.4.1 Detention under the Mental Health Act (MHA) 1983 (admission to hospital for assessment and/or treatment for mental disorder).[136]

4.4.2 Court order under (for England) section 25 Children Act (CA) 1989 (placement in secure accommodation)[137] and (for Wales) section 119 Social Services and Well-being (Wales) Act 2014. (However, a secure accommodation order cannot be made in relation to young person aged over 16 who has been accommodated under section 20(5) CA 1989.[138])

4.4.3 An order of the Court of Protection (placement in any setting where the young person lacks capacity under the Mental Capacity Act 2005 to make decisions about their care arrangements – so not applicable to those aged under 16).[139]

4.4.4 An order under the inherent jurisdiction of the High Court (where none of the above legal mechanisms apply).[140]

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[135] More detailed guidance is provided in the 39 Essex Chambers *Guidance Note: Deprivation of Liberty and those under 18*.

[136] Guidance on the process for admission to hospital under the Mental Health Act 1983 is provided in the Mental Health Act 1983 Codes of Practice. Chapter 19 of both the English and Welsh versions provides guidance on issues specific to children and young people.

[137] Guidance is provided in chapter 4 of *Court Order and proceedings, For local authorities*, April 2014, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/306282/Statutory_guidance_on_court_orders_and_pre-proceedings.pdf

[138] Children (Secure Accommodation) Regulations 1991 reg 5(2)(a). Section 20(5) of the Children Act 1989 applies to those aged 16 and over but under 21.

[139] See sections 4A and 16(2)(a) and Schedule 1A of the MCA 2005. The interface between the Mental Capacity Act 2005 and the Mental Health Act 1983 (cases where the Court of Protection cannot authorise a person's deprivation of liberty under the MCA 2005) is considered in *Manchester University Hospitals NHS Foundation Trust v JS and others (Schedule 1A Mental Capacity Act 2005)* [2023] EWCOP 33.

[140] The application procedure was set out in *Re A-F (Children) No 2* [2018] EWHC 2129 (Fam).

4.5 This chapter focuses on care settings in which children and young people are often placed, giving examples of measures that may give rise to their deprivation of liberty. The chapter is divided into the following parts. Part 1 considers the factors relevant to determining a deprivation of liberty. Part 2 considers the differing scenarios in which a child or young person may be deprived of their liberty:

PART 1

B: Determining a deprivation of liberty of children and young people

4.6 As confirmed by the Supreme Court,[141] the same three-part test for a deprivation of liberty (set out in *Storck v Germany*[142]) applies to all under 18s as well as adults. However, as explained below, there are differences in how the first condition ("the objective component of confinement in a particular restricted place for a not negligible length of time"), referred to below as 'the confinement condition' and the second condition ("the subjective component of lack of consent"), referred to below as 'the lack of consent condition', are determined in relation to children as compared to young people. In particular, whereas it might be possible for parents to consent to the confinement of their child aged under 16 years, the Supreme Court in *Re D (A Child)*[143] held that this is **not possible** for young people aged 16 and over.

Deprivation of liberty: the confinement condition

4.7 In *Re D (A Child),* the Supreme Court held that "the crux of the matter" when considering whether the confinement condition is met in relation to someone aged under 18 is to ask whether "the restrictions fall within normal parental control for a child of this age".[144] If they go beyond normal parental control, the confinement condition will be met – the child or young person will be confined.

[141] In *Cheshire West* at paragraph 37; see also *Re D (A Child)* [2019] UKSC 42 at paragraph 1. The three conditions are often referred to as the '*Storck* limbs' or '*Storck* components' because they were first set out by the European Court of Human Rights in the case of *Storck v Germany* (2006) 43 EHHR 6.
[142] *Storck v Germany* (2006) 43 EHHR 6.
[143] [2019] UKSC 42.
[144] Paragraph 39 in the judgment of Lady Hale.

4.8 Accordingly, it will be necessary to consider the restrictions placed on the child or young person and compare these with the restrictions that parents (or others with parental responsibility[145]) would place on their non-disabled child as part of their parenting responsibilities. As Lady Hale made clear, the child's cognitive impairments are irrelevant:

> "It follows that a mentally disabled child who is subject to a level of control beyond that which is normal for a child of his age has been confined within the meaning of article 5."[146]

4.9 This comparator approach nuances the 'acid test' set out in *Cheshire West*[147] by taking into account that as children mature, parental supervision and control will diminish. So, the type of restrictions that are typically placed on children by their parents might be 'normal parental control' for a five-year-old, but not for a 15-year-old. The greater the divergence between the constraints that are placed on the child or young person's freedoms and the parental control which would usually be expected for someone of that age, the more likely that the confinement condition is met. The courts have emphasised that the determination as to whether a child or young person is confined is fact specific, requiring 'a close examination of the 'concrete' situation on the ground'.[148]

4.10 For young people, the *Cheshire West* acid test is also a helpful means of determining whether the confinement condition is met and continues to be applied by the courts.[149] This is because if a young person aged 16 or 17 is under continuous supervision and control and is not free to leave (the components of the acid test), such restrictions are clearly beyond normal parental control. Typically, parents would have little supervision

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[145] For example, if a child or young person is subject to a care order the local authority will share parental responsibility with the parents (see sections 31 and 33 of the Children Act 1989). Parental responsibility is defined under section 3 of the Children Act 1989 as 'all the rights, duties and powers, responsibilities which by law a parent has in relation to the child [meaning anyone aged under 18] and his property'. Further information can be found at: https://www.gov.uk/parental-rights-responsibilities

[146] *Re D (A Child)* [2019] UKSC 42at paragraph 41.

[147] *Cheshire West* at paragraphs 48-39.

[148] *Re D (Deprivation of Liberty)* [2015] EWHC 922 Fam at paragraph 68. In *Re A-F (Children)* [2018] EWHC 138 (Fam) Sir James Munby P (at paragraph 43) gave suggestions on when a child aged 10, 11 or 12 might be confined, but emphasised that these were 'little more than a "rule of thumb"' and that 'all must depend on the particular circumstances of the case'. See also *Re RD (Deprivation of Liberty)* [2018] EWFC 47 where the court found that 'on balance' a 14-and-a-half girl was not confined.

[149] See for example, *Manchester University Hospitals NHS Foundation Trust v JS & Anor* [2023] EWCOP 12 at paragraph 25.

and control once their child has reached their 16th birthday, at which point they are free to leave in the 'acid test' sense (being able to move to live somewhere else[150]). Put another way, it would be unusual for the acid test to produce a different result to the comparator approach when applied to a 16- or 17-year-old than it would when applied to someone aged 18 or over.

4.11 As stated in Chapter 2, it is important to note that the question whether a person is confined focuses on what restrictions are being placed on that person's physical liberty and is not concerned with the justification for such restrictions. The fact that the care arrangements have been made in the child or young person's best interests or that they are imposed in a family-like environment (or even the family home) is not relevant. Neither does it matter that the child or young person is compliant with the restrictions imposed, nor that the measures taken are intended to make the person's life as enjoyable as possible. As Lady Hale commented in *Cheshire West,* "[a] gilded cage is still a cage".[151]

4.12 When considering the proposed measures, it is important to note that a deprivation of liberty under Article 5 ECHR is concerned with the restrictions on a person's **physical** liberty. Placing restrictions on a person's use of social media (such as their mobile phone) is an interference with that person's Article 8 ECHR rights (respect for private and family life, including autonomy), which would need to be justified under Article 8. Such restrictions would not necessarily be relevant to whether a deprivation of liberty under Article 5 has arisen. As explained in *Manchester City Council v P (Refusal of Restrictions on Mobile Phone)*[152] restrictions on the use of social media "do not… by themselves constitute an objective component of confinement of P in a particular restricted place for a not negligible length of time".[153] However, those proposing such restrictions must ensure that they have a legal authority for taking such action, including a justification for interfering with the person's Article 8 ECHR rights.[154]

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[150] See *JE v DE & Others* [2006] EWHC 3459 (Fam) at paragraph 115.
[151] *Cheshire West* at paragraph 46.
[152] [2023] EWHC 133 (Fam) at paragraph 46.
[153] MacDonald J accepted that there may be circumstances in which such restrictions form an integral element of the person's deprivation of liberty, but was not persuaded that they applied in this case.
[154] See the discussion in *Manchester City Council v P (Refusal of Restrictions on Mobile Phone)* [2023] EWHC 133 (Fam) at paragraphs 52-58 in which MacDonald J concluded that the restrictions could be made by the local authority in the exercise of its parental responsibility for the young person. The judge noted (at paragraph 60) that the authorisation of the court would be required where 'the use of physical restraint or other force to remove the mobile phone or other devise from a 16 year old adolescent' was contemplated.

Deprivation of liberty: the lack of valid consent condition

4.13 Valid consent is discussed at paragraphs 2.16-2.20. This section sets out how the concept applies in relation, first, to young people, and then to children.

i) Young people and the lack of valid consent condition

4.14 If a 16- or 17-year-old has the capacity to decide on their arrangements and consents to them, that young person will not be deprived of their liberty. However, if the young person is not willing or not able[155] to give consent to the confinement the lack of valid consent condition will be met. This is because the Supreme Court held in *Re D* that the parents (or others with parental responsibility) of a young person aged 16 or over cannot consent to their confinement.

4.15 Where a young person lacks the capacity to make decisions about their care arrangements which meet the confinement condition, that young person will be deprived of their liberty. The exception to this would be if no public body is involved (directly, or indirectly) with the young person's case (which is likely to be rare).

ii) Children and the lack of valid consent condition

4.16 It is possible for children aged under 16 or (where there is no care order) their parents (or certain others with parental responsibility) to consent to the child's confinement so that no deprivation of liberty arises. However, for the reasons set out below, determining whether valid consent has been given (by either the child or parents) will require careful consideration.

[155] The Code of Practice to the Mental Capacity Act 2005 notes (at para 12.13) that there may be circumstances in which a young person is unable to make the relevant decision but not 'because of an impairment of, or disturbance in the functioning of the mind or brain', so does not lack capacity as defined by the Mental Capacity Act 2005 (section 2). The Code of Practice to the Mental Health Act 1983 provides more detailed guidance on this point (paragraphs 19.31-19.33 of the English version; paragraphs 19.16-19.21 of the Welsh version).

Determining Gillick competence

4.17 To give valid consent a child must demonstrate that they are '*Gillick* competent'. This term derives from the House of Lords decision in *Gillick v West Norfolk and Wisbech Health Authority*,[156] which held that a child with "sufficient understanding and intelligence" to make the decision can consent to the proposed intervention. There is no statutory test for determining whether a child is *Gillick* competent. However, some judges have borrowed certain aspects of the functional element of the test in section 3 of the MCA 2005 to flesh out the *Gillick* test.[157]

4.18 The English Code of Practice to the Mental Health Act 1983 suggests a similar approach:

> "19.36 When considering whether a child has the competence to decide about the proposed intervention, practitioners may find it helpful to consider the following questions.
>
> - Does the child understand the information that is relevant to the decision that needs to be made?
> - Can the child hold the information in their mind long enough so that they can use it to make the decision?
> - Is the child able to weigh up that information and use it to arrive at a decision?
> - Is the child able to communicate their decision (by talking, using sign language or any other means)?
>
> 19.37 A child may lack the competence to make the decision in question either because they have not as yet developed the necessary intelligence and understanding to make that particular decision; or for another reason, such as because their mental disorder adversely affects their ability to make the decision. In either case, the child will be considered to lack Gillick competence."[158]

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[156] [1986] AC 112.

[157] See *Re S (child as parent: adoption: consent)* [2017] EWHC 2729 (Fam) at paragraph 15 and *JA (A Minor: Medical Treatment: Child Diagnosed with HIV)* [2014] EWHC 1135 at paragraph 68. A similar approach was taken in *An NHS Trust v ST (Refusal of Deprivation of Liberty Order)* [2022] EWHC 719 (Fam). When considering whether the child (aged 14) was *Gillick* competent, it was noted that she was able to understand simple information about relevant information but 'was considered unable to retain the information or use and weigh it, in order to make a relevant decision' (at paragraph 26). The differences between *Gillick* competency and mental capacity were emphasised in *An NHS Trust v X (No 2)* [2021] EWHC 65 (Fam).

[158] Less detailed guidance is provided in the Welsh Code at paragraphs 19.22-19.24.

Ensuring valid consent

4.19 If a child is competent to make the decision and the other requirements for valid consent are met (such consent being voluntary and based on sufficient information about the care arrangements giving rise to the confinement),[159] that child can consent to their confinement so that no deprivation of liberty arises.[160] However, the courts have highlighted the need for caution when considering whether a child is able and willing to give valid consent to their confinement. Even if assessed to be competent to make this decision, the child's genuine consent may be in doubt if they keep changing their mind about living in the placement or being subject to the restrictions giving rise to their confinement.[161] In *Re T (A Child)*,[162] Lady Black noted (at paragraph 160):

> "…an apparently balanced and free decision made by a child may be quickly revised and/or reversed. The facts of this case clearly demonstrate how insecure may be the child's apparent consent. Having said that, there may also be cases in which the child is expressing a carefully considered and firm view."

Parental consent and the scope of parental responsibility

4.20 If the child is not competent to consent to the confinement and is not subject to a care order, it might be possible for the child's parents (or certain others with parental responsibility)[163] to consent on the child's behalf provided that this is "an appropriate exercise of parental responsibility" in relation to that child.[164] Accordingly, where a child lacks *Gillick* competence and parental consent to that child's confinement is deemed to fall within the scope of parental responsibility,[165] there will be no deprivation of liberty because there is valid consent.[166]

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[159] See paragraphs 2.16-2.20.
[160] *Re C (A Child)* [2016] EWHC 3473 (Fam) (also known as *A Local Authority v D and others*).
[161] See discussion in *Re C (A Child)* [2016] EWHC 3473 (Fam), in particular at paragraphs 57 and 58.
[162] [2021] UKSC 35.
[163] In *Lincolnshire County Council v TGA and others* [2022] EWHC 2323 (Fam) parental responsibility was exercised by the child's testamentary guardians.
[164] *Re D (A Child) (Deprivation of Liberty)* [2015] EWHC 922 at paragraph 56. See also *Lincolnshire County Council v TGA and others* [2022] EWHC 2323 (Fam); *Lancashire County Council v PX and others* [2022] EWHC 2379 (Fam) and *RN (Deprivation of Liberty and Parental Consent)* [2022] EWHC 2576 (Fam).
[165] This is sometimes also referred to as the 'zone of parental responsibility' - see for example, *Re D (A Child) (Deprivation of Liberty)* [2015] EWHC 922 at paragraph 55.

[166] The cases in which the courts have considered the possibility of parents being able to consent to their child's confinement concern children deemed to lack the competence to make such decisions. Although the courts have not addressed this specifically, we suggest that the role of parental consent in the context of whether a deprivation of liberty has arisen is limited to children

4.21 A key factor in determining whether giving consent to their child's confinement falls within the proper exercise of parental responsibility will be whether parents are acting in their child's best interests.[167]

4.22 Guidance on "the scope of parental responsibility" in the MHA Codes highlight a range of factors to consider when determining if parental consent can authorise the proposed intervention (such as medical treatment). These include the type and invasiveness of that intervention and whether the child is resisting it, as well as whether the parents are acting in their child's best interests and if one of the parents is opposed to the decision.[168] It is suggested that such factors are also relevant to the question whether parents can consent to their child's confinement, with the extent to which restraint is used being of particular importance. In *Re Z (A child: deprivation of liberty: transition plan)*[169] the court agreed that the anticipated measures for transporting a 14-year-old autistic boy from his family home to his placement in a residential school would, if needed, give rise to a deprivation of liberty. The measures (which involved police presence as well as physical and chemical restraint by means of medication) would amount to a confinement which the parents could not consent to because "it was beyond the scope of what they could lawfully agree".[170]

Care orders, foster carers and the lack of valid consent

4.23 If the child is subject to a care order (interim or final), it will not be possible for either the parents (or others with parental responsibility) or the local authority to consent to the confinement on the child's behalf. As explained by Keehan J in *Re AB (A child: deprivation of liberty)*: [171]

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who are not *Gillick* competent. By way of comparison, both the English and Welsh MHA Codes advise against relying on parental consent where a competent child does not consent to their admission to hospital or treatment for mental disorder (paragraphs 19.39 and 19.66 of the English Code, and paragraph 19.26 of the Welsh Code).

[167] *Re D (A Child) (Deprivation of Liberty)* [2015] EWHC 922 at paragraph 58 and *Lincolnshire County Council v TGA and others* [2022] EWHC 2323 (Fam) at paragraph 58. 'Best interests' here does not mean 'best interests' for purposes of the MCA 2005, although in practice the two approaches are similar (e.g. see *Fixsler & Anor v Manchester University NHS Foundation Trust & Anor* [2021] EWCA Civ 1018, paragraphs 24-29).

[168] Paragraphs 19.41-19.42 and 19.48 of the English Code; paragraphs 19.25-19.31 of the Welsh Code.

[169] [2020] EWHC 3038 (Fam).

[170] Paragraph 44.

[171] [2015] EWHC 3125 (Fam).

> "Where a child is in the care of a local authority and subject to an interim care, or a care, order, may the local authority in the exercise of its statutory parental responsibility (see s.33(3)(a) of the Children Act 1989) consent to what would otherwise amount to a deprivation of liberty? The answer, in my judgment, is an emphatic "no". In taking a child into care and instituting care proceedings, the local authority is acting as an organ of the state. To permit a local authority in such circumstances to consent to the deprivation of liberty of a child would (1) breach Article 5 of the Convention, which provides "no one should be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law", (2) would not afford the "proper safeguards which will secure the legal justifications for the constraints under which they are made out", and (3) would not meet the need for a periodic independent check on whether the arrangements made for them are in their best interests (per Lady Hale in Cheshire West at paragraphs 56 and 57)."[172]

4.24 This means a deprivation of liberty will arise where the measures in place for such a child go beyond normal parental control and that child is not able and willing to consent to those measures. This is because the child is confined, there is no consent to the confinement and as the child is in the local authority's care, the state is responsible for the confinement. The same approach also applies in relation to foster carers, the courts being clear that they do not have parental responsibility enabling the carer to provide a valid consent to confinement.[173]

[172] See also *Re A-F (Children)* [2018] EWHC 138 (Fam) at paragraph 12 and *Re D (A Child)* [2019] UKSC 42 at paragraph 18.
[173] See *Re A-F (Children)* [2018] EWHC 138 (Fam) at paragraph 12.

C: Liberty-restricting measures

4.25 Mere placement in foster care, a children's home or residential special school of someone lacking decision-making capacity will not in itself constitute a deprivation of liberty. However, the combined effect of more specific measures may do. As explained above, the comparator approach identified by the Supreme Court in *Re D (A Child)* means that constraints may fall within normal parental control for a five-year-old but be beyond normal parental control (and therefore amount to liberty-restricting measures) when applied to a 15-year-old. Whereas continual supervision and control of a five-year-old would be universally expected, it would not be for a 15-year-old.

4.26 The following list of measures might be identified in settings such as foster care arrangements, children's homes or residential special schools. Some are more relevant to one care setting than another. When considering the measures placed on the child or young person in question, it will be important to consider how they compare with the restrictions that are placed on a child or young person of the same age, as part of normal parental control.

- Decision on where to reside 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 the child or young person 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 lap strap 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 (e.g. padded tent to sleep in);
- Searching of the person and/or their belongings;[174]
- Restricted access to personal belongings to prevent harm;
- Medication with a sedative or tranquilising effect;

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

- 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);[175]
- 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;[176]
- 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;
- Restricted access to parts of the property, such as the kitchen or certain cupboards therein, to minimise health and safety risks.

[175] Guidance about restrictive practices includes *Reducing the Need for Restraint and Restrictive Intervention, Children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties in health and social care services and special education settings* (2019); *Positive and Proactive Care: reducing the need for restrictive interventions* (2014); *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). The Government's call for evidence on the use of restrictive practices in schools closed on 11th May 2023.

[176] See Department of Education, *'Behaviour and discipline in schools: Advice for headteachers and school staff'* (January 2022).

PART 2

4.27 Examples of care arrangements that might be put in place for children and young people aged under 18 in various different settings are set out below. For each of these scenarios, the relevant factors to consider when determining if a deprivation of liberty has arisen are considered first, in relation to young people aged 16 or 17 and second, in relation to a child aged under 16. The relevance of the young person's capacity to decide and the child's competence to decide are explained. For each scenario we comment on whether or not a deprivation of liberty has arisen. However, as noted above, the courts have emphasised that the determination of a deprivation of liberty will turn upon the facts of each particular case.

D: Foster homes for looked after children and young people[177]

4.28 Foster care arrangements range from emergency provision to long-term placements with varying aims. Short breaks[178] also form part of a continuum of services to support children and young people in need and their families. Their Foster Care Agreement requires carers to care for any child or young person placed with them as if that person was a member of the foster carer's own family. While foster carers do not have parental responsibility for the child or young person in their care, local authorities are expected to ensure that "the most appropriate person to take a decision about the child has the authority to do so, and that there is clarity about who has the authority to decide what".[179]

[177] 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) (note that paras 3.9-3.24 are replaced by paras 3.192-3.201 ('Delegation of authority') of '*The Children Act 1989 Guidance and Regulations Volume care planning, placement and case review*', July 2012.

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

[179] 'The Children Act 1989 Guidance and Regulations Volume care planning, placement and case review', July 2021, paras 3.192-3.201.

Foster home: a deprivation of liberty

4.29 The measures in the following scenario are likely to amount to a deprivation of liberty (where David (aged 16) lacks capacity to make decisions about such measures):

- 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. David's placement has been arranged under section 20 Children Act (CA) 1989.[180] 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. There is an appropriate care plan in place for when David needs to use the toilet or to manage emergency situations that might occur during the night. David's parents are fully aware of the care arrangements in place for David and agree that they are needed.

  Factors pointing to David being deprived of his liberty:

  a) **The confinement condition is met**: David is regularly locked in his room for 12 out of 24 hours, the doors to the house are locked and David is supervised and accompanied by a foster parent on a 1:1 basis throughout the day. He is therefore under constant supervision and control and not free to leave (the acid test). The restrictions placed on him go beyond normal parental control for a non-disabled young person aged 16 (the age comparator test).

  b) ***The lack of valid consent condition is met:*** David is unable to consent to his confinement, and no-one with parental responsibility can do so.[181]

  c) ***The state responsibility condition is met****:* the placement has been arranged by the local authority in accordance with section 20 CA 1989.

4.30 If David was aged 14 (and if he lacked *Gillick* competence to decide on the care arrangements), it is suggested that such arrangements would still amount to a

[180] In Wales such arrangements are set out in section 76 of the Social Services and Well-being (Wales) Act 2014

[181] *Re D (A Child)* [2019] UKSC 42.

confinement. This is because the measures go beyond normal parental control for a non-disabled 14-year-old. Given that the state responsibility condition would also still be met, whether David was deprived of his liberty would therefore depend on whether his biological parents' consent to the measures that confine him fall within the scope of parental responsibility: whether or not his foster parents consented is not relevant (see paragraph 4.23 above). Factors to consider include whether there are any concerns that the arrangements are not in David's best interests[182] and how they accord with David's wishes and feelings. The more the arrangements are against his will, the more likely they are to fall outside the scope of parental responsibility: see paragraph 4.21 above.

Foster home: potential deprivation of liberty

4.31 We suggest that the measures in the following scenario may give rise to a deprivation of liberty (where Michaela (aged 16) lacks capacity to make decisions about such measures):

- Michaela is a 16-year-old girl who is subject to a care order (section 31 CA 1989). She has a severe learning disability, as well as 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'. Her foster mother provides her with intensive support in most aspects of daily living (including basic life skills and personal care) and sets clear boundaries and routines for Michaela. 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 Michaela wished to leave the home by herself, she 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.

[182] See for example: *Re D (Deprivation of Liberty)* [2015] EWHC 922 Fam and *Lincolnshire County Council and v TGA and Ors* [2022] EWHC 2323 (Fam).

Key factors pointing to Michaela's potential deprivation of liberty:

a) **The confinement condition may be met**: These facts are similar to those of 'MIG' who aged 18 was found by the Supreme Court in Cheshire West 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 the same age. Although the measures are termed as provision of support, cumulatively their impact may amount to a level of supervision and control that go beyond normal parental control for a 16-year-old.
b) **The lack of valid consent condition:** if it is concluded that Michaela is confined, she will be unable to consent to her confinement (as she lacks the capacity to do so)
c) **The state responsibility condition:** this condition is met because Michaela is subject to a care order.

4.32 If Michaela was aged 14 (and if she lacked *Gillick* competence to decide on the care arrangements), the question whether she is deprived of her liberty will depend on whether the measures go beyond normal parental control for a non-disabled 14-year-old. If they do not, the first condition (the confinement condition) will not be met, so no further inquiry is needed. However, if she is confined, Michaela will be deprived of her liberty. As she is on a care order, the lack of valid consent condition is met (because neither the local authority nor her parents can consent to Michaela's confinement[183]) and the state responsibility condition is met because she is in the local authority's care.

Foster home: not a deprivation of liberty

9.1 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.

[183] *Re AB (a child) (deprivation of liberty: consent)* [2015] EWHC 3125.

Key factors pointing away from deprivation of liberty:

a) 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. As the confinement condition is not met, no deprivation of liberty can arise.
b) The same would apply if Nathan was younger than 16 – as the measures do not exceed normal parental control for a 16-year-old, they will not (by definition) go beyond normal control for a child aged under 16.

E: Children's homes

4.33 A children's home (defined in section 1 Care Standards Act 2000) is generally an establishment providing care and accommodation wholly or mainly for children. In England children's homes are regulated by the Children's Homes (England) Regulations 2015[184] and the Guide to the Children's Homes Regulations including the Quality Standards.[185] The Regulation and Inspection of Social Care (Wales) Act 2016 and regulations issued under this Act[186] apply to children's homes in Wales. 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.

4.34 Cases have highlighted the worrying dearth of appropriate placements for children and young people with complex needs. As a result of this shortage of provision, local authorities have applied to the High Court for deprivation of liberty orders for placements in settings that fall within the definition of a children's home but are not registered as such (notwithstanding the legal requirement to do so). The Supreme Court has held that where cases engage 'imperative considerations of necessity' (where there is 'absolutely no alternative, and where the child (or someone else) is likely to come to grave harm if the court does not act'), the High Court can authorise the deprivation of liberty under its inherent jurisdiction.[187]

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[184] (SI 2015 No 541).
[185] Department for Education, April 2015, available at: https://assets.publishing.service.gov.uk/media/5a7f1b54ed915d74e33f45f0/Guide_to_Children_s_Home_Standards_inc_quality_standards_Version_1.17_FINAL.pdf.
[186] See for example, Regulated Services (Registration) (Wales) Regulations (WSI 2017 No 1098)
[187] *Re T (A Child)* [2021] UKSC 35. This approach was confirmed notwithstanding the amended regulations Care Planning, Placement and Case Review (England) (Amendment) Regulations 2021,

Children's home: a deprivation of liberty

4.35 We suggest that the measures in the following scenario are likely to amount to a deprivation of liberty (where Ahmed (aged 16) lacks capacity to make decisions about such measures):

- Ahmed, a 16-year-old boy with autism and learning disability resides in a children's home and attends specialist school. His placement has been arranged by the local authority with his parents under section 20 CA 1989. 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:

a) The confinement condition is met: the intensive and continuous nature of the control and supervision exercised over him, including the use of the 'safe space' on a regular basis and the use of physical restraint go beyond normal parental control. In addition, although not specifically noted, given that he has 2:1 support, it is clear that Ahmed is not free to leave the children's home (whereas young people should be free to live where they choose once they reach the age of 16).

b) The lack of valid consent condition is met: Ahmed lacks the capacity to consent to his confinement.

c) The state responsibility condition is met: Ahmed has been placed in the children's home by the local authority and his parents under section 20 CA 1989.

4.36 It is suggested that the measures in place for Ahmed would go beyond normal parental control even if he was much younger, for example aged 12. The level of restrictions placed on him, the use of the 'safe space' and the frequent use of physical restraint exceed normal parental control for a non-disabled 12-year-old. The state responsibility condition would also be met given that he has been placed in the children's home under

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see *A Mother v Derby City Council & Anor* [2021] EWCA Civ 1867 and *TMBC v AM & Ors (DOL Order for Children Under 16)* [2021] EWHC 2472 (Fam). It should be noted that the President's Guidance referred to in these cases has been revised. See: President of the Family Division, Revised Practice Guidance on the Court's approach to unregistered placements, September 2023: https://www.judiciary.uk/guidance-and-resources/revised-practice-guidance-on-the-courts-approach-to-unregistered-placements/.

section 20 CA 1989. If Ahmed did not have *Gillick* competence to decide on the arrangements then, like David (in the scenario above) whether Ahmed is deprived of his liberty therefore depends on whether his parents can validly consent to his confinement. This will require consideration of a range of factors including whether there are any concerns that the arrangements are not in Ahmed's best interests,[188] and how these accord with Ahmed's wishes and feelings. The more the arrangements are against his will, the more likely they are to fall outside the scope of parental responsibility. In Ahmed's case, a factor indicating that his parents cannot consent to his confinement is the regular use of physical restraint. Further investigation would also be needed to ascertain whether his father (if he has parental responsibility) agrees with the care arrangements in place for his son (see discussion on disputes between parents in the MHA Code's guidance on the scope of parental responsibility).[189]

Children's home: potential deprivation of liberty (age dependent)

4.37 We suggest that the measures in the following scenario are likely to give rise to a deprivation of liberty (where Joanna (aged 16) lacks capacity to make decisions about such measures) but may not be a deprivation of liberty if Joanna is aged under 16:

- Joanna, aged 16, has autism, ADHD, severe learning disability and epilepsy, and aggressive and self-harming behaviours. She resides in a children's home from Monday to Friday (under section 20 CA 1989), which her parents can visit at any time, and spends the weekends at her parents' home. During term time she attends school. 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 a deprivation of liberty where Joanna is 16:

[188] *Lincolnshire County Council v TGA and others* [2022] EWHC 2323 (Fam), paragraphs 51 and 58.
[189] Department of Health, Mental Health Act 1983 (2015), paragraph 19.41 notes that where one parent agrees to the proposed decision but the other 'disagrees strongly' with it, it may not be appropriate to rely on parental consent.

a) The confinement condition is met: although similar circumstances were held in *RK v BCC, YB and AK*[190] not to amount to a deprivation of liberty, as noted by Lady Hale in *Re D (A Child)*[191] (paragraph 33), this decision preceded Cheshire West and the facts of the case were similar to that of the young person in Re D (A Child). Given Joanna's age, the restrictions placed on her go beyond normal parental control. The continuous nature of the supervision and control to which she is subjected, and the fact that she is not free to leave her situation amount to a confinement.

a) The lack of valid consent condition is met: Joanna lacks the capacity to consent to her confinement

b) The state responsibility condition is met: Joanna has been placed in the children's home by the local authority under section 20 CA 1989

4.38 If Joanna is aged 14 and not *Gillick* competent to decide on the care arrangements, the question whether she is deprived of her liberty will depend on whether the measures go beyond normal parental control for a non-disabled 14-year-old. For example, one difference between Joanna aged 17 and Joanna aged 14, is that the elder Joanna should be free to leave the placement (young people aged 16 and over can choose to leave the family home if they so wish), whereas the younger Joanna is not (others decide for her). If the measures do not exceed normal parental control, the first condition (the confinement condition) will not be met, so no further inquiry is needed. If Joanna aged 14 is confined, whether she is deprived of her liberty will depend on whether her parents are willing and able to consent to the confinement on her behalf. Factors to consider are set out in guidance on the scope of parental responsibility (see paragraphs 4.19-4.22 above). The state responsibility condition will be met given that she has been placed in the children's home under section 20 CA 1989.

Children's home: not a deprivation of liberty

4.39 The following scenario is unlikely to amount to a deprivation of liberty (where Connie (aged 16) lacks capacity to make decisions about such measures):

- 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

[190] [2011] EWCA Civ 1305.
[191] [2019] UKSC 42.

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:

a) Connie's age and the extent to which the measures applied to her are comparable to those which would be applied to a non-disabled young person of the same age.
b) The same would apply if Connie was younger than 16 – as the measures do not exceed normal parental control for a 16-year-old, they will not (by definition) go beyond normal control for a child aged under 16.

F: Educational establishments

4.40 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.[192]

4.41 Proportionate restraint is permitted.[193] 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.[194] Guidance issued by the Department for Education notes that "Restrictions that alone, or in combination, deprive children and young people of their liberty, without lawful authority, will breach Article 5 of the ECHR (the right to liberty)".[195]

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[192] 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 Regulations and National Minimum Standards.
[193] See s. 550A Education Act 1996. In relation to young people lacking capacity to decide the matter, ss.5-6 MCA 2005 will also be relevant.
[194] See s. 93 of the Education and Inspections Act 2006.

[195] *Reducing the Need for Restraint and Restrictive Intervention Children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties in health and social care services and special education settings* (2019), at paragraph 6.7.

Residential special school: a deprivation of liberty

4.42 The measures in the following scenario are likely to amount to a deprivation of liberty (where Dan (aged 17) lacks capacity to make decisions about such measures):

- Dan, aged 17, has been resident in a school for some years. He has autism and a 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 Dan had been encouraged to withdraw as a safe place.

  Key factors pointing to a deprivation of liberty:

  a) **The confinement condition is met**: the particular techniques used to manage Dan's behaviour, the use of seclusion in a blue room from which he was prevented from leaving [196] are all beyond normal parental control for a young person aged 17. They also meet the acid test (he is under continuous supervision and control and not free to leave).
  b) **The lack of valid consent condition is met:** Dan lacks the capacity to consent to his confinement
  c) **The state responsibility condition is met:** It is likely that Dan has been placed in the children's home by the local authority and his parents under section 20 CA 1989.

4.43 It is suggested that the situation would be the same for a child under 16, even as young as 10. Dan aged 10 would be confined given that placing a child in seclusion goes beyond normal parental control. As with Dan, aged 17, the state is responsible due to its direct or indirect involvement. It is also suggested that although it is possible for parents of under 16s to consent to their child's confinement where the child is not

[196] 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.

competent to do so, this would not be possible in Dan's case because consenting to such restrictions would not fall within the proper exercise of parental responsibility.[197]

Residential special school: potential deprivation of liberty (age dependent)

4.44 We suggest that the measures in the following scenario are likely to give rise to a deprivation of liberty (where Gary (aged 17) lacks capacity to make decisions about sure measures) but may not be where Gary is aged under 16:

- Gary is 17 years old and has severe learning disability. He is non-weight bearing. Throughout the year, in accordance with his Education, Health and Care (EHC) plan and with agreement of his parents, 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 two to five children and young people reside. Entry/exit is via a 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.

  Key factors pointing to a potential deprivation of liberty:

  a) The confinement condition is met: Gary is not free to leave (he is not able to use the keypad for entry/ exit to the home) and the level of supervision and control over his day-to-day life exceeds normal parental control for a 17-year-old without his disabilities. Although the measures are termed as 'provision of support', in light of MIG's case (discussed at paragraph 2.26), and given that Gary has been determined to lack capacity to make decisions about his care arrangements, we suggest that in reality staff are making the relevant decisions, not Gary. The action taken by staff in relation to his wheelchair also suggests that he is under their control and supervision.
  - The lack of valid consent condition is met: If Gary is confined, he lacks the capacity to consent to his confinement.

[197] See the English Mental Health Act Code of Practice at paragraph 26.106 which states that seclusion should only be used for patients who are detained under the Mental Health Act 1983.

- The state responsibility condition is met: Gary has been placed in the school in accordance with his Education and Health Care Plan.

4.45 If Gary is aged 15 and is not *Gillick* competent to decide on the care arrangements, the question whether he is deprived of his liberty would first of all, like Gary aged 17, depend on whether the measures go beyond normal parental control for a non-disabled 15-year-old. We suggest that such measures do exceed normal parental control for a 15-year-old and therefore the confinement condition is met. The state responsibility condition would still be met (he is placed in the school as part of his EHC plan). Accordingly, whether Gary aged 15 is deprived of his liberty would depend on whether his parents consent to such measures and whether such consent falls within the scope of parental responsibility, taking into account factors such as Gary's wishes and feelings (see the note on the scope of parental responsibility at paragraphs 4.19-4.22 above).

Residential special school: not a deprivation of liberty

4.46 The following scenario may amount to a deprivation of liberty (where Vanessa (aged 16) lacks capacity to make decisions about her care arrangements) but may not be where Vanessa is aged under 16:

- Vanessa is 16 years old and is autistic. For 38 weeks per year, in accordance with her EHC plan, Vanessa lives in a school set in 25 acres which has 11 house groups, each accommodating between four and eight 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 to a possible deprivation of liberty (Vanessa aged 16):

a) The confinement condition is probably met: Although the restrictions on Vanessa are low key, it looks as if she is under continuous supervision and control (staff will know where she is throughout the day and night and she has a structured, predictable daily routine) and not free to leave. Comparing her situation with a 16-year-old without her disabilities, we suggest that the restrictions placed on Vanessa exceed normal parental control.

b) The lack of valid consent condition is met: if it is concluded that Vanessa is confined, she will be unable to consent to her confinement (as she lacks the capacity to do so).

c) The state responsibility condition is met: Vanessa has been placed in the school as part of the EHC plan.

4.47 If Vanessa is aged under 16 (and lacks *Gillick* competence to decide on her care arrangements), the question whether she is deprived of her liberty would first of all, like Vanessa aged 16, depend on whether the confinement condition is met – whether the restrictions placed on her exceed normal parental control for a child her age. Arguably, if she is aged 15 this condition would be met, whereas if she was 12 she might not be. If Vanessa is confined, whether she is deprived of her liberty will depend on whether her parents are willing and able to consent to her confinement (the State responsibility condition will be met because she is placed in the school as part of her EHC plan). Factors that would support the conclusion that consenting to these restrictions on Vanessa's behalf fall within the scope of parental responsibility (see paragraphs 4.19-4.22 above) are the low level of restrictions placed on her and their similarity with the restrictions placed on pupils attending a boarding school. However, it would be important to ascertain Vanessa's wishes and feelings.

G: Considerations for front-line practitioners

4.48 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 child or young person go out of the establishment without the carer's permission? Can they spend nights away? When are they expected to return? What will happen if they do not return? Will the police be called to bring them back? How do the arrangements differ to the norm for someone of their age who is not disabled?
- To what extent do the rules and sanctions differ from non-disabled age appropriate settings?
- Are there regular private times, where the child or young 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 child or young person?
- Is medication with a sedative effect used? If so, what type? How often? And what effect does it have on the child or young person?
- How structured is the child or young person's routine compared with someone of the same age and relative maturity who is not disabled?
- To what extent is the child or young person's contact with the outside world restricted?[198]
- Is the child or young person prevented from keeping certain items in their room, such as stationery, or other items which may be used to cause harm? If so, how and in what circumstances?

[198] Note: we have included contact here because it is a pointer to investigating whether there are other controls on the person's physical liberty, rather than because restricting contact is, itself, gives rise to a deprivation of liberty. And any restriction on contact will need to be justified in any event: see paragraph 2.67.

5. Deprivation of liberty in hospital

A: Introduction

4.1 This chapter focuses on deprivation of liberty of people lacking the capacity to consent to care, treatment and confinement in a clinical setting for the 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. Questions relating to deprivation of liberty in the psychiatric setting are dealt with in Chapter 6. Deprivation of liberty in a hospice and palliative care setting is the focus of chapter 10.

4.2 Please also note that there may be specific considerations about children and young people which apply in this context, for whom this chapter should be read in conjunction with chapter 4.

4.3 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. Restrictions on the patient may be reasonably necessary to deliver appropriate care effectively and safely, when this is the least restrictive way of meeting their best interests. Those restrictions may include restraint if the person using restraint reasonably believes that it is necessary to restrain the patient in order to prevent harm to the patient, and it is proportionate to the likelihood and seriousness of the harm.[199] The difficult issue to identify is the point at which the level, duration and intensity of the restrictions or restraint may amount to a deprivation of liberty.

4.4 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

[199] Sections 6(1)-(3) MCA 2005.

authorised) cannot be resolved prior to the administration of such treatment. But the priority is always to assess and provide care in someone's best interests if they cannot make the relevant decisions for themselves.

4.5 Section 4B MCA 2005 allows for there to be a deprivation of liberty "while a decision as respects any relevant issue is sought from the court" if there is a question about deprivation of liberty and any deprivation is necessary for the purpose of providing "life sustaining treatment" or "a vital act".

4.6 As soon as a potential 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'[200]), under the MHA 1983, or from the Court of Protection.[201] 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.[202]

4.7 Like the rest of this guidance, this chapter goes no further to consider what should be done to authorise a potential deprivation of liberty, but will focus on how to identify if there may be a deprivation that requires consideration.

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[200] 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* [2014] EWCOP 30, at paragraph 101.

[201] For further discussion, see the guidance note prepared by members of the 39 Essex Chambers Court of Protection team: *Deprivation of Liberty in a Hospital Setting*: https://www.39essex.com/information-hub/insight/mental-capacity-guidance-note-deprivation-liberty-hospital-setting.

[202] See ss.136, 5(2) and 5(4) MHA 1983. Section 5 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.

B: Deprivation of liberty and the hospital setting

4.8 There is now a small body of case law on the issue of deprivation of liberty in the context of acute medical treatment, but there is still considerable uncertainty, and there should be a low threshold for seeking specialist legal advice.

4.9 Remember that the definition of deprivation of liberty is that someone, without valid consent / capacity to consent to it, and imputable to the state, is "under continuous supervision and control" and is "not free to leave".

Imputable to the state

4.10 For these purposes we can expect that any provision of medical treatment in hospital will be imputable to the state, whether in the NHS or in the private sector. Independent hospitals, like the NHS, will be regulated by the state through CQC / HIW registration and inspection, whether or not the care is commissioned by the NHS.

4.11 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 hospitals are required to apply for an authorisation if the care and treatment of their patient may be a deprivation of their liberty.

4.12 It is therefore necessary to consider whether the totality of the care and treatment arrangements may 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 the NHS or privately.

Capacity / consent / advance consent

4.13 Even if the patient has capacity to make decisions about their care and treatment in the ordinary course of events – ie there is no underlying mental health disorder or disability – it is not unusual for such capacity to be lost in an acute illness. Assessment of the patient's capacity for the relevant decisions is vital, including any changes to this during an admission.

4.14 If a patient with capacity to do so consents to the admission, then it is no deprivation of liberty. We think that this may reasonably extend to patients who consent to a foreseeable and relatively short-term situation, for example a short period of post-operative care, in which capacity may predictably be lost. It becomes less appropriate to rely on such advance consent as a longer time passes, or if the situation evolves beyond what was discussed and agreed with the patient. See more broadly in relation to the concept of advance consent paragraph 2.20 above.

4.15 If a patient with capacity to do so does not consent, then there is no legal basis in the Mental Capacity Act / DOLS for a deprivation of liberty, but the MHA 1983 may be available.

4.16 As set out in chapter 4, for children under 16, parental consent can mean that there is no deprivation of liberty, and that applies equally in hospital. However, professionals should be slow to rely simply on parental consent to negate what would otherwise be a deprivation of liberty for a child under 16 who is objecting to the admission or to the treatment involved, and especially so if the child is *Gillick* competent to make their own decisions on those issues. That should better be seen as a substantive dispute about the treatment and admission itself, which should be considered and resolved by the court, including authorisation of any deprivation of liberty involved.

4.17 For the purpose of this guidance, we will focus on the objective element – the application of the "acid test" of continuous supervision and control and being not free to leave, for a non-negligible period of time.

"A non-negligible period"

4.18 Starting with timescale, this is dealt with generally in the previous chapter at paragraphs 3.32-3.35. In the context of the clinical setting, it is important to consider the duration of the whole potential deprivation of liberty, not to underplay this by segmenting the care artificially according to the ward or department. For instance, though the average stay in ICU may be short, this should not be taken in isolation to dismiss the possibility of a deprivation of liberty there on the basis of the timescale alone, if it would be followed by a further period of care in another part of the hospital and if the care as a whole may amount to a deprivation of liberty.

4.19 Likewise, 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. The more intensive the restrictions upon the person (including restraint, 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.

4.20 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 DOLS Code of Practice. This suggests that an urgent Deprivation of Liberty Safeguards 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 3.32-3.35, there may well be cases in which a person is in fact deprived of their liberty within that period of time.

4.21 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, even if they occur relatively rarely. This is to ensure 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.

4.22 The duration for which the restrictions will be imposed is a factor in whether or not there may be a deprivation of liberty, and the risk that something that was not a deprivation of liberty initially may become one may increase over time. But *there is no specific period of time where it is safe to say cannot be a deprivation of liberty*; there is no legal basis for the rule of thumb sometimes adopted that there is no deprivation of liberty unless it would last longer than 7 days.

4.23 In the clinical context, cases have held that there is a deprivation of liberty in provision of care or treatment measured in hours – for example care in childbirth in *Re FG*[203] (see below), or giving treatment over around 21 hours for a paracetamol overdose in *Re P*[204]

4.24 The key is to consider the overall intensity, frequency, and duration of the restrictions, and their impact on the patient as a whole.

The acid test – "free to leave"

4.25 As noted at paragraph 3.36 above, the acid test set out in the supreme court in the *Cheshire West* judgment, i.e. continuous (or complete) supervision and control' and 'lack of freedom to leave', did not address the situations of those in general hospitals, from A&E departments, through general wards, to intensive care units, or those in transit in ambulances.

4.26 "Free to leave" needs some nuance in the clinical context. Ordinarily it is important to understand, in other settings, that this does not just mean being able to go out for activities or trips, but the ability to pack your bags and go to live somewhere else if you want to. Few people, however, would consider themselves to be "living" in a hospital, especially if it is an admission for acute, physical medical treatment. In this sense, the focus for the clinical setting is really about the ability to discharge oneself, or, perhaps, to secure a transfer to another hospital, for example, if that was wanted.

4.27 Here, this is often complicated by a patient being physically unable to get up and go. It is not appropriate to dismiss the question of whether someone is "free to leave" simply because they are unable to do so. The better question may be to ask what would happen if a family member, for example, sought to take them home, or to another hospital. If the answer is that this would be prevented, or at least would be substantially held up subject to a process of best interests decision making, then it may be appropriate to consider that person as not free to leave for these purposes.

[203] [2014] EWCOP 30.
[204] [2014] EWHC 1650 (Fam).

The acid test – "continuous supervision and control"

4.28 In hospital, one would expect 24 hour staffing to happen. Wards can be locked (or at least patients effectively prevented from leaving freely due to keypads for which they may not have the code), and other restrictive interventions such as bedrails can be used to lower the risk of falls. Patient observations should be carried out regularly, and patients can be under 1:1 care, or greater. Physical restraint may be used at times. Medication is sometimes used to manage behaviour, including medication being given covertly.

4.29 None of these in themselves necessarily amount to a deprivation of liberty, but of course each of these, and more, may be a factor in considering whether there is a risk that the patient is deprived of their liberty according to the acid test, perhaps nowhere more so than in intensive care units, where the patient is surely under "continuous supervision and control". But is that the right question to ask in that context?

Ferreira

4.30 Maria Ferreira died on 7 December 2013, in intensive care in an NHS hospital. Her family wanted there to be a jury for her inquest, as there would have had to be if she had died "in state detention"; her family argued that though the hospital had not sought a DOLS authorisation, she should be treated as if in state detention as she was "under continuous supervision and control and not free to leave", meeting the acid test for a deprivation of liberty.

4.31 The Court of Appeal[205] did not dispute that she was under continuous supervision and control, but held that the *Cheshire West* acid test should not simply be applied in this context.

[205] [2017] EWCA Civ 31.

4.32 Under a significant sub-heading, Lady Justice Arden (giving the single judgment with which the other two judges agreed) said:

> [L]*ife-saving medical treatment: in general no deprivation of liberty,*
>
> […] *any deprivation of liberty resulting from the administration of life-saving treatment to a person falls outside Article 5(1)" (as it was said in Austin) "so long as [it is] rendered unavoidable as a result of circumstances beyond the control of the authorities and is necessary to avert a real risk of serious injury or damage, and [is] kept to the minimum required for that purpose.*
>
> […]
>
> *The purpose of Article 5(1)(e) is to protect persons of unsound mind. This does not apply where a person of unsound mind is receiving materially the same medical treatment as a person of sound mind. Article 5(1)(e) is thus not concerned with the treatment of the physical illness of a person of unsound mind.*
>
> […]
>
> *In the case of a patient in intensive care, the true cause of their not being free to leave is their underlying illness, which was the reason why they were taken into intensive care. The person may have been rendered unresponsive by reason of treatment they have received, such as sedation, but, while that treatment is an immediate cause, it is not the real cause. The real cause is their illness, a matter for which (in the absent of special circumstances) the state is not responsible.*

4.33 With great respect, the reasoning in the last paragraph needs some care. The Supreme Court judgment in *Cheshire West* itself dismissed the argument that the disability, rather than the care, should be seen as the cause of the restrictions.

4.34 But *Ferreira* makes clear that there are at least some medical treatment situations where the acid test should not be applied as it would in any other setting, and it is fair to say that Article 5 is more concerned with living arrangements than with medical treatment, although urgent medical treatment can still be a deprivation of liberty.

4.35 In an earlier case, *NHS Trust & Ors v FG*,[206] the court approved a proposed care plan for a woman with schizoaffective disorder in the very late stages of pregnancy who, it was feared, might be non-compliant with obstetric care and lacked capacity for making those decisions; the plan also potentially involved restraint if needed to secure the safe delivery of the baby. The judge, explicitly applying the *Cheshire West* acid test, held that the arrangements for the woman would be a deprivation of her liberty, which he duly authorised.

4.36 The Court of Appeal in *Ferreira* recognised that the scenario in *FG* would still be regarded as a deprivation of liberty, as the care proposed for her was not the same as for any patient with her physical health need (pregnancy), but was more restrictive for her as a result of her mental health needs. Article 5 was still necessary to protect her from discrimination.

4.37 So, the proposed treatment and associated restrictions must be materially the same as they would be for any other patient with that physical health need, regardless of their mental health, before reliance can be placed on the *Ferreira* exception to say that the acid test does not apply, and Article 5 to not be engaged, even if they are under continuous supervision and control and not free to leave.

4.38 To summarise: large numbers of patients who are clearly under continuous supervision and control and not free to leave, including almost everyone in intensive care, are not necessarily to be regarded as deprived of their liberty if that treatment is materially the same as for any other patient with those healthcare needs.

4.39 No doubt this is a good outcome for the health system, but it leaves the problem of defining exactly where the exception applies – where to draw "the Ferreira line" - which subsequent case law has only partly helped with.

[206] [2014] EWCOP 30.

"The *Ferreira* line"

4.40 Though the context of *Ferreira* was of a patient in intensive care, there is nothing in the judgment to limit the principle to that setting. Arden LJ used the subheading that "life-saving medical treatment" is generally not a deprivation of liberty. There is no doubt that this can extend beyond intensive care settings.

4.41 In the Court of Appeal in *Briggs*,[207] King LJ said (at paragraph 106) that:

> *In my view, Ferreira confirms what I myself would regard as an obvious point, namely that the question of deprivation of liberty does not arise where a person who lacks capacity is so unwell that they are at risk of dying if they were anywhere other than in hospital and therefore, by virtue of their physical condition, they are unable to leave the hospital.*

4.42 In *M v A Hospital NHS Trust*,[208] Jackson J referred to the "fiction" that "a person without any real awareness was being deprived of their liberty by virtue of receiving life-sustaining treatment."

4.43 In *PL v Sutton CCG*,[209] Cobb J considered an application about withdrawal of artificial nutrition and hydration for a 79 year old lady who was resident in a nursing home. To effect the planned withdrawal, she would first be moved to hospital, and the court considered whether she might be deprived of her liberty there. The judge said that she would not, relying on *Ferreira* to say that the real cause of her not being free to leave was her illness, not her care: she would be "in a state of very low cognition and possibly unconscious, receiving palliative care, as her life ebbs away."[210] That may be right, but it is certainly difficult, then, to say this step is "life-saving medical treatment."

4.44 In the litigation around the short life of Alfie Evans, the parents argued at one point that he was deprived of his liberty in the hospital, dismissed in the Court of Appeal[211] by King LJ, summarising the *Ferreira* judgment as saying that:

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[207] [2017] EWCA Civ 1169.
[208] [2017] EWCOP 19, at paragraph 39.
[209] [2017] EWCOP 22.
[210] See paragraph 79.
[211] [2018] EWCA Civ 805.

> *a person is not being deprived of their liberty where they are receiving treatment and are physically restricted by their physical infirmities and by the treatment they are receiving* […] *Arden LJ concluded* [in *Ferreira*] […] *that restrictions resulting from the administration of treatment, because they are the "well-known consequences of a person's condition, when such treatment is required", do not amount to a deprivation of liberty.*

4.45 Each of these judgments seems to go a little further than the initial description of "life-saving medical treatment", but leaves open the question of exactly where the *Ferreira* exception ends and Article 5, and the *Cheshire West* acid test for confinement, starts to apply.

4.46 In *Re D (A Child)*[212], a case mostly concerned with the scope of parental authority to authorise a deprivation of liberty for a child, Lady Arden, by then a justice of the Supreme Court, referred to her own leading judgment in Ferreira. She said at paragraph 120 (emphasis added):

> It follows that there will be cases where a person loses their liberty but the acid test in Cheshire West, as Lady Hale describes it, does not apply. That conclusion is shown by observing that D's case is about living arrangements. It is not about a child, or anyone else, needing life-saving emergency medical treatment. For the reasons which the Court of Appeal (McFarlane LJ, Sir Ross Cranston and myself) gave in R (Ferreira) v Inner South London Senior Coroner [2018] QB 487, the situation where a person is taken into (in that case) an intensive care unit for the purpose of life-saving treatment and is unable to give their consent to their consequent loss of liberty, does not result in a deprivation of liberty for article 5 purposes so long as the loss of liberty is due to the need to provide care for them on an urgent basis because of their serious medical condition, is necessary and unavoidable, and results from circumstances beyond the state's control.

4.47 During the COVID pandemic, guidance was issued by the government,[213] presumably

[212] [2019] UKSC 42.
[213] [Withdrawn] The Mental Capacity Act (2005) (MCA) and deprivation of liberty safeguards (DoLS) during the coronavirus (COVID-19) pandemic - GOV.UK (www.gov.uk).

with a view to deterring a raft of DOLS applications, asserting that "life-saving treatment being provided in care homes or hospitals" is no deprivation of liberty, and that this "includes treatment to prevent the deterioration of a person with covid" and "it is reasonable to apply this principle in both care homes and hospitals". The guidance has now been withdrawn.

4.48 Chapter 12 of draft Code of Practice for the Liberty Protection Safeguards went further and asserted that:

> a deprivation of liberty will not occur if the person is treated for a physical illness and the treatment is given under arrangements that are the same as would have been in place for a person who did not have a mental disorder. In other words, the restrictions on the person are caused by physical health problems and the treatment being provided… this approach should be applied to any form of medical treatment for physical health problems and in whatever setting the treatment is being delivered. It should not be limited to hospital settings…

4.49 We have already cautioned against reliance on the draft Code of Practice in general (see paragraph 1.9 above). This proposed interpretation of *Ferreira* – any treatment for a physical illness, anywhere – goes substantially further than the case law to date appears to support. An associated case study in the draft Code of Practice appears to discount as a potential deprivation of liberty a situation where a resident in a care home needs "constant one to one support at all times to help her get about" on the basis that this is the result of a stroke, and therefore (apparently) characterised as medical treatment. We suggest that that this should not be relied on as an authoritative interpretation of *Ferreira*, based on the current case law.

Conclusion

4.50 The law on deprivation of liberty in the context of acute medical treatment is still evolving, and likely to develop further. There can legitimately be doubt and disagreement about the extent to which *Ferreira* means that Article 5 is not engaged in this context and therefore what might otherwise clearly be a deprivation of liberty is not held to be one.

4.51 We consider that:

4.51.1 The safest ground to rely on the *Ferreira* exception is that closest to the scenario in which the case arose: life-saving treatment in intensive care, but it is clear from the reasoning and from subsequent case law that *Ferreira* does not apply only to intensive care.

4.51.2 We do not yet have clear case-law on the limit of the Ferreira exception, but the longer a patient is in hospital, and the further down the acuity slope they progress, the harder it may be to characterise their treatment as within the *Ferreira* exception.

4.51.3 That is especially the case for those who have become medically optimised for discharge, and may only still be in hospital due to lack of appropriate discharge package options.

4.51.4 Clearly, if the restrictions associated with the treatment go beyond what is required for any other patient with that physical health need, then *Ferreira* cannot be relied on to disapply Article 5.

4.51.5 In that situation, do not discount the possibility of a deprivation of liberty because the restrictions are likely only to be short-lived; there are certainly cases in which restrictions over a period of hours have been held to be a deprivation of liberty.

4.51.6 If in doubt, it is appropriate to err on the side of caution and seek authorisation *if there might be* a deprivation of liberty if the acid test criteria are met and it is not clear that the *Ferreira* exception applies.

4.51.7 Support within the hospital legal team may be able to advise on their interpretation of the *Ferreira* judgment – it is helpful if this is considered and addressed in a formal policy – or to seek legal advice and, if need be, to refer the case to court; delay in doing this is unlikely to be helpful.

4.51.8 Restrictions which are of particular concern (for example bringing a patient into hospital unwillingly by force or treating them against their wishes using restraint / sedation or deception) may well be part of a care plan which in itself requires consideration by the court to resolve a dispute over the patient's capacity to make the relevant decisions, or to determine what is in the patient's best interests. If so, the court can deal with any deprivation of liberty alongside those substantive issues.

4.52 Note that the disapplication of Article 5 by the court in *Ferreira* does not leave the patient without other safeguards, including the MCA's regulation of the assessment of their capacity and decisions about their best interests, the professional individual and organisational regulation through the NMC / GMC / CQC / CSI, for example, the legal framework for clinical negligence, NHS and independent sector complaints processes, the relevant Ombudsman, and other human rights such as Article 8.

4.53 Taking into account the case law on deprivation of liberty in the context of medical treatment, the scenarios below consider various clinical settings, starting with the patient journey into hospital by ambulance, and 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

4.54 Because, as set out above, the legal position regarding what amounts to a deprivation of liberty in hospital settings can be 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.

D: Conveyance by ambulance to or from hospital

4.55 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 MCA, as long as it is considered that being in the hospital or care home will be in their best interests.[214]

4.56 That said, the journey into hospital should not be seen in isolation. The purpose of the conveyance to hospital is likely to be for the patient to access/receive investigations or treatment, and if these are likely to be against the patient's wishes, or require a degree of restraint / restriction that warrants court review, or if the individual's capacity to make the relevant decisions about their best interests are in dispute, then this should be considered and resolved by the court before the admission, time permitting, so that the court can also consider the plans for conveyance and approve them as part of the overall plan.

4.57 The DOLS Code suggests[215] that there may be exceptional circumstances where taking a person to a hospital or a care home in itself 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 for the journey itself 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 or physically restrained for the purpose of transportation, or
- where the journey is exceptionally long

[214] Paragraph 2.14 of the DOLS Code.
[215] Paragraph 2.15.

4.58 We do not in general in this guidance address **how** authority is to be sought for deprivation of liberty in particular cases. However, we should make clear that a DOLS 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.[216] If there is a real risk 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.[217] 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[218]. 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 situation, 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 there will also amount to a deprivation of liberty).[219]

Transportation by ambulance: a deprivation of liberty

4.59 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. She has a moderate learning disability and can be uncooperative and violent at times. Jane has given birth to 2 children. They were 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

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[216] *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).*"

[217] 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 as to matters to be considered when arranging ambulance transfers, relevant beyond the context with which that case is concerned.

[218] 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).

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

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.

Key factors pointing to a deprivation of liberty in the conveyance itself:

- 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 use during the journey for a period lasting potentially over an hour.

Note: in this scenario it is likely that the overall care plan itself – including the proposed treatment and care after the admission – would need consideration and approval by the court, which would include authorisation as appropriate about the conveyance into hospital.

Transportation by ambulance: potential deprivation of liberty

4.60 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 the journey may take up to 5 hours to complete. Ahmed will require continuous care, monitoring and supervision during the course of the journey.

Key factors pointing to a potential deprivation of liberty in the conveyance itself:

- 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 about the potential for a deprivation of liberty to arise in such cases. Though the *Ferreira* judgment has not yet been tested in court in the context of a journey by ambulance, there may be an argument that this journey is just part of essential medical treatment for Ahmed, as it would be for any other patient, and so may not engage Article 5 in this context.

Transportation by ambulance: not a deprivation of liberty

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

- Trisha lives at home with support. She has 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 in the conveyance itself:

- the short length of the journey and the short duration of the restraint
- note that this is on the basis that the acid test would not be met, rather than that the Ferreira exception means that the acid test does not apply.

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

4.62 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.

4.63 As set out at paragraph 5.3 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.

4.64 The following are examples of potentially liberty-restricting measures that may be found in an A&E Department:

- physical restraint and the intensity, frequency and duration of any restraint
- the use of sedation
- the use of catheters and/or intravenous drips
- the use of close 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

A&E: a deprivation of liberty

4.65 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 lacks capacity to make relevant decisions about his care and treatment. He resists attempts by staff to take a blood test and start N-acetylcysteine treatment, in his best interests. 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 and watched/observed 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
- 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.

It may not be appropriate to rely on *Ferreira* here, as the issue is the additional restraint etc for Dan due to his behaviour, rather than the medication in itself which is the appropriate treatment for anyone with that physical health need.

A&E: potential deprivation of liberty

4.66 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 neurosurgery unit. John is assessed as lacking capacity to make relevant 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 neurosurgery 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
- 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

Note – if the need to manage his behaviour in this way is a reflection of the physical brain injury itself, rather than any pre-existing condition, then there is an argument that this is also an aspect of the essential medical treatment that he needs, as would any other patient, ie Ferreira may mean that it is not a deprivation of liberty at all.

A&E – not a deprivation of liberty

4.67 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 one morning she finds Olga sitting dazed on the kitchen floor. It appears that she has fallen and knocked her head on a 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
- note that this is on the basis that the acid test would not be met, rather than that the Ferreira exception means that the acid test does not apply.

F: Intensive Care Units ('ICU')

4.68 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.

4.69 As *Ferreira* makes clear, even care or treatment which clearly amounts to putting the patient under "continuous supervision and control" and being "not free to leave" may not amount to a deprivation of their liberty where this is essential medical treatment for their physical health and is the same as any other patient would need for that condition.

4.70 This is a difficult area, and we hope that there is likely to be further 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. Those delivering such care and treatment will be protected from liability for that treatment 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). It is easier to defend a deprivation of liberty without an authorisation than a failure to assess a patient's capacity for a decision about medical treatment or a failure to act in their best interests if they lack that capacity.

4.71 Subject to the *Ferreira* exception applying, i.e. taking into the extent to which the restrictions relate to underlying / pre-existing mental health rather than due to the current physical condition being treated, 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
- 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: not a deprivation of liberty

4.72 The measures in the following scenario are not 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 when he was unconscious 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 had 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 was allowed to normalise, and he was ventilated for a further 48 hours (72 in total), after which time it was 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 was that there could be significant, possibly complete, recovery, however, any recovery would occur over weeks to months. In the meantime he would have to stay in a hospital environment to optimise his rehabilitation. Mr Smith's family were unhappy that he had to remain in hospital and would like him to return home as soon as possible where they would care for him.

- This is likely to fall within the Ferreira exception. The essential medical treatment here is the same as would be for any other patient with this physical health need.
- Notwithstanding the care amounting to continuous supervision and control, and Mr Smith being not free to leave, it is unlikely that Article 5 would be engaged in this scenario, and the acid test should not simply be applied.

ICU: potential deprivation of liberty

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

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

We need to know more to consider whether the scenario falls within the Ferreira exception. Subject to that, key factors pointing to a potential 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 would 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

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

- Mr Dillett is a 55 year old man, who was diagnosed with oesophageal cancer. He was suitable for an oesophagectomy and receives adjuvant chemotherapy prior to his operation. He attended a pre-operative clinic and received 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 had capacity to make his own decision about his care and treatment and gave consent to the operation and to the consequential treatment plan
- the circumstances have not gone beyond those discussed and agreed at the time of Mr Dillett's consent

G: Acute ward

4.75 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

4.76 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 noticed 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. She is assessed to lack capacity to make relevant decisions about her care and treatment. 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:

- This is likely to go beyond the scope of the Ferreira exception. Mrs Jones is no longer in hospital for essential medical treatment, but to allow an opportunity for professionals to make arrangements for discharge to a care home, against her wishes
- 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: deprivation of liberty

4.77 The measures in the following scenarios are likely to amount to a deprivation of liberty.

- Ali is a 15 year old girl. She has no mental health diagnosis, but has been known to social services for many years as a result of an abusive home life. She has been removed from the family into foster care under an interim care order, while care proceedings are ongoing. Ali was moved from the foster family to a residential placement as a result of her self-harming behaviour. She will frequently swallow inedible and dangerous things, cuts herself opportunistically, and at times of emotional dysregulation she headbangs. She has had to be treated in hospital for self-inflicted injuries on numerous occasions. The current admission began when she was brought into hospital by carers at the residential placement after an incident of self-harm. There was no need for substantial medical treatment, but the placement has made clear that they too are unable to manage her safely, and have served notice. There is nowhere for Ali to be safely discharged to, though she has no medical reason to be in hospital. She is being kept on a paediatric

ward that is not suitable for her needs, and the ward is mostly occupied by very young children who are very sick. Ali demands constant attention and is hugely disruptive to the ward environment, reducing its capacity to function effectively, and resulting in potential new admissions being turned away. She is aggressive and hostile to staff and to the families of other patients. She is supported on at least a 2:1 basis to prevent her leaving the ward and to mitigate the risks of her ongoing self-harming behaviour. She is physically restrained to keep her safe on a daily basis. At times she will agree to taking medication which helps her to regulate her behaviour. At other times this is given against her wishes, either forcefully, or covertly. Social services are trying to find a suitable discharge placement but it is evident that this will take some time. The local authority, exercising parental responsibility under the interim care order, considers Ali's admission and treatment in the hospital is necessary in the interim. The local authority and the hospital do not consider that Ali is *Gillick* competent to decide whether to remain on the ward.

Key factors pointing towards a deprivation of liberty:

- no medical need to be in hospital, so clearly the Ferreira exception does not apply
- the restrictions exceed those which would be expected by reference to 'normal parental control' over a 15 year old
- use of intensive observation and physical restraint, as well as medication which is used at least party to control behaviour, and at times without her agreement
- Ali is clearly not free to leave, and is under continuous supervision and control
- there is no valid consent, either from her or from anyone with parental responsibility (though she is under 16, the interim care order means that neither the parents nor local authority can give such consent)

Note: although this guidance is not intended to cover how any deprivation of liberty can be authorised, it is important to remember that DOLS cannot be used in relation to someone under 18 years of age, so any deprivation of liberty is likely to need authorisation by the court. Early legal advice is likely to be advisable.

Acute Ward: potential deprivation of liberty

4.78 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. He lacks capacity to make decisions about his care and treatment. 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 clinically assisted nutrition and hydration via a feeding tube. He requires 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 uncertainty on whether the duration of the treatment and admission has taken this beyond the scope of the Ferreira exception
- the monitoring of Alex on the ward and the length of his stay
- whether he is free to leave will depend upon whether the hospital would, in fact, prevent Rose taking him out of the hospital 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

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 a mild learning disability. 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 and subsequent care. 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, depending on the extent to which restrictions on Daryl would be the same for any patient with his presenting physical health need, or they are more restrictive, for example, due to his learning disability

I: Questions for front-line practitioners

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

- is the medical treatment proposed, and any restrictions associated with it, materially the same as it would be for any patient with the same physical health need? (If so, the *Ferreira* exception may apply, depending on the nature of the treatment and how liberally the case should be interpreted)
- 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 fewer restrictive options available/have these been considered?
- 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 when the person is persistently trying to leave?
- is the patient prevented from leaving by distraction, locked doors (or those with keypads/baffle locks), 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?[220]
- 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?

[220] Note: we have included contact here because it is a pointer to investigating whether there are other controls on the person's physical liberty, rather than because restricting contact is, itself, gives rise to a deprivation of liberty. And any restriction on contact will need to be justified in any event: see paragraph 2.67.

- 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?
- do 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?

6. The psychiatric setting

A: Introduction

6.1 This chapter considers how to identify deprivation of liberty in psychiatric hospitals. Such hospitals vary greatly depending on the level of security and the client group.

6.2 Please also see Chapters 7 and 8 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

6.3 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.

6.4 The same definition appears in s.206 National Health Service (Wales) Act 2006. This is also the definition used by the MHA 1983.

6.5 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.

6.6 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:

6.6.1 acute wards
6.6.2 rehabilitation wards or “stepdown” placements
6.6.3 CAMHS (Children and Adolescent Mental Health Services) wards;
6.6.4 assessment and treatment units (ATUs), and
6.6.5 dementia specialist units

6.7 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 Integrated Care Board ('ICB').[221] In all these settings patients may be treated for their mental 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 confinement; or (2) if it does, they can consent to the restrictions amounting to confinement. A patient can only be an ‘informal’ or ‘voluntary’ patient in such circumstances if they have the ability 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* [222] and paragraphs 2.16-2.20 above. We reiterate our view that it is not possible to consent in advance to being confined in such a situation: see paragraph 2.20.

6.8 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, depending on their age and circumstances:

6.8.1 the provisions of the MHA 1983;
6.8.2 DOLS, i.e. the provisions of Schedule A1 Mental Capacity Act 2005 (“DOLS”);
6.8.3 by way of an order made by the Court of Protection.
6.8.4 by way of an order made under the inherent jurisdiction of the High Court (in relation to a person under 18, or, very unusually, in relation to a person over 18).

[221] 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 2.21.
[222] [2013] EWHC 272 (Fam).

6.9 The decision as to which legal framework to use is outside the scope of this document but will first require an assessment of:

6.1.1. 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*"[223] that they may do so;

6.1.2. if so, whether the patient can, and does, consent to those arrangements.

6.10 In addition to the availability of legal frameworks to authorise deprivation of liberty, practitioners must apply the provisions of the relevant MHA Code of Practice for Engand or Wales, 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*."[224] This also includes treatment in the community.

6.1 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).

6.11 It should be noted that the Care Quality Commission has expressed the view – in relation to adults – that any incapacitated patient who requires psychiatric admission is likely to satisfy the "acid test" for deprivation of liberty.[225]

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[223] *AM v South London and Maudsley NHS Foundation Trust* [2013] UKUT 365 AAC.
[224] S118 (1) (b).
[225] "Monitoring the Mental Health Act 2013/4" (page 47).

C: The Mental Health Units (Use of Force) Act 2018

6.12 The use of force in the mental health setting in England (not Wales) is also subject to the provisions of the Mental Health Units (Use of Force) Act 2018, commonly known as 'Seni's Law,' after Olaseni (Seni) Lewis, a young Black man who died after being restrained by police officers in a psychiatric hospital. Our view is that any situation where force is being used falling within the scope of the Act on anything more than a one-off basis is a very strong pointer to the person in question being confined for purposes of this guidance.

6.13 For purposes of the 2018 Act, the statutory guidance[226] identifies that the types of unit would be considered within the definition of a mental health unit include non-exhaustively:

- acute mental health wards for adults of working age and psychiatric intensive care units;
- long stay or rehabilitation mental health wards for working age adults;
- forensic inpatient or secure wards (low, medium and high);
- child and adolescent mental health wards;
- wards for older people with mental health problems;
- wards for people with autism or a learning disability;
- specialist mental health eating disorder services;
- inpatient mother and baby units;
- acute hospital wards where patients are "detained under the Mental Health Act 1983 for assessment and treatment of their mental disorder.

[226] Available at https://www.gov.uk/government/publications/mental-health-units-use-of-force-act-2018/mental-health-units-use-of-force-act-2018-statutory-guidance-for-nhs-organisations-in-england-and-police-forces-in-england-and-wales.

6.14 Conversely, the statutory guidance identifies that the following services are considered to be outside of the definition of a mental health unit and therefore not covered by the requirements of the Act (again, not an exhaustive list):

- accident and emergency departments;
- suites for the reception of patients under ss.135 / 136 Mental Health Act 1983 that are outside of a mental health unit;
- outpatient departments or clinics;
- mental health transport vehicles.

6.15 The use of force includes physical, mechanical or chemical restraint of a patient, or the isolation of a patient (which includes seclusion and segregation), force being defined as:

- physical restraint: the use of physical contact that is intended to prevent, restrict or subdue movement of any part of the patient's body. This would include holding a patient to give them a depot injection
- mechanical restraint: the use of a device that is intended to prevent, restrict or subdue movement of any part of the patient's body, and is for the primary purpose of behavioural control
- chemical restraint: the use of medication that is intended to prevent, restrict or subdue movement of any part of the patient's body. This includes the use of rapid tranquillisation.

D: Psychiatric hospitals generally: measures which restrict liberty

6.16 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 please
- 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
- use of seclusion[227], 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

[227] Seclusion is defined in the 2015 MHA Code of Practice for England at paragraph 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."*

E: An acute ward

6.17 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

6.18 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 keypad 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

6.19 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

6.20 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.

F: a rehabilitation or "step down" ward

6.21 This setting will share some of the features of the acute ward, and many of the measures outlined at paragraph 6.12 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

6.22 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

6.23 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 and she is considered not to have capacity to consent to any confinement to which she might be subject to secure her care needs. 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. 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

6.24 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 and to consent to any confinement to which she might be subject to secure her care needs. 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

Note: if the arrangements did give rise to confinement, it will be necessary to consider whether Naomi has capacity to consent to them.

G: a CAMHS ward

6.25 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 6.12 are likely to be present. However, the environment should be suitable for the age of the child or young person 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.[228]

6.26 In particular given the scarcity of CAMHS beds, and the resulting severity of the conditions likely to be affecting the children and young people who are admitted to them, and hence the nature of the restrictions to which they will be subjected to secure their interests (and / or those of others), we cannot identify scenarios in the CAMHS setting which do not give rise to a real risk of deprivation of liberty (where the individual lacks the material competence or capacity to consent to the restrictions imposed upon them).

6.27 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 between the ages of 16 and 17 lacks capacity to consent or refuse care arrangements which amount to a deprivation of liberty: *Re D.*[229] The MHA Codes of Practice advise that a child who is *Gillick* competent to do so can consent to their admission to hospital and it also advises against relying on parental consent to override the child's refusal of admission.[230] In relation to under 16s who lack the *Gillick* competence to make decisions about their care arrangements, as discussed at paragraph 4.16, it may be possible for biological parents to consent to their child's confinement so that no deprivation of liberty arises, provided that this falls within the proper exercise of their parental responsibilities.[231] Given the inevitably extensive restrictions to which their child will be subject, we suggest that real caution must be exercised before relying upon the consent of a person with parental responsibility to admit a child under 16 to an in-patient CAMHS ward.

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[228] See generally chapter 19 of the Mental Health Act Codes of Practice for both England Wales.
[229] [2011] EWCA Civ 1305. As discussed in chapter 4, the Supreme Court in *Re D* held that a young person who is subject to a level of control beyond that which is normal for a young person of the same age has been confined within the meaning of Article 5(1) and that parents cannot consent to the confinement on the young person's behalf (see paragraphs 41 and 42).
[230] See paragraphs 4.19-4.21 above.
[231] However, if the child is subject to a care order, neither the parents nor the local authority can consent to the child's confinement: See *Re A-F (Children)* [2018] EWHC 138 (Fam) at paragraph 12.

A CAMHS ward: a deprivation of liberty

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

- Ms Anna Beacon is 16 years old and suffers with severe anorexia. She is admitted to a CAMHS ward run by an NHS Foundation Trust 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 permitted to leave her hospital bed for a number of weeks during the re-feeding process.

Key factors pointing to a deprivation of liberty:

- the confinement condition is met: the nursing care that Anna will be receiving while on the ward will mean that she is subject to constant supervision and control. She will also be subject to physical/chemical sedation during the course of her stay on the ward and will not be free to leave the ward. The restrictions placed on Anna go beyond normal parental control for a non-disabled young person aged 16 (the age comparator test)
- the lack of valid consent condition is met: Anna is unable to consent to her confinement, and no-one with parental responsibility can do so[232]
- the state responsibility condition is met: Anna has been placed in a CAMHS ward which is managed and funded by the NHS

If Anna was aged 14 (and if she lacked *Gillick* competence to decide on her care arrangements), it is suggested that such arrangements would still amount to a deprivation of liberty. This is because the measures go beyond normal parental control for a non-disabled 14 year old so she would be confined. The State responsibility condition would still be met (the confinement taking place in an NHS hospital). Whether Anna was deprived of her liberty would therefore depend on whether her parents could consent to the restrictions that are being placed on Anna. Given the invasiveness of the proposed treatment, the significant restrictions to be placed on Anna (in particular, the use of physical and chemical restraint) it is suggested

[232] *Re D (A Child)* [2019] UKSC 42

that consenting to such measures falls outside the scope of parental responsibility (see paragraphs 4.19-4.21 above).[233]

[233] See Department of Health, Mental Health Act 1983: Code of Practice, para 19.41 which refers to the wishes of the child and whether the child is resisting the decision. See also Example B (page 204 of the Code).

H: an Assessment and Treatment Unit (ATU)

6.29 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 6.21 above, some or all of which may be present in ATUs, there is consistent and troubling evidence of restrictive practices in such units.[234] These include:

- physical restraint
- chemical restraint
- seclusion (often described in misleading terms, not recognised as such and thus not reviewed in accordance with the Code of Practice to the MHA 1983)
- blanket rules not justified by the needs of the individual patient. This can be exacerbated by pressure on staff through low numbers

6.30 We cannot identify scenarios in the ATU setting which do 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

6.31 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.

[234] See, for instance, the report of the Joint Committee on Human Rights on the Detention of young people with learning disability and / or autism (HC 121; HL Paper 10, 2019), available at https://committees.parliament.uk/work/3253/detention-of-children-and-young-people-with-learning-disabilities-andor-autism-inquiry/publications/.

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

I: a dementia specialist unit

6.32 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

6.33 As such, we consider it highly likely that a patient in this setting who lacks capacity to consent to admission will 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

J. Summary of questions for front-line staff

6.34 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 (for instance to prepare refreshments or access items for leisure activities)?
- 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?[235]
- 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?

[235] Note: we have included contact here because it is a pointer to investigating whether there are other controls on the person's physical liberty, rather than because restricting contact is, itself, gives rise to a deprivation of liberty. And any restriction on contact will need to be justified in any event: see paragraph 2.67.

7. The care home setting

A: Introduction

6.35 By far the highest number of applications for authorisations under the Deprivation of Liberty Safeguards (DOLS) are made by care homes.[236] 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.*

6.36 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.

6.37 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 mealtimes 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 – which is concerned with those over 18[237] – looks at the type of liberty-restricting

[236] Residential homes and nursing homes together making up around 60% of all applications in England in 2022-23: see the NHS Digital Statistics for England for the year 1 April 2023 – 31 March 2024.
[237] See Chapter 4 for the considerations that arise in relation to those under 18.

measures which could be present in the following settings which come within the definition of a care home:

6.37.1 A residential care home for older adults;

6.37.2 A care home with nursing;

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

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

6.37.5 An arrangement for respite.

6.38 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 liberty. Following the scenarios are questions which can 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

6.39 In 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 and the Social Services and Well-Being (Wales) Act 2014 to provide care and support. However, 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*[238] (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.*"

6.40 Some care home residents will <u>both</u> have capacity to consent to their care and support arrangements, including restrictions that follow on from these arrangements, <u>and</u> will have consented to them. As explained at paragraph 2.11, 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.

6.41 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:

6.41.1 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.[239] 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

[238] [2010] EWHC 978 (Fam).
[239] Schedule A1 to the MCA 2005, Paragraphs 1(2) and 2.

family life. (See *London Borough of Hillingdon v Neary*,[240] and also *Re AJ (Deprivation of Liberty Safeguards)*.[241] 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. Further, an individual subject to authorisation must be supported at all times by either a Relevant Person's Representative and / or an Independent Mental Capacity Advocate, whose tasks include ensuring that the individual is supported to exercise their right to challenge their authorisation – with the supervisory body acting as 'backstop' to ensure that the case is brought before the court if the RPR / IMCA does not carry out their task properly.[242]

6.41.2 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 5(1)(e); (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;

6.41.3 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. Note that it is arguable[243] (although has not been expressly confirmed by a court) that a person who has been placed "in the custody" of a designated person at the care home by their Responsible Clinician exercising

[240] [2011] EWCOP 1377.
[241] [2015] EWCOP 5.
[242] See *AJ (Deprivation Of Liberty Safeguards)* [2015] EWCOP 5 and also *RD & Ors (Duties and Powers of Relevant Person's Representatives and Section 39D IMCAS)* [2016] EWCOP 49.
[243] And the approach taken by the Department of Health and Social Care and Ministry of Justice: see, for instance, the 2019 Mental Health Casework Section Guidance: Discharge conditions that amount to deprivation of liberty at page 4.

their powers under s.17(3) does not, in fact, require a DOLS authorisation, as s.17(3) itself provides authority for the deprivation of their liberty. However, a parallel DOLS authorisation secures the person access to the support and appeal mechanisms set out at paragraph 7.7.2 above.[244]

6.41.4 A guardianship order under s.7 MHA 1983. This gives the guardian (usually a social worker acting on behalf of the local authority) the following powers:[245]

(1) the power to require the patient to reside at a place specified by the guardian;

(2) the power to require the patient to attend at specified places and times for medical treatment, occupation, education or training;

(3) 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;

(4) if certain conditions are met, guardianship can be used alongside DOLS: see Schedule 1A to the MCA 2005. Guardianship alone does not authorise deprivation of liberty,[246] so where the person is deprived of their liberty in a care home, a DOLS authorisation will be required. However, the mere exercise of the power of the guardian to require a patient to live at a specific place does not itself necessarily give rise to a deprivation of liberty.[247]

6.41.5 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 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.[248] A CTO does not provide authority to deprive people of their liberty, nor can conditions on a

[244] Albeit, as addressed in the guidance noted in the footnote immediately above and *DY v A City Council & Anor* [2022] EWCOP 51, complexities will arise if the primary purpose of the confinement is for public protection.
[245] Section 8(1)(a) MHA 1983.
[246] *A Local Authority v AB* [2020] EWCOP 39.
[247] See *NL v Hampshire County Council* [2014] UKUT 475 (AAC).
[248] By analogy also with the *NL* case discussed immediately above.

CTO give rise to a deprivation of liberty,[249] but a DOLS authorisation may be used together with a CTO where they are compatible: see Schedule 1A to the MCA 2005;

6.41.6 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, nor can conditions on a discharge give rise to a deprivation of liberty.[250] However, where the person lacks the 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;

6.41.7 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.

[249] *Welsh Ministers v PJ* [2018] UKSC 66.
[250] *Secretary of State for Justice v MM* [2018] UKSC 60.

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

6.42 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 way. These challenges include:

6.42.1 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?

6.42.2 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?

6.42.3 Promoting family and private life: how can care settings promote important intimate (which may include sexual) relations between residents?\

6.43 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;[251]
- 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;

[251] The CQC consider this to be a relevant factor in their document "Using Surveillance," April 2022, 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;[252]
- Use of restraint in the event of objections or resistance to personal care. (In *Re AJ*,[253] 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 or bucket chairs;
- 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

6.44 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 and 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. He lacks capacity to make decision as to his residence and care arrangements. Peter has his own room at the home. He can summon staff by bell if he needs help. Peter 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. Peter is unable to remember a number and dial it himself. He rarely asks to make phone calls. Peter is visited regularly by Jackie. She has asked to be allowed to stay overnight with Peter in his room but this

[252] Note: we have included contact here because it is a pointer to investigating whether there are other controls on the person's physical liberty, rather than because restricting contact is, itself, gives rise to a deprivation of liberty. And any restriction on contact will need to be justified in any event: see paragraph 2.67.
[253] [2015] EWCOP 5.

request has been refused. The home has a keypad entry system, so service users would need to be able to use the keypad 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 him 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 and cannot go out unaccompanied.
- His discontent is managed by distraction.

Note: the denial of overnight visits from his wife is not necessarily a matter constraining Peter's physical liberty but it is a matter which will require justification as an interference with his (and her) rights under Article 8: see paragraph 2.67.

Care home for older adults: potential deprivation of liberty

6.45 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. Mr Ghauri 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, Mr Ghauri had capacity to make the decision to move. However, his dementia has progressed, and staff consider he may now be less able to make more complex decisions. He has his own room. Mr Ghauri 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. Mr Ghauri 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 when expected 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 to live somewhere else. 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

6.46 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. Mrs Banotti lives in a 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. Mrs Banotti 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, Mrs Banotti 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 at 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, both temporarily and permanently, whatever the level of supervision and control to which she may be subjected. However, she is not under continuous supervision and control.

Note: this scenario may not give rise to a question of deprivation of liberty, but it does – or should – give rise to a separate safeguarding issue requiring investigation as to Mrs Banotti's circumstances.

D: A care home with nursing

6.47 The challenges to providing care in the least restrictive way identified in paragraph 7.8 will be present here. The liberty-restricting measures described in paragraph 7.9 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 and to manage behaviour.
- 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 7.9).
- 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 confinement. However, it should be noted that not every resident who lacks capacity will be deprived of their liberty: if they have the capacity to do so, they can consent to the arrangements and no deprivation of liberty will arise.

Care home with nursing: a deprivation of liberty

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

Mr Lopez

- 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 has resided for the last month. Due to Mr Lopez co-existing physical and other mental health difficulties, including schizoaffective 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

- Mrs Neville is 85. She lives in a care home with nursing and has Alzheimer's dementia, which is now advanced. Mrs Neville is very confused and disorientated and can now only manage very simple conversations. She is physically fit and mobile. Mrs Neville 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

6.49 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 20s. He has lived for the last thirty years in a housing association flat where he has a tenancy support worker. Mr Alexander is subject to a guardianship order and the local authority is his guardian. He also has a CPN.

Last year, Mr Alexander 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, Mr Alexander 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. Mr Alexander 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 7.7.4). 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

6.50 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.[254] 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 7.9 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, if the care plan for the person involves measures to ensure that the person stays there;
- 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.[255]

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

6.51 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 five 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:

[254] However, it should be noted that protection of the public alone cannot justify a DOLS authorisation.

[255] Note: we have included contact here because it is a pointer to investigating whether there are other controls on the person's physical liberty, rather than because restricting contact is, itself, gives rise to a deprivation of liberty. And any restriction on contact will need to be justified in any event: see paragraph 2.67.

(1) to reside at the care home;
(2) to take treatment as prescribed by his RC;
(3) to maintain contact with his social supervisor.

The care plan agreed between the local authority and the Mental Health Trust includes provisions to ensure that Harry does not leave the care home. 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 five years ago. Harry 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. Harry is only allowed community contact accompanied by a worker which includes going to the local pub two nights a week. It is considered by the local authority that he does not have capacity to agree to the arrangements put in place.

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

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

- Milon is 25 years old. He has a diagnosis of schizophrenia which is complicated by his use of illicit drugs. Milon has accumulated a number of criminal convictions, mainly for shoplifting. He has become estranged from his parents and does not have his own accommodation. Milon 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 him 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 7.7.5.)
- 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:

6.53 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, Jim was transferred to hospital and responded to treatment and was returned to prison where he completed his sentence. Since then, Jim 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:
    (1) To reside in a care home for people with mental health problems;
    (2) To attend a day centre 3 times a week;
    (3) 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 alone does not itself prevent him from doing so: see paragraph 7.7.5.

Note: the fact that there is a disagreement between Jim and his RC as to where he should live is an issue that requires investigation and resolution, potentially through the involvement of an advocate.

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

6.54 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 7.9);
- 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.[256]

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

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

[256] Note: we have included contact here because it is a pointer to investigating whether there are other controls on the person's physical liberty, rather than because restricting contact is, itself, gives rise to a deprivation of liberty. And any restriction on contact will need to be justified in any event: see paragraph 2.67.

- John Jones is 18. He was the subject of a care order six years ago on the grounds of severe neglect. John has a learning disability, a diagnosis of ADHD, and presents with challenging behaviour. He lacks capacity to make decisions about his care and treatment. John 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 (CQC) 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

6.56 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 him 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. Max is on medication to try to calm down his agitation. He works five 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

6.57 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 deceased and she has no other family. For the last 15 years she has lived in a small group home with four other women of similar age, one of whom she has known since childhood when they attended the same school. Staff are present 24 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 three days a week. Rina is able to travel independently. She has a key worker with whom she plans her week. When Rina 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 that 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:

- 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.

Note: because the arrangements do not give rise to a confinement of Rina there is, strictly, no need to consider her capacity to consent to them.

G: Questions for frontline staff

6.58 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 any way? 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, guardianship, or s.17(3) MHA 1983 leave? 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?[257]
- 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?

[257] Note: we have included contact here because it is a pointer to investigating whether there are other controls on the person's physical liberty, rather than because restricting contact is, itself, gives rise to a deprivation of liberty. And any restriction on contact will need to be justified in any event: see paragraph 2.67.

Appendix: Respite placements

6.59 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.

6.60 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 3.32-3.35 deal with this important point.

6.61 In particular, we repeat 3.34:

> Because the period will vary from setting to setting, we have deliberately avoided giving a period of time that can be considered "safe".' Our view is that it is unlikely under any circumstances to extend beyond a few (two-three) 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.[258] 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. Furthermore, even if the Code was trying to say that there is no deprivation of liberty where the period of confinement lasts less than 7 days, this could not make it so in law. The law – here – is set by the courts, which have confirmed that a deprivation of liberty can arise in very much less time than that.

[258] Most obviously paragraphs 6.3 and 6.4.

6.62 Attention is also drawn to the comments of Baker J in *Re AJ*[259] 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."

6.63 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:

- 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?

6.64 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 9. 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 9.

- Peter, the care home resident with dementia described in paragraph 7.10, normally lives with his wife Jackie who provides most 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.

[259] [2015] EWCOP 5.

- Max, who is described in paragraph 7.22, in fact lives with Greta full-time, with some help from the local authority. She wants to go away for a long weekend. Greta 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 7.23, has 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. Her routine of going to college will be no different, as the care home is very close to her home. If Rina wishes to go home during this period, she has keys to the family home and can return there without staff support, although she has never chosen to do this.

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.

6.65 For those who are deprived of their liberty in respite placements, it is important, perhaps, to highlight 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.

6.66 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 placement.[260] 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).

6.67 We should emphasise that we consider that this route[261] 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 A1[262] if there is such a degree of regularity.[263]

6.68 In any situation such as that described immediately above, it will be necessary to consider the care plan as a whole and whether the individual's home as well as regular and defined respite stays, amounts to a deprivation of liberty and therefore the Standard Authorisation should logically cater for the respite stay (whereas the home placement would need be covered by an order of the Court of Protection).

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[260] If it is a hospital or care home falling within the scope of Schedule A1.
[261] 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).
[262] I.e. the first condition that must be satisfied for them to meet the best interests requirement under Schedule A1.
[263] 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 determining this point, 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.

8. Supported living services, shared lives schemes and extra care housing

A: Introduction

4.1 This chapter focuses upon the intensity of care regimes provided to those adults[264] lacking the capacity to decide on their care arrangements in supported living services, shared lives and extra care housing schemes. The Deprivation of Liberty Safeguards are not available in such situations, therefore any deprivation of liberty will require authorisation by the Court of Protection.

B: What is a supported living service?

4.2 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[265] 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.

4.3 Supported living services need only be registered with the Care Quality Commission or Care Inspectorate Wales 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,

[264] The issues that arise in relation to those under 18 are addressed in Chapter 4.
[265] Tenancy issues are outside the scope of this guidance, but can be found at 'Guidance Note: Capacity and Housing Issues' (39 Essex Chambers).

where nursing or personal care is provided to those, for example, with more complex needs, such care will be a regulated activity requiring registration.

4.4 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

4.5 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;[266]
- 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;

[266] Note: we have included these here because they are a pointer to investigating whether there are other controls on the person's physical liberty, rather than they themselves rise to a deprivation of liberty. Any such restrictions have to be justified in any event: see paragraph 2.67.

- Restricted access to modes of social communication, such as internet, landline or mobile telephone, correspondence;[267]
- Positive behavioural reward systems, to reward "good" behaviour;
- Restricted access to family, depending on level of risk and availability of staff and resources;[268]
- Lack of flexibility, in terms of having activities timetabled, set mealtimes, expected sleep times.

Supported living: a deprivation of liberty

4.6 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

[267] Note: we have included these here because they are a pointer to investigating whether there are other controls on the person's physical liberty, rather than they themselves rise to a deprivation of liberty. Any such restrictions have to be justified in any event: see paragraph 2.67.

[268] Note: we have included contact here because it is a pointer to investigating whether there are other controls on the person's physical liberty, rather than because restricting contact is, itself, gives rise to a deprivation of liberty. And any restriction on contact will need to be justified in any event: see paragraph 2.67.

Supported living: potential deprivation of liberty

4.7 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;
- it is important to consider the steps that would be taken if he did not return.

Supported living: not a deprivation of liberty

4.8 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?

4.9 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 carer 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.

4.10 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.

4.11 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 and its associated Regulations (SI 2014 / 2936). 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.

Shared Lives schemes: liberty-restricting measures

4.12 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

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

- Nora is 18 years old with a 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 detained. 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.[269]

Shared Lives schemes: potential deprivation of liberty

4.14 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

[269] Based upon the case of *MIG* in the Supreme Court.

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 headphones 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 carer accompanying him.

Shared Lives schemes: no deprivation of liberty

4.15 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. Every Sunday she goes to church and every Tuesday she goes shopping with Mrs Baker. The family go out together on regular excursions and holiday twice a year.

Key factors pointing away from 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?

4.16 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.

4.17 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.

4.18 Moving into extra care housing may be a 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

4.19 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

4.20 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 unless a carer accompanies him.

Extra care housing: potential deprivation of liberty

4.21 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

4.22 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/complete supervision or control

E: Questions for front-line practitioners

4.23 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?[270]
- 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?[271]
- To what extent is the person able to decline assistance when it is available?

[270] Note: we have included these here because they are a pointer to investigating whether there are other controls on the person's physical liberty, rather than they themselves rise to a deprivation of liberty. Any such restrictions have to be justified in any event: see paragraph 2.67.

[271] Note: we have included contact here because it is a pointer to investigating whether there are other controls on the person's physical liberty, rather than because restricting contact is, itself, gives rise to a deprivation of liberty. And any restriction on contact will need to be justified in any event: see paragraph 2.67.

9. Deprivation of liberty at home

A: Introduction

9.2 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 8.[272] The position of children is considered in Chapter 4. It may also be useful to have regard to paragraph 2.20.4 in relation to the application of the test for capacity to consent to confinement in relation to concrete circumstances with which the person is familiar – a situation which may arise in the home setting.

B: Determination of State responsibility

9.3 Consideration of the State's obligations under Article 5 ECHR was examined in the case of *Staffordshire County Council v SRK and others*.[273] This case considered if a deprivation of liberty could occur in circumstances where a care package was being funded privately for a person who had been assessed as lacking capacity to make the relevant decisions and if this has to be authorised through the Court of Protection (see also paragraphs 2.53ff). In that case, neither the local authority nor any other public body such as the Integrated Care Board (ICB) had any input in to the care arrangements in place for SRK. However, the outcome of the case was that the State knew or ought to have known of the circumstances of the care regime and therefore had indirect responsibility. This case identified that as SRK had a compensation award, the Court had appointed a deputy to act on SRK's behalf, making best interest decisions and so equated to the State having knowledge of the care regime as the Court was aware of the situation. In that case, a court order was required to authorise

[272] 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).
[273] [2016] EWCOP 27.

the deprivation of liberty as SRK's circumstances fell outside those which could be authorised by way of a DOLS authorisation.

9.4 The case is of particular importance to financial deputies. They should bring to the local authority's attention any care regime which requires further consideration and examination given the clear indication given that even with commissioned private care in a person's own home, this can equate to a deprivation of the person's liberty which must be authorised.

C: Depriving the liberty of a person in their home

9.5 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 to deciding what constitutes a deprivation of liberty,[274] it is entirely 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.

9.6 An example of such a case is *Re AEL*,[275] decided in 2021. This case involved a woman who had a number of physical and mental disabilities as a result of a rare chromosomal condition. After the residential unit she lived in closed, she returned to the care of her family with a care regime provided through direct payments from the local authority, LB Hillingdon. She was assessed as requiring 24-hour care and 2:1 supervision in the community for some activities. An application was made by the local authority to authorise the deprivation of liberty which was disputed by AEL's father who did not believe that AEL was the subject of 'continuous supervision and control.' He also strongly resisted the characterisation of the situation as deprivation of liberty on the basis that the care he was providing was loving and the least restrictive necessary to secure AEL's welfare and, indeed, her life.

9.7 It was argued before SJ Hilder that AEL's case was similar to three other cases where deprivation of liberty had not been found to occur.[276] SJ Hilder did not agree that

[274] Paragraph 57.
[275] [2021] EWCOP 9.
[276] *W City Council v L* [2015] EWCOP 20, *Bournemouth BC v PS & DS* [2015] EWCOP 39 and *Rochdale MBC v KW* [2014] EWCOP 45.

AEL's case was similar, and also appeared to cast doubt upon the correctness of the three decisions in question.

9.8 SJ Hilder considered that the key aspects of AEL's care regime which meant that she was not free and was subject to continuous supervision and control were as follows:

- AEL was never left alone; she required and was given 24-hour care and supervision. It was irrelevant that this was benign and did not appear to be resented by AEL;

- All the activities AEL undertook were risk assessed by her parents and/or carers and so although she was given the opportunity to make choices, this was limited by the risk assessments completed and AEL would be stopped from participating in activities which her parents or carers might consider would compromise her safety.

D: The home environment: liberty restricting measures

9.9 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).

9.10 However, it is important to remember that MIG was found to be deprived of her liberty in an adult foster placement – a home-like environment, for instance – in circumstances where the supervision and control to which she was subject was "intensive support in most aspects of daily living,"[277] even though she attended a further education college daily during term time and was taken on trips and holidays by her foster mother.

9.11 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;

[277] *Cheshire West* at paragraph 13.

- 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;
- The use of real-time monitoring within the home environment (for instance by use of CCTV or other assistive technology);[278]
- 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 keypad) 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;[279]
- Use of medication to sedate or manage behaviour, including PRN.

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

9.12 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.

Care arrangements in the home: a deprivation of liberty

9.13 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

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

[279] 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*.

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.

A s.117 MHA 1983 meeting takes place. Veronica attends the meeting and pleads not to go to a care home. The ICB 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 24/7 and Veronica never being left by those carers
- 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

9.14 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

9.15 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:

- Susan is able to access the community on her own and so is not subject to continuous supervision and control – her whereabouts may not be known at all times

F: Considerations for front-line practitioners

9.16 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 keypad)?
- 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 or any other activities that they may or may not engage in?[280]
- Are they ever left alone in the property and if so, are there whereabouts known at this time?
- Can they go out alone and without restrictions?

[280] Note: we have included contact here because it is a pointer to investigating whether there are other controls on the person's physical liberty, rather than because restricting contact is, itself, gives rise to a deprivation of liberty. And any restriction on contact will need to be justified in any event: see paragraph 2.67.

10. The hospice and palliative setting

A: Introduction

10.1 Palliative care and end of life care is available across all care settings from acute hospitals, specialist units such as hospices, care homes and one's own home. It could be being delivered by NHS staff, by NHS-commissioned staff, or other providers. Most hospices are distinct, local charities funded by their communities with only a very small proportion of the cost covered by NHS commissioners. They are part of the independent sector. Private providers also offer home-based care.

B: Palliative care provided in a hospice or in hospital

10.2 This part of the guidance concentrates on care provided in a hospice or a hospital to a person as an in-patient for a terminal illness.

10.3 The same broad approach as taken in Chapter 5 will apply, and we therefore do not repeat paragraphs 5.30-5.52 above. There are two key differences:

10.1.1. We suggest that, in general, the nature of care and treatment being delivered means that it will not be easy to satisfy the *Ferreira* exception. Although there will be occasions when hospice / palliative care can be described as the description of immediately necessary life-saving medical treatment, it is not common for this to be the case in this setting.[281] This means that it will be necessary to consider the "acid test" as set out in Chapter 2;

10.1.2. Conversely, provided the proposed treatment and treatment plan is explained to the person on admission and the person has capacity[282] to do so, and 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

[281] And, as noted at paragraph 5.43, the case of *PL v Sutton CCG* [2017] EWCOP 22, concerning palliative care following the withdrawal of life-sustaining treatment is perhaps difficult to square with the judgment in *Ferreira*.
[282] Or competence in the case of a child under 16.

falling within the scope of the Article 5(1).[283] This, however, must be kept under review during the person's stay in the hospice and consideration given as to whether the care and treatment provided to the patient differs from the agreed treatment plan (because of changes to the patient's condition) such that the consent given on admission is no longer valid and the person may be deprived of their liberty if they are unable to consent to such a change of plan.[284]

10.4 However, if the person lacks capacity to make decisions about their care and treatment at the time of admission, 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.[285]

10.5 When looking at the factual situation, two matters are likely to be relevant:

10.1.1. Most people suffering from a terminal illness are usually only admitted to a hospice to manage complex symptoms or towards the end of their life. Therefore, it may be that they are not in the relevant place for long enough for Article 5(1) ECHR to be engaged. Further, given that admissions are unlikely to be against the person's will, there may be more "wriggle room" to say that the impact of any restrictions to which they are subject are less, such that the "non-negligible" period of time is longer than it might be in other situations: see further paragraphs 3.31-3.35; and

10.1.2. A hospice is also unlikely to insist on a person remaining in the hospice if the family wanted them to return home with suitable care. In some situations, therefore, it might well be that the person could be seen as "free to leave" in a way that they might not be in other situations.

[283] The subjective element is discussed further at paragraphs 2.16-2.20.
[284] 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.
[285] Given the regulation of hospices, then even if the hospice is run by a private charity, the 'state imputability' limb will always be satisfied: see further chapter 2.55.

10.6 We recognise the need for proportionality in identifying when those in in-patient hospice / palliative settings are to be said to be deprived of their liberty. However, proportionality can only go so far. Despite accounting for the factors set out above, there will still be circumstances that give rise to a deprivation of liberty requiring authorisation. If the person is in an in-patient facility registered as a hospital, and are over 18, that authorisation will be by way of DOLS authorisation; otherwise, a court order will be required.

10.7 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 and the person can no longer consent to the change of plan;
- Administering sedatives to decrease anxiety and agitation, for instance in the context of an acute mental health disturbance;
- Chemical restraint for delirium or terminal agitation;
- 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.

10.8 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.

In-patient palliative care: a deprivation of liberty

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

- Mariam is 34 years old. She has a four year-old daughter and two 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 its beautiful gardens. Mariam has agreed with her partner and

the hospice team 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. Mariam 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. At the point of admission, she is assessed as lacking capacity to consent to her admission and the proposed treatment plan. Although confused, Mariam 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 must be restrained by staff to ensure that she remains at the hospice to receive care. Mariam's partner has now told Hospice staff that he is unable to cope with her 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. 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 several weeks.
- The care plan has materially changed from what she agreed to and planned when she had capacity to do so (e.g. she is no longer going home at weekends).

In-patient palliative care: not a deprivation of liberty#

10.10 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, Mandeep 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 care wishes and preferences when she began to die. 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, Mandeep agreed to care that reflected the terms of the advance care plan. Not long after she is admitted, Mandeep loses capacity to make care and treatment decisions. The Hospice continues to care and treat her in accordance with the agreed care package that includes some periodical sedation for anxieties that she is unable to articulate.

Key factors pointing away from a deprivation of liberty:

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

C: Palliative care provided at home

10.11 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.

Palliative care at home: a deprivation of liberty

- Winston had lived a long life and was used to doing his own thing. He had always been active and walked daily. Winston had developed parkinsonism and a probable Lewy Body dementia in the last couple of years. Not only had he become less steady on his feet, but his capacity fluctuated. Winston now needed someone to help him following a couple of nasty falls in the street and allagreed, including him, that he shouldn't go out alone anymore. The problem was that, as his short-term memory worsened, Winston had forgotten the initial conversation and subsequent reminders of it within about an hour. His behaviour was also changing, and he had become increasingly irritable and frustrated when he wanted to have some fresh air, but there was no carer to walk with him. Winston's care package allowed for two visits a day so that he could exercise. Matters came to a head when he began insisting upon "being let off the lead" as he put it when there was no one to accompany him. His wife worried that she could not chase after him when one day he became aggressive and walked out alone. She managed to persuade him back in and thereafter began to lock the doors.

Key factors pointing towards a deprivation of liberty:

- Winston is not free to leave, and it is highly likely that he is under supervision and control from his wife (even if she might well resist such a characterisation).
- Even if Winston might at one stage have indicated his willingness to be confined, it is unclear that he did so with sufficient clarity for it to constitute consent in advance; in any event, it would be problematic to rely upon such consent in light of the increased surveillance of him required as his condition has deteriorated.

Palliative care at home: not a deprivation of liberty

- Christiana knew from childhood that she was likely to develop Huntington's Disease, as she carried the gene. She had vague memories of her grandfather's death in the family home when she was a young child. Her late teenage years had been spent caring for her mother as she progressed through the disease. Christiana's mother experienced uncontrolled abnormal limb movement, physical dependency, mental health disturbances and advancing dementia. It was an unwritten agreement in her closely-knit family that they looked after their own and that, like her mother, she would die in her own bed. To have some sense of control and positivity, Christiana was devoted to healthy living and exercise to help maintain independence for as long as possible. Nevertheless, she and her family were realists. Planning was part of this, and they were all extremely well informed. Consequently, Christiana's Advance Care Plan was meticulous and detailed: it included consent in advance for any medications necessary to manage both her symptoms and behaviours if it came to that; her preference to be at home was clear, but she authorised whatever actions or interventions her family and clinical team agreed to be in her best interests. As her disease progressed, exercise became more difficult, as did leaving the house. Christiana's siblings held Lasting Powers of Attorney for health and welfare for her. As her disease progressed, exercise became more difficult as did leaving the house. Latterly, Christiana's dementia frequently led to her becoming trapped in a cycle of demands and behaviours that escalated in response to attempted negotiation. In discussion with her clinicians, the family were finding that increasingly the administration of medication was the only way to break these cycles of behaviour and to help with Christiana's anxiety.

Factors pointing away from a deprivation of liberty

- The extent and detail of her Advance/anticipatory Care Planning including her consent to medication required to manage her behaviours in such a way as to restrict her movements.

Note: it is Christiana's advance consent to the administration of medication with a sedative effect which is relevant here; not the fact that the siblings who are involved in administering it hold Lasting Powers of Attorney. An attorney does not have the power lawfully to deprive the donor of their liberty, or to seek to consent on their behalf to arrangements which confine them.

D: Questions for front-line practitioners

10.12 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? How often do these occur, and for how long?
- For what period will they endure?
- What are the effects on P 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?
- Is force or restraint (including sedation) being used to admit the patient to a hospital or hospice to which the person is resisting admission?
- Is force being used to prevent a patient leaving the place?
- Are they 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 substantially 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? To what extent? How is this done? How often does this happen, and for how long?
- Are family, friends or carers, prevented from moving the patient to another care setting or prevented from taking them out at all (even for a short period)?
- Is the patient prevented from going outside the place where they are being cared for (escorted or otherwise)?
- Is the patient's behaviour and movements being controlled through the regular use of medication or physical / environmental measures, for example seating from which the patient cannot get up, or by raised bed rails that prevent the patient leaving their bed?
- Do 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?

11. Further resources

Note: these chapters concentrate on resources relating to deprivation of liberty. Broader resources relating to the Mental Capacity Act 2005 can be found on the SCIE website.[i]

A: *Cheshire West* and its implications

- *Cheshire West* judgment, available on Bailii[ii].
- "**Psychiatry and the Law: An enduring interest for Lord Rodger**": The Lord Rodger Memorial Lecture 2014, a speech[iii] given by Lady Hale in October 2014, which includes a discussion of the judgment.
- *Deprivation of Liberty in the Shadows of the Institution*: [iv] a book (available for free online) by Lucy Series placing the decision in its longer-term context.
- *A Practical Guide to the Law of Deprivation of Liberty*[v]: a book by Ben Troke covering both what constitutes a deprivation of liberty and how to authorise it.

B: Procedures for the authorisation of deprivation of liberty

DOLS

- ADASS's forms[vi] for applications for DOLS authorisations (January 2015). Note: at the time of writing (January 2024), these are likely to be revised.

Judicial authorisation of deprivation of liberty[286]

- Practice Direction: 11A – deprivation of liberty applications[vii] (the material paragraphs for these purposes are paragraphs 27 and onwards).
- COP DOL11 form[viii].
- Model order[ix] (in Word).
- A guide[x] to **applications for judicial authorisation of deprivation of liberty** written by members of the 39 Essex Chambers Court of Protection team.

C: Other resources relating to deprivation of liberty

- DOLS Code of Practice[xi] (though Chapter 2 must now be read subject to the cases decided since the Guide was written – see paragraph 2.65-2.67 of the main body of this guidance).
- The work of the Nuffield Family Justice Observatory on deprivation of liberty of children..

[286] Note, all the documents in this section are under revision at the time of writing (January 2024).

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[i] https://www.scie.org.uk/mca
[ii] http://www.bailii.org/uk/cases/UKSC/2014/19.html
[iii] https://www.supremecourt.uk/docs/speech-141031.pdf
[iv] https://bristoluniversitypress.co.uk/deprivation-of-liberty-in-the-shadows-of-the-institution.
[v] http://www.lawbriefpublishing.com/product/deprivationofliberty/
[vi] https://www.gov.uk/government/publications/deprivation-of-liberty-safeguards-forms-and-guidance
[vii] https://www.judiciary.uk/wp-content/uploads/2022/09/pd-11a-deprivation-of-liberty-application-1.pdf
[viii] http://hmctsformfinder.justice.gov.uk/courtfinder/forms/cop-dol10-eng.pdf
[ix] https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fcourtofprotectionhandbook.files.wordpress.com%2F2019%2F02%2Fno.3-copdol11-draft-order.doc&wdOrigin=BROWSELINK
[x] https://www.39essex.com/information-hub/insight/judicial-deprivation-liberty-authorisations
[xi] http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087309.pdf